SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND SAFE ABORTION
The Problem and the Context in MENA

Introduction

The World Health Organization (WHO) first recognized unsafe abortion as a public health issue in 1967, and in 2003 it developed technical and policy guidelines for the States to pass abortion laws to protect women's health. The report mentioned that - "*It is likely that the numbers of unsafe abortions will continue to increase unless women's access to safe abortion and contraception – and support to empower women (including their freedom to decide whether and when to have a child) – are put in place and further strengthened.*

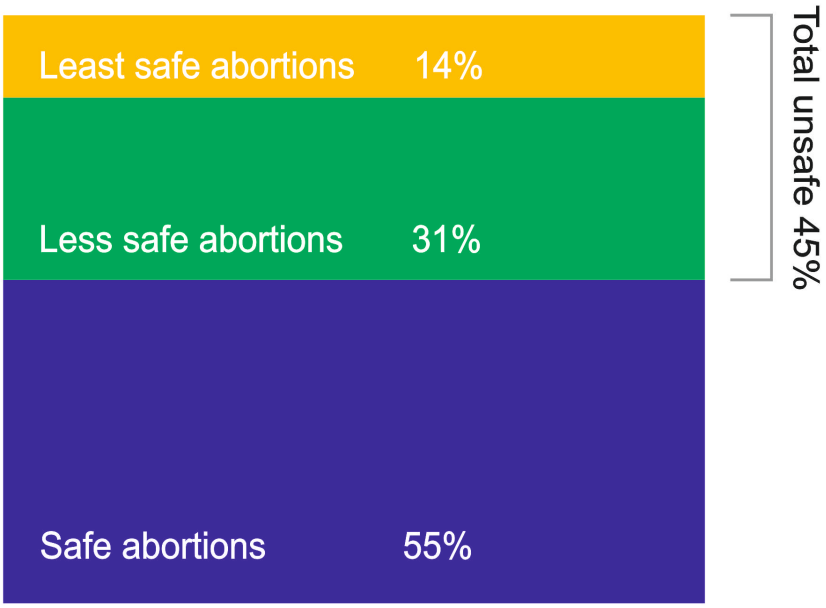
Sexual and reproductive health and rights have been recognized as key parts of the international development agenda. They also form part of two Sustainable Development Goals: numbers 3 (on good health and well-being) and 5 (on gender equality and empowerment). At the International Conference on Population and Development in 1994, 179 governments signed a program of action that included a commitment to prevent unsafe abortion. Though ICPC's final report did not recognize abortion as a woman's right, it emphasized that in the countries where it is legal, women should have access to safe medical procedures and that more research should be undertaken to understand the phenomenon. Providing timely, safe and quality post abortion care has been enshrined in many resolutions and agreements, such as ICPD; ICPD+5 and the Beijing Platform of Action, However, only the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa from 2003 (Maputo Protocol) recognizes abortion as a human right in specific circumstances. It states:

State Parties shall take all appropriate measures to ... protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.

Only a few North African countries have signed or ratified the Maputo Protocol, and those few have done so only very recently. In 2015, Beji Essebsi, then president of Tunisia, signed the protocol, but Tunisia did not ratify it until 2018, and laws have yet to be harmonized according to its principles. Sudan has signed but not ratified it. Algeria officially ratified the protocol in 2016, but its application is problematic, as abortion in the cases indicated above is not considered a human right under the country's laws. Mauritania ratified the protocol in 2005, but it has not changed its laws; abortion in Mauritania is still criminalized under article 293 of the Penal Code. Egypt, Morocco, and Libya have neither signed nor ratified the protocol.

Of the 73 million abortions that take place each year worldwide, an estimated 45% (35 million) of all abortions are unsafe (Guttmacher/WHO, 2019). Six out of 10 (61%) of all

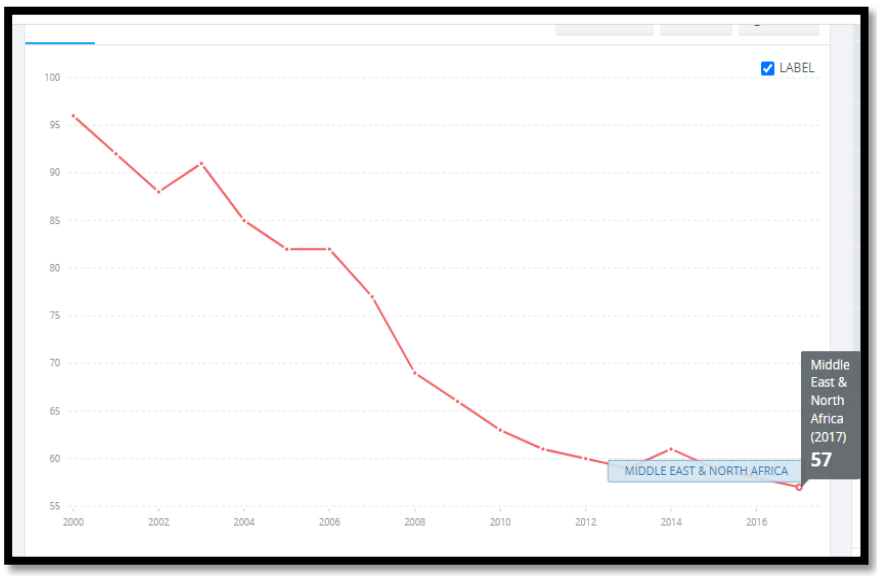
unintended pregnancies,



Source- Ganatra B et al, Global regional and sub-regional classification of abortion by safety ,2010-2014

Developing countries bear the burden of 97% of all unsafe abortions including the Middle East and Northern Africa region. MENA is highly diverse in socio-economic development, political systems, health indicators, women's status, official interpretations of Islam and individual religious expressions. While considered taboo, premarital sex and unwanted pregnancies are increasingly common among adolescents and young people in key countries across the region. Yet only a few governments – Iran, Morocco and Tunisia support sexual and reproductive health programs for young people.Although the overall abortion rate has declined, the proportion of unsafe abortions is increasing, especially in developing regions. Each year, 4.7–13.2% of maternal deaths can be attributed to unsafe abortion, In developed regions, it is estimated that 30 women die for every 100 000 unsafe abortions, in developing regions that number rises to 220 deaths per 100 000 unsafe abortions. There is strong evidence linking unsafe abortions with increased maternal morbidity and mortality and most abortion-related maternal deaths are due to unsafe and illegal abortions. Despite efforts to achieve Sustainable Development Goals (SDGs) 3 of reducing maternal mortality, maternal mortality remains a global challenge. The Countries in the MENA region have made tremendous progress in reduction of maternal mortality. The maternal mortality ratio (MMR) declined by about 50 per cent in the MENA region from 1990 to 2015 (from 220 to 110 maternal deaths per 100,000 live births).

Figure 2 – Maternal Mortality Ratio (Modeled estimate, per 100,000 live births) – Middle East and North Africa



Source – WHO, UNICEF, WBG and UN Population Division, Trends in Maternal Mortality-2000-2017. Geneva, WHO, 2019

The leading causes of maternal mortality in MENA have barely shifted since 1990. Pregnancy and delivery-related complications such as hemorrhage (20%), hypertensive disorders (15%), maternal sepsis and other infections (10%), obstructed labor (10%), and abortive outcomes (13%) endure as the major causes of maternal death. Together, these preventable causes accounted for almost 70 % of all maternal deaths in MENA.

Abortion is one of the oldest medical practices, evidence of which dates back to ancient Egypt, Greece, and Rome. Abortion techniques used by Egyptian pharaohs were documented in the ancient Ebers Papyrus (1550 B.C.). It is believed that during the Middle Ages, abortion techniques were adopted and accepted by Western Europe and later diffused across the globe. Today, medical and scientific advances have made abortion a safe procedure when offered under medical supervision and with high standards of care. Yet each year, thousands of women in MENA die and millions more are left with temporary or permanent disabilities because of unsafe abortion. Unsafe abortion is one of the most neglected public health challenges in MENA. Many women with unintended pregnancies resort to clandestine abortions that are not safe. According to the World Health Organization, around 1.5 million abortions in MENA in 2003 were performed in unsanitary settings, by unskilled providers, or both. Complications from those abortions accounted for 11 percent of maternal deaths in the region.

For many years the MENA region has been plagued by ongoing conflicts, detrimentally affecting the health status of the most vulnerable population, women and children. The WHO report, 6th edition, 2008 estimates the total number of maternal deaths in Arab countries to be 14,000 in 2007. Wars and displacement in the MENA region also contribute to high levels of maternal deaths (some of which are probably still related to unsafe abortion). The Fragile States Index, produced by the Fund for Peace, placed five MENA countries (Afghanistan, Iraq, Sudan, Syria, and Yemen) on “very high alert” or “high alert,” suggesting that these factors are likely to continue to affect maternal mortality in the near future. Outbreaks of diseases have been occurring in many parts of MENA region and particularly in countries affected by conflict. Outbreak of wild polio virus in Syria and cholera in Yemen are some examples of continued public health challenges in this region. Degradation of the health system in countries in the

region that are affected by conflict poses a serious challenge to the attainment of rights to health by women and children.

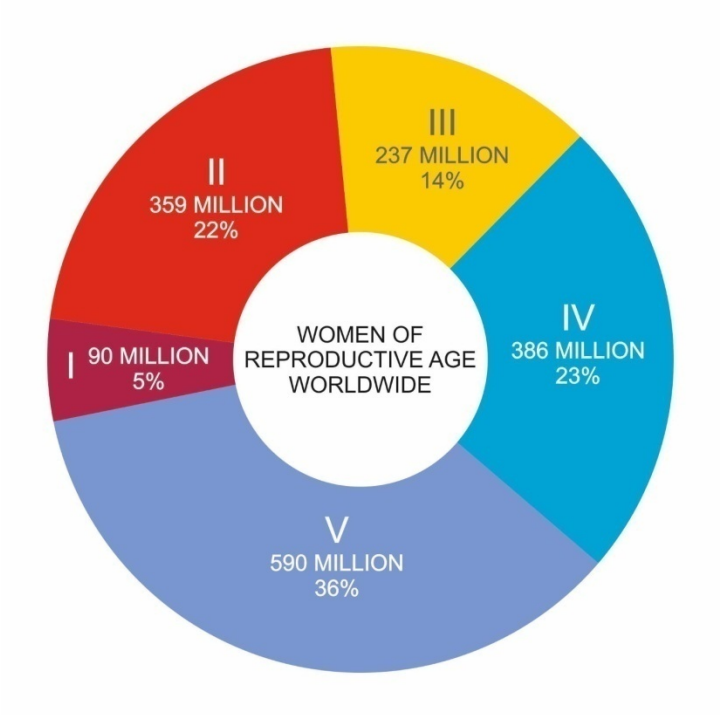
The impact of abortion bans on women's health in MENA region is understudied, and reliable data on unsafe abortion in countries where access to safe abortion is difficult or nonexistent are lacking. The reason is that states where abortion is illegal do not collect data on that topic (or at least do not make them public) and "social and political issues constrain the epidemiologic studies related to abortion. The occupied Palestinian territory is often absent from official statistics, as it is not recognized as a state.

Legal Context of Abortion

Throughout the world, there is considerable variation in abortion laws. Restrictive anti-abortion laws are associated with high rates of "less safe" and "least safe" abortions and are therefore seen as a determinant of maternal mortality.

Category of abortion laws from most to least restrictive countries

According to a United Nations (UN) report with data gathered up to 2019, abortion is allowed in 98% of countries in order to save a woman's life. Other commonly-accepted reasons are preserving physical (72%) or mental health (69%), in cases of rape or incest (61%), and in cases of fetal impairment (61%). The diagram below shows the categories from most restrictive to least restrictive countries for abortions



Category 1- Abortion is prohibited altogether (24 countries including 2 MENA countries)
The law do not permit abortion under any circumstances, including when the woman's life or health is at risk.

Category II - To save women's life (42 Countries including 7 MENA countries)

The laws of the countries permit abortion when the woman's life is at risk.

Category III - To prevent health (56 countries including 7 MENA countries)
The laws of countries permit abortion on the basis of health or therapeutic grounds. The countries permit abortion only when the woman's physical health is at risk. Algeria explicitly permits abortion to preserve the woman's mental health. WHO advises that the countries permitting abortion on health grounds should interpret "health" to mean ***"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."***

Category IV - Broad social or economic ground (14 countries- No MENA country)
These laws are generally interpreted liberally to permit abortion under a broad range of circumstances. These countries often take into account a woman's actual or reasonably foreseeable environment and her social or economic circumstances in considering the potential impact of pregnancy and childbearing.

Category V- On request - Gestational limits vary (73 countries- 2 MENA Countries)
All Countries in this category have gestational limits of 12 weeks unless otherwise indicated. Gestational limits are calculated from the first day of the last menstrual period, which is considered to occur two weeks prior to conception. Where laws specify that gestational age limits are calculated from the date of conception, these limits have been extended by two weeks

Table 1 Countries under each category of abortion laws from most to least restrictive countries

Category 1	Category 2	Category 3	Category 4	Category 5	Indicators
Egypt Iraq	Bahrain Lebanon Libya Oman Sudan Syria UAE (F, SA, PA) Yemen (SA)	Algeria Jordan Kuwait (F SA PA) Morocco(SA) Qatar (F) Saudi Arabia (SA PA)	No County from MENA	Tunisia Turkey	F-Abortion permitted in Fetal impairment R- Abortion permitted in case of Rape) (SA-Spousal Authorization required PA- Parental Authorization Required

Unsafe abortion, Intersectionality & economic costs

It is not just about unsafe abortion but the intersectionality-social, cultural, political, and economic processes that affect our lives. It must address the interlocking effects of identities, oppressions, and privileges to fully understand the range and complexity of women's experiences. Women and men not only experience the effects of gender in their lives, but they are also affected by their race, ethnicity, class, sexual orientation, and (dis)ability, among other aspects of their identities. These identities do not operate separately from one another, but work in tandem to shape the social, cultural, economic, and political

conditions of individuals and social groups (Kimala Price, *San Diego State University, Department of Women's Studies, San Diego, California, 2011)*

Restrictive abortion regulation can cause distress and stigma, and risk constituting a violation of human rights of women and girls, including the right to privacy and the right to non-discrimination and equality, while also imposing financial burdens on women and girls. Regulations that force women to travel to attain legal care, or require mandatory counseling or waiting periods, lead to loss of income and other financial costs, and can make abortion inaccessible to women with low resources. Whether legal or illegal, abortion is frequently censured by religious teachings and ideologies, hidden due to fear of reprisals or because of social condemnation and restrictive laws, whether de facto or de jure.

Lack of access to safe, affordable, timely and respectful abortion care, and the stigma associated with abortion, pose risks to women's physical and mental well-being throughout the life-course. Inaccessibility of quality abortion care risks violating a range of human rights of women and girls, including the right to life; the right to the highest attainable standard of physical and mental health; the right to benefit from scientific progress and its realization; the right to decide freely and responsibly on the number, spacing and timing of children; and the right to be free from torture, cruel, inhuman and degrading treatment and punishment.

WHO fact sheet, 2021 mention that unsafe abortion is a leading, but preventable, cause of maternal deaths and morbidities. It can lead to physical and mental health complications and social and financial burdens for women, communities and health systems. Lack of access to safe, timely, affordable and respectful abortion care is a critical public health and human rights issue (WHO fact sheet, 2021). It called for Comprehensive abortion care which includes the provision of information, abortion management and post-abortion care. It encompasses care related to miscarriage, induced abortion, incomplete abortion and fetal death & is included in the list of essential health care services, WHO, 2020.

In Turkey, in 1983, in response to population growth, the government passed a law allowing fertility regulation, termination of pregnancy on request up to 10 weeks after conception, and sterilization. A married woman seeking an abortion was required only to obtain her husband's permission or submit a formal statement of assumption of all responsibility prior to the procedure. In recent years, however, President Erdogan has taken a pronatalist stance and urged Turkish couples to have at least three children. Since 2012, he has been calling abortion murder, expressing opposition to the provision of abortion services and threatening to restrict the law. Women protested against these threats in such large numbers in 2012 that to date there have been no changes to the law itself. But administrative changes were made in order to make the procedure for booking an appointment for an abortion which is still primarily provided by gynecologists in hospitals more difficult.

A report from Turkey describes the situation in rural areas: "Despite the liberal nature of the abortion law, the number of legal abortions up to 10 weeks performed in the country has been sharply restricted by the requirement that the procedure be carried out only by or under the supervision of gynaecologists. This factor is especially critical in rural Turkey, where medical specialists of any type are uncommon. Many rural health facilities that are without a trained specialist are excluded from providing services. Consequently, a rural Turkish woman seeking an abortion within the first 10 weeks of pregnancy may not be able to obtain one.

In a recent study from Gabon, it was noted that the cultural stigma of abortion affected attitudes of health personnel, leading to their indifference for women seeking treatment for abortion-related complications. The estimated mean time between diagnosis and initiation of treatment for women with abortion-related complications was 23.7 hours, compared with 1.2 hours for women with postpartum hemorrhage or eclampsia. The authors conclude that women who died of abortion complications "were not given attention in as timely a manner as those needing care for other pregnancy-related complications. Given the relevance of the length of time between admission to hospital and the initiation of treatment as a principal determinant of life or death, it is hard not to conclude that postponement of treatment in the case of women who died from abortion-related complications was partially responsible for the fatal outcomes. Estimates from 2006 study show that complications of unsafe abortions cost health systems in developing countries US$ 553 million per year for post-abortion treatments. In addition, households experienced US$ 922 million in loss of income due to long-term disability related to unsafe abortion, Countries and health systems could make substantial monetary savings by providing greater access to modern contraception and quality induced abortion.

A set of scoping reviews from 2021 indicate that abortion regulations – by being linked to fertility – affect women's education, participation on the labor market and positive contribution to GDP growth. The legal status of abortion can also affect children's educational outcomes, and their earnings on the labor market later in life. For example, legalization of abortion – by reducing the number of unwanted pregnancies and thus increasing the likelihood that children are born wanted – can be linked to greater parental investments in children, including in girls' schooling

Summary

The path toward safer abortions is clear: The benefits of expanding legal grounds for abortion begin to accrue as soon as women no longer have to risk their health by resorting to clandestine abortion. Although legality is the first step toward safer abortion, legal reform is not enough in itself. It must be accompanied by political will and full implementation of the law so that all women—despite inability to pay or reluctance to face social stigma—can seek out a legal, safe abortion.

In MENA, reform efforts, including progressive interpretations of Islam, have resulted in laws allowing for early abortion on request in two countries; six others permit abortion on health grounds and three more also allow abortion in cases of rape or fetal impairment. However, medical and social factors limit access to safe abortion services in all but Turkey and Tunisia. To address this situation, efforts are increasing in a few countries to introduce post-abortion care, document the magnitude of unsafe abortion and understand women's experience of unplanned pregnancy. Religious fatāwa have been issued allowing abortions in certain circumstances. An understanding of variations in Muslim beliefs and practices, and the interplay between politics, religion, history and reproductive rights is key to understanding abortion in different Muslim societies. More needs to be done to build on efforts to increase women's rights, engage community leaders, support progressive religious leaders and government officials and promote advocacy among health professionals.