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Assessment of Safe and Unsafe Abortion among Palestinian Women in Hebron Governorate in Southern West Bank- Palestine

Conducted by

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Jerusalem

January 2015

Acknowledgments

As part of a broader project, this research was funded by the Safe Abortion Action Fund (SAAF) whose assistance and support are gratefully acknowledged.

Conducting this study couldn't have been possible without the sincere efforts and commitment of many people who contributed to its making. I first thank Ms. Amina Stavridis- Executive Director of the Palestinian Family Planning and Protection Association for her trust, support and flexibility in the overall supervision of this study throughout its completion.

The dedication of Ms. Iman Jadou in fieldwork coordination and follow up is much appreciated. My gratitude extends to PFPPA staffs; Fatmeh Raba'i, Maysa Shaladeh, Ayesha ElHour, and Ruba ElWawy who collected the quantitative data from the targeted women and to Muhammad Abu Areesh and Dana Sharif for serving as the note takers in the focus group discussions and experts meeting. Ahmad Buirat diligent work on the quantitative data entry and statistical analysis is also highly valued.

Palestinian Family Planning and Protection Association and I are grateful to all colleagues and experts who responded to our invitation to participate in the focus group discussions or the experts meeting assisting us to cherish our goal in this project.

Last but not least, we owe sincere thanks to each and every woman whose contribution constituted an invaluable substance in this study; thanks for their time, honesty and courage to participate and answer such critical and sensitive questions that touch on their intimate life experiences and spaces; to them all we shall remain obliged.

Executive Summary

This assessment employed a descriptive cross-sectional mixed-method approach to address the question of abortion with particular emphasis on unsafe abortion of women in Hebron governorate- Southern West Bank- Palestine. In the quantitative part of the study, women attending the PFPPA clinics and service delivery points at four urban and rural sites were targeted with a questionnaire. Using purposive non-random sampling method, a total of 541 participants was chosen from women who had at least one abortion experience during their lifetime and are service users at the said facilities.
At the qualitative part of the study various stakeholders were interviewed using different interviewing format. Two focus group interviews were conducted; the first was with health and social work professionals selected from MOH and NGOs while the second was with the PFPPA staff solely. At the macro policy and strategic levels, expert opinion was solicited through a small group interview with selected stakeholders being senior service providers, managers, policy makers or planners in the areas of; healthcare, human rights, law and social work. A total of 21 professionals and experts participated in this qualitative study component.

The study sheds some light and provided insights on abortion experience spontaneous and induced; safe and unsafe as well as pertinent reproductive health aspects such as age of marriage, age at first childbirth, and family planning methods use and none-use. It evidently showed that abortion is not a rare experience for Palestinian women in Hebron-Southern West Bank. The overall percent of women who experienced abortion at least once in their lifetime was more than 70 % of the total. Around 49% of the participants confidants told them they too underwent the same experience. Of the total; around half were married, more than 40% had their first pregnancy and 28% had their first childbirth, all at18 years of age or less.

Family planning methods utilization pattern and reasons for none-use indicate that women still endure the major burden and responsibility for family planning. Despite the highest safety, effectiveness and none-invasiveness of the male condom its utilization remains pretty low (7.7%) compared with the invasive women used methods particularly noting the IUDs (64.5%). Furthermore, in more than 40% of those who do not use a family planning method, the husbands' unwillingness to use a method or let the wife use one is the reason for the none-use. As such, family planning methods utilization pattern and reasons for none-use provide strong evidence on gender inequity in decision making power within the Palestinian family even with regards to matters that relate to and directly impact the women's life, body and wellbeing in the first place. It also rings the bell as to the role and usefulness of the relevant health education and awareness raising efforts that have been going on for years now without reaping fruit.

Back to abortion, among those who reported having gone through abortion, two thirds (66.3%) had more than one abortion; more than a tenth (11/3%) had it induced and more than two thirds (60.5%) had it spontaneous. But then spontaneous does not necessarily imply complete abortion especially noting that around 50% of the aborted women

received treatment for incomplete abortion which ranked first in the participants service utilization of post-abortion care. In addition, sever vaginal bleeding was the complication endured by most (52.2%). Furthermore, more than two thirds (67.6%) of the conducted abortions were clandestine covertly done with the prior knowledge of nobody except the woman herself. This is an extremely hazardous and vulnerable position that the woman opts for in an issue that is a fundamental human right to her: the right to choice and the right to bodily integrity. The reason/s why would a woman choose to take this risky path is a suggested area for future qualitative research.

A total of 46% of the aborted women articulated having experienced negative feelings of sin, guilt, regret and self blame implied in killing their own babies when they were asked about how they felt after abortion. About obstacle encountered in relation to abortion the most reoccurring obstacles women reported were: compelled home abortions due to the presence of military checkpoints. Continuous bleeding, absence of any form of support, lack of awareness about abortion altogether, prolonged hospitalization days until full recovery from post-abortion complications, fear from psychological effects, financial difficulties in relation to covering pertinent expenses and strike in hospitals. Surprisingly, none of them mentioned anything related to abortion service availability as per se although abortion is not a service on offer as was agreed by all.

Beyond the participants themselves, of their total, 48.98% (n=265) said a female relative or friend confided to them about a personal experience of abortion that was induced for 81.1% (n=215). This presents further evidence about abortion being not insignificantly occurring in Palestine despite prohibitive laws and traditions of blame, sin and guilt.

Interpreting the findings on women's knowledge about abortion it should be observed that the responses come from PFPPA service users. Given that abortion services including education is part of PFPPA mandate, these respondents have a particularly biased exposure to information on abortion. Nevertheless these findings indicate that women still hold wrong information about such critical issues that hold significant implications for the direction, intensity and focus of any future awareness raising campaign on abortion. For example, around a half (49.5%) thinks that appearance of signs like high temperature, pain, and persistent bleeding for a long period of time is considered normal post-abortion and so don't warrant concern. Around two thirds (56.90%) agree that pregnancy does not happen but after 40 days of abortion. Therefore using a family planning method can be started any time during that period. Around 15% said that a woman who experiences abortion must get pregnant immediately. And a majority (93.0%) agrees that abortion is absolutely prohibited religiously except in cases where continuing the pregnancy poses a risk to the woman's life.

The qualitative part of the study generated information rich data on various aspects of from the perspective of the stakeholder being service providers, policy makers or planners in healthcare, human rights, law and social work.
In focus group discussions and experts interview ample evidence on the lack of recognition of women right to health (RTH) unfolded. Discussions showed that there is no information given by health professionals to women about available abortion services

because such services are not openly available at the first place. Hence women rarely go to health institutions for abortion. Abortion is not an accepted or encouraged practice; not by healthcare providers themselves or by the wider public. There is no clinic known to women where they can get an abortion, if they need. Therefore, rather than being guided by professional information and practice, women abortion experiences are largely shaped by; female family members, *dayas* or traditional healers' remedies, advices and harmful unsafe practices. Furthermore, women have no clue about; psychosocial counseling they are entitled to as part of post-abortion services, emergency contraception and its role in unwanted pregnancy prevention, or about incomplete spontaneous abortion among women. Therefore aborting women don't take signs of incomplete abortion seriously until they become too grave with serious post-abortion complications. This includes the most commonly reported one of sever vaginal bleeding that compels long hospital stay until recovery and so rises the healthcare cost for an already overburdened health system.

Participating service providers and experts' accounts of women experiences with spontaneous and induced abortions suggest the presence of serious gaps and deficits in human right based approach to service provision alongside utter gender insensitivity. They also reveal important legal, extra-legal and procedural barriers to women access to dignified abortion information and services that deserve utter professional attendance.
Legally and technically, only hospitals are entitled to conduct abortions and only under tight grounds of religious permissibility and medical necessity that is restricted to pregnancy posing a threat to the woman's life.

Family planning methods despite being on offer with high affordability for women yet the margin of unmet needs remains attention drawing. This is because; information about their availability is lacking, women are reluctant to use a method due to distrusting the effectiveness of the methods or largely due to spousal objection. As a result, in cases of unwanted pregnancy these women resort to home induced abortion using numerous risky homemade procedures and remedies.

As for counselling and education regarding abortion, participants agreed that psychological counselling for women is nonexistent expect in few NOGs where pre and post abortion counselling is part of the routine work in line with the mandate of the organisation. Overall however, participants confirmed that there is an obvious lack of information about abortion among healthcare providers themselves which explains the reason why they do not exert much effort to educate women let alone men about the subject.

Concerning barriers to access abortion, participants talked about procedural that include legal barriers and extra-legal that include all others. Collectively, they brought out numerous barriers they recognize are present, some low profiled and some more visibly. These include; institutional and legal restrictions on abortion performing institutions (hospitals), conscientious objection toward abortion among healthcare providers, lack of providers' professional practice regarding abortion, abortion as a taboo both normatively and religiously was a strongly held notion amongst participants most alarmingly health professionals, lack of government commitment by influence of religion and right to

abortion unconvinced public opinion, imposition of 'extra' requirements, and finally exceptional barriers faced by women with extramarital pregnancy resulting from rape or incest.

In terms of inter-organisational collaboration and health system preparedness participants first emphasized the needs to tackle abortion as a whole and not in a fragmented manner; including both spontaneous and induced abortion. Because of all the associated compounded stigma and infidelity accusations that could be brought to the table to combat activism for improved abortion information, services and laws those who work on the subject have wisely gone for the collective approach in the form of coalition building and should continue to do so in expansion. Those of them who were interviewed in this study agreed that the abortion coalition is a platform that augments all efforts for achieving the changes aspired for through campaigns of lobbying, persuasion and pressuring policy makers and political leadership to put the question of abortion on the development map and national strategic health plans, participants agreed. This includes integration of abortion related indicators into national maternal health database to be reported on in the PCBS future health surveys and MOH annual report, they emphasised. Harm reduction model given its great potential to enhance the health system preparedness to the gradual realisation of the women RTH as regards to abortion information, services and legal liberalization within the boundaries of enlightened Islamic Shari'a, was one elucidating point one lead expert articulated.

Experts particularly noted that except for the conventional D&C/E&C that is therapeutically performed in hospitals for incomplete abortions, for the Ministry of Health abortion is not on the agenda in any other way. It is not an included part of any policy document, any strategic or operational plan, any technical protocol, any awareness campaign, any training activity, any service program, or any recognized healthcare/outcomes report. This means that MOH needs to substantially invest in every aspect and level of these so that it can appropriately and effectively address abortion care as comprehensive and strategic as it should rightly be, all agreed.

In conclusion, this study provided compelling evidence on the need for open and increased provision with quality abortion related services. Abortion services with appropriate control measures, clear professional and administrative protocols and technical guidelines in place must be made universally available to women under a revised enlightened abortion law. The qualitative and qualitative data this study engendered on abortion with the recognition of them being largely rooted in the extremely tight relevant laws must trigger sincere efforts for the amendments and redress of these exclusivist laws with full sensitivity to the cultural context and in line with the insightful interpretations of Islamic principles.

In light of the above, made recommendations fall into the four broad domains of action; at the public opinion front, advocacy for accurate understanding of liberal Islamic abortion law done in full active engagement of religious leaders to secure religious coverage and optimize credibility of such critical religion based arguments. Presence and

active participation of Parliamentarians could be a strategic lobbying move toward setting the scene for the anticipated legal intervention.

At the legal front, advocacy, networking and lobbying for liberalisation of the present abortion laws and pertinent regulations is an imperative need. This study emphasised that existing Palestinian laws and regulations on abortion are extremely tight and restrictive depriving women of their basic human right to health and impact their physical and psychological health adversely. In addition, these laws are totally inconsiderate of the duty bearers' right to protection in relation to their role as service providers including in the case of abortion services and care. Therefore, advocacy for the removal of legal barriers to women's access to abortion is strongly recommended. New legal provisions whether in penal law or public health law or else are all subject to progressive amendments aimed at respecting, protecting and fulfilling the human rights of right holders who are women and their families at the recipients and duty bearers who are men and women at the provision end of the care giving process. Discourse creation is one effective entry point to create and encourage visibility, familiarity and questionability about existing laws and regulations both within professional and public spaces with the view of eventual elimination of all legal barriers to safe abortion.

At the human rights front, MOH policy and institutional strengthening to conform to RTH realisation and enhance synergy with abortion coalition activism is the third recommendations domain. This imposes an obligation for MOH to move forward as effectively as possible to the maximum of available resources. In this context, it is important to distinguish the inability from the unwillingness of the State to comply with its right to health obligations as a signatory to relevant international treaties. Review and modification of existing abortion law is certainly one ability domain for the Ministry to act upon as the lead national body in charge of health of all Palestinians.

In terms of health specific policies, it is recommended to develop, implement and monitor service delivery protocols that are rights-based. In the same line, it is recommended to conduct values clarification training with all management, volunteers and staff, including clinic staff, to ensure all support a woman's right to choose to terminate an unwanted pregnancy and commitment to the respectful dignified provision of abortion-related services for all. Adoption, implementation and monitoring of ; a clear policy on conscientious objection with women's rights at the heart of it, a policy that facilitates women's access to abortion, including to medical abortion, and development and monitoring the effectiveness of referral networks for abortion services are three highly recommended policy level interventions.

At the healthcare front, all women's healthcare providers must redress information and healthcare service delivery with respect to abortion and reproductive health more broadly. No unwanted pregnancy should happen so that abortion, especially the unsafe, is brought to a minimum. Unmet family planning must be addressed. This means that consistent universal awareness campaigns for information dissemination about available family planning methods with particular emphasis on emergency contraception and male condom must be a prime target. Furthermore, affordability of family planning services

and choices within them must be maintained alongside making women informed about this affordability as well as about contraceptive methods failure rates to enable women make an informed choice about the method most convenient to her.

Across the board, lack of information was a major finding in this study. More effective means of providing information and education on the subject of abortion are required. The collaboration between key players is a basic requirement to ensure success by increasing knowledge as a preventive level intervention. Early introductions of pertinent information entails ending selective traditional approach to offering reproductive and sexual health education in school health education to raise the level of male and female youth preparedness to deal with issues arising from ignorance in relation to sexuality, rape, incest where girls and women at home and in schools could suffer the consequences without knowing what to do about them.

The study showed important deficits in post-abortion care and the management of abortion complications which are very essential strategies to prevent and reduce the number of unsafe abortions. Appropriate protocols and guidelines for health service professionals are much needed for ensuring equity of access and quality of the offered healthcare services. Strengthening and expanding existing alliances such as the abortion coalition and development of new ones with other NGOs, women and governance organizations can support women's access to abortion services, particularly those who cannot afford the services.

The study revealed the presence of significant procedural (including legal) and extralegal barriers to the already restricted abortion services and care on offer. These are all subject for thorough inspection, revision and rectification guided by the harm reduction model anchored in human rights principles. Currently, these principles are not respected, protected or fulfilled vis-à-vis the question of safe abortion and comprehensive abortion care for women in Palestine. This was found to be connected to the evident lack of healthcare providers' recognition of and commitment to the woman human right to health which was a key finding in this study. Hence, under the conscientious objection argument for example, some professionals interviewed in this study articulated their perceived entitlement to refuse to provide the needed information let alone services to women in relation to abortion. Conversely, the rights-based arguments for the provision of abortion services are founded in basic human rights, namely a woman's right to bodily integrity and autonomy. Given the Palestinian highly restrictive social and legal environment in this regard, it is strongly recommended to adopt and promote the harm reduction model in implementing comprehensive abortion care.

In closure, for more informed data driven planning, replicating this study in the other governorates is recommended for a fuller picture. In addition, other complementary methodologies including national surveys with random sample selection and in-depth qualitative research would serve as appropriate quality checks and add to the credibility and trustworthiness of this study results, or rectify them. Both ways, the outcome is that women's health benefits and progress in MDG5 on maternal health improvement is enhanced.

الملخص التنفيذي

هذه دراسة تقديرية وصفية مقطعية أعتُمد فيها المنهج المختلط في تناول مسألة الإجهاض، مع تركيز خاص على الإجهاض غير الآمن بين النساء في محافظة الخليل جنوبي الضفة الغربية - فلسطين. في الجزء الكمي من الدراسة، تم استهداف النساء اللواتي حضرن الى عيادات جمعية تنظيم وحماية الأسرة الفلسطينية ونقاط تقديم الخدمة في أربعة مواقع في المناطق الحضرية والريفية في المحافظة بواسطة الاستبيان، حيث باستخدام الطريقة القصدية غير العشوائية في سحب العينات تم اختيار ما مجموعه **541** أمرأة من النساء اللواتي مررن بتجربة الإجهاض مرة واحدة على الأقل خلال سني حياتهن ويتلقين الخدمة في المرافق المذكورة للجمعية. أما في الجزء النوعي من الدراسة فقد أجريت مقابلات مع أطراف مختلفة من الجهات المعنية باستخدام نمط مختلف من المقابلات تبعا للجهة المستهدفة. أجريت مقابلتين مع مجموعتي نقاش بؤرية ؛ كان أولها مع العاملين في مجال الصحة والعمل الاجتماعي مع عينة مختارة من العاملين في وزارة الصحة والمنظمات غير الحكومية بينما كانت الثانية مع موظفي جمعية تنظيم وحماية الأسرة الفلسطينية بشكل خاص. وعلى الصعيد السياساتي والاستراتيجي، فقد تمت مقابلة مجموعة واحدة منتقاة من الخبراء الذين يحتلون مواقع متقدمة في مؤسساتهم كمقدمي خدمات اومديرين أوصانعي سياسات أو مخططين في مجالات الرعاية الصحية، وحقوق الإنسان، والقانون والعمل الاجتماعي. وقد شارك ما مجموعه **21** من المهنيين والخبراء في الجزء النوعي من الدراسة.

تلقي هذه الدراسة الضوء وتبصّر المعنيين حول تجربة الإجهاض، تلقائيا كان أو متعمداً، آمنا أو غير آمن، بالإضافة إلى جوانب الصحة الإنجابية ذات الصلة مثل سن الزواج والعمر عند الولادة الأولى، واستخدام وسائل تنظيم الأسرة وعدم استخدامها. أظهرت الدراسة بشكل قطعي بان الإجهاض ليس تجربة نادرة للمرأة الفلسطينية في محافظة الخليل- جنوب الضفة الغربية. فقد بلغت القيمة الإجمالية للنساء اللاتي تعرضن للإجهاض مرة واحدة على الأقل في حياتهن أكثر من **70**٪ من مجموع المشاركات. ولحوالى **49**٪ من المشاركات أسرّت نساء مقربات بخضوعهن لنفس التجربة ايضاً. من مجموع المشاركات؛ حوالي النصف كن قد تزوجن، وأكثر من **40**٪ حملن للمرة الأولى، و **28**٪ وضعن للمرة الأولى ، هذا كله وهن ما زلن في سن **18** عاما أو أقل.

كشفت انماط استخدام وسائل تنظيم الأسرة وأسباب عدم الاستخدام التي بينتها الدراسة بأن المرأة لا تزال تتحمل العبء الأكبر والمسؤولية عن تنظيم الأسرة. وعلى الرغم من أعلى مستويات السلامة والفعالية والاستخدام الخارجي للواقي الذكري بقيت مستويات استخدامة منخفضة جدا (**7.7**٪) مقارنة بالوسائل النسائية التدخلية الداخلية الاستخدام. وبشكل خاص فقد سجل اللولب قيمة مقدارها **64.5**٪ للإستخدام بين النساء المشاركات. علاوة على ذلك، ففي أكثر من **40**٪ من النساء اللواتي لا يستخدمن أية وسيلة من وسائل تنظيم الأسرة فإن عدم رغبة الأزواج لاستخدام وسيلة أو السماح للزوجة باستخدام واحدة هو السبب في عدم استخدام أي منها. على هذا النحو، فإن أنماط استخدام وأسباب عدم استخدام وسائل تنظيم الأسرة تقدم دليلا ساطعا على الظلم المبني على النوع وعدم المساواة بين الجنسين في مساحة صنع القرار داخل الأسرة الفلسطينية حتى فيما يتعلق بالمسائل التي تؤثر تأثيرا مباشرا وتمس بحياة وجسد المرأة وعافيتها في المقام الأول . وكذلك فإن هذه النتائج أيضا تدق ناقوسا بشأن جدوى ومردود مبادارات وجهود التثقيف الصحي والتوعية ذات الصلة التي ما برحت مستمرة منذ سنوات حتى الآن دون جني الثمار.

وبالعودة إلى الإجهاض، من بين النساء اللآتي افدن بمرورهن بتجربة الإجهاض فقد خضعت ثلثي (**66.3**٪) المشاركات للإجهاض لأكثر من مرة واحدة؛ ولأكثر من العُشر (**11/03**٪) كان الإجهاض متعمدامقارنة بأكثر من الثلثين (**60.5**٪) ممن اجهضن تلقائياً، علما بأن هذا لا يعني بالضرورة بأن الإجهاض كان كاملا خصوصا وأن حوالي **50**٪ من النساء المجهضة قد تلقت العلاج للإجهاض غير المكتمل،ما وضع هذه الخدمة بالذات في المرتبة الأولى من حيث استخدام المشاركات لرعاية ما بعد الإجهاض، كما وأن النزيف المهبلي الحاد قد كان المضاعفات

الأكثر حدوثاً (52.2٪)بين صفوف النساء المشاركات في الدراسة. علاوة على ذلك، فإن أكثر من ثلثي (67.6٪) حالات الإجهاض كانت قد أجريت بمنتهى السرية دون معرفة مسبقة من أحد سوى المرأة نفسها، ما يضعها في حالة غاية في الخطورة والإنكشاف في شأن هو حق إنساني أساسي لها: الحق في الاختيار والحق في السلامة الجسدية. وأما الأسباب التي تدفع المرأة لأن تختار مثل هذا الطريق المحفوف بالمخاطر فهي مجال مقترح للبحث النوعي في المستقبل.

عندما سُئلن عن شعورهن فيما بعد الإجهاض، أفادت ما مجموعه 46٪ من النساء المجهضات بمعاناتهن من العديد من المشاعر السلبية كالإحساس بارتكاب خطيئة والشعور بالذنب والندم ولوم النفس لما يتضمنة الإجهاض من قتلٍ لأطفالهن، حسبما يعتقدن. أما عن العقبات التي واجهتها النساء فيما يتعلق بالإجهاض فقد كانت أكثر العقبات تكراراً هوإضطرارهن للإجهاض المنزلي القصري الناجم عن وجود الحواجز ونقاط التفتيش العسكرية. تلا ذلك النزيف المستمر، وغياب كافة أشكال الدعم، ونقص الوعي حول الإجهاض عموما، وطول ايام المكوث في المستشفى حتى الشفاء التام من مضاعفات ما بعد الإجهاض، والخوف من الآثار النفسية، والصعوبات المالية فيما يتعلق بتغطية النفقات ذات الصلة وإضراب المستشفيات. والمثير للدهشة هو أن أياً من النساء لم تأت على ذكر مسألة توفر خدمة الإجهاض بحد ذاتها على الرغم من أن الإجهاض ليس خدمة معروضة أو متاحة كما اتفق عليه الجميع. علاوة على المشاركات أنفسهن، افادت 48.98٪ (ن = 265) منهن بأن صديقة أو قريبة قد اسرّت لهن عن تجربة شخصية لها بالإجهاض، من أولئك أفصحت 81.1٪ (ن = 215) بأن تلك الأجهاضات كانت متعمدة، ما يقدم دليلا إضافيا حول أن الإجهاض يجري بقدر لا يستهان به في فلسطين رغما عن القوانين المكبّلة والتقاليد اللوامة والمخطّئة والمذنّبة.

عند تفسير النتائج المتعلقة بمعرفة النساء حول الإجهاض يجدر الملاحظة بأن الاستجابات تأتي من النساءالمنتفعات من خدمات جمعية تنظيم وحماية الأسرة،حيث التوعية جزء لا يتجزأ من خدمات الإجهاض المقدمة في كافة مواقع تقديم الخدمات التابعة للجمعية، وبذا فإن هذه العينة منحازة حكماً جرّاء تعرضها وخبرتها المتضمنة لمعلومات حول الإجهاض.ومع ذلك، تظهر هذه النتائج أن المرأة ما زالت تحمل معلومات خاطئة عن قضايا هامة كهذه، الأمر الذي له دلالاته على اتجاه وغزارة وتركيز وكثافة حملات التوعية المستقبلية الخاصة بالإجهاض. فعلى سبيل المثال، تعتقد حوالي نصف المشاركات (49.5٪) بأن ظهور علامات كارتفاع درجة الحرارة والشعور بالألم بالاضافة الى النزيف المستمر لفترة طويلة من الزمن أمورا طبيعية الحدوث بعد تعرض النساء للإجهاض وان ذلك لا يدعوا الى القلق. بينما تؤمن نحو الثلثين (56.90٪) منهن بأن فرصة الحمل لا تحدث بعد الاجهاض مباشرة وانها تحتاج الى ما بعد 40 يوما ليتحقق ذلك وانه بامكان النساء المجهضات استخدام وسائل تنظيم الأسرة في أي وقت خلال هذه الفترة. وقالت حوالي 15٪ منهن بأنه على المرأة التي تتعرض للإجهاض الحمل مجددا على الفور. بينما تتفق أغلبية بلغت (93.0٪) على أن الإجهاض أمر محظور تماما دينيا باستثناء عندما يشكل الحمل خطرا على حياة المرأة إذا ما استمرت به.

أما الجزء النوعي من الدراسة فقد ولّد بيانات غنية بالمعلومات حول العديد من النواحي ومن مناظير مختلفة لأصحاب العلاقة بمن فيهم مقدمي الخدمات، وصانعي السياسات والمخططين في مجال الرعاية الصحية، وحقوق الإنسان، والقانون والعمل الاجتماعي. وتكشفت أدلة وافرة حول قصور كبير في الاعتراف بحق المرأة في الصحة وذلك في كل من مجموعات النقاش البؤرية ومقابلات الخبراء. وأظهرت النقاشات أنه لا يوجد أية معلومات مقدمة من العاملين في مجال الصحة للنساء حول خدمات الإجهاض المتاحة لأن مثل هذه الخدمات غير متوفرة علنا في المقام الأول، لذا فإن المرأة نادرا ما تقصد المؤسسات الصحية للإجهاض، فممارسة الإجهاض لا تلقى القبول اوالتشجيع لا من قبل مقدمي الرعاية الصحية أنفسهم ولا من قبل الجمهور الأوسع بشكل أعم ، إذ ليست هناك عيادة معروفة للنساء حيث يمكن لهن الحصول على خدمات الإجهاض، عند الحاجة. لذلك، فبدلا من أن تسترشد النساء وتستند الى المعلومات والممارسة المهنية في ذلك، تصيغ تجربتها مع الإجهاض نصائح ووصفات وممارسات ضارّة وغير آمنة تتلقاها من نساء الأسرة، والدايات والمعلاجات التقليديات. وعلاوة على ذلك، فإن النساء ليس لديهن أدنى فكرة عن

المشورة النفسية والاجتماعية التي يستحقّينها كجزء من خدمات ما بعد الإجهاض وموانع الحمل الطارئة ودورها في الوقاية من الحمل غير المرغوب فيه، أو الإجهاض التلقائي غير المكتمل. وبالتالي فإن النساء المجهضات لا تأخذ علامات الإجهاض غير المكتمل على محمل الجد قبل ان تبلغ مستوى تحدث فيه مضاعفات خطيرة بما في ذلك النزيف المهبلي الحاد والأكثر شيوعا والذي تضطر المرأة جراءة الى المكوث في المستشفى فترة طويلة حتى الشفاء، ما يرفع تكلفة الرعاية الصحية في نظام صحي مثقل أصلاً.

تدل شهادات مقدمي الخدمة والخبراء حول خبرات النساء مع الإجهاض التلقائي والمتعمد على وجود ثغرات هائلة وقصور كبير في تبني النهج القائم على حقوق الإنسان في تقديم الخدمات إلى جانب عدم الاكتراث بتضمين مفهوم النوع الإجتماعي في تلك الخدمات. كما أنها تكشف عن الحواجز والمعيقات القانونية وغير القانونية والإجرائية الهامة التي تواجهها المرأة عند سعيها الى الوصول والحصول على معلومات وخدمات الإجهاض بشكل يحفظ كرامتها ، ما يستحق أقصى مستويات المباشرة والإهتمام من المهنيين ذوي الصلة، سيما وأنه قانونيا وتقنيا، يحق فقط للمستشفيات إجراء عمليات الإجهاض، وفقط ضمن أسقفة ضيقة جدا من الجواز الديني والضرورة الطبية التي تنحصر في الحمل الذي يشكل خطرا على حياة المرأة.

على الرغم من قدرة النساء على تحمل تكاليف وسائل تنظيم الأسرة المعروضه فإن هامش الاحتياجات غير الملباة لا يزال ملفتا، وذلك لأن هناك نقصاً في المعلومات حول توفر تلك الخدمات، الى جانب تردد النساء في استخدام الوسائل العروضة لضعف الموثوقية بفعاليتها وإلى حد كبير بسبب اعتراض الأزواج بشأن الإستخدام. ونتيجة لذلك، فإنه في حالات الحمل غير المرغوب به تلجأ هؤلاء النساء إلى الإجهاض المتعمد في المنزل باستخدام العديد من الإجراءات والوصفات المنزلية الخطرة.

ومن جهة أخرى، فقد أجمع المشاركون بأن خدمات التوعية والإرشاد النفسي بشأن الإجهاض معدومة باستثناء في بعض المنظمات غير الحكومية حيث المشورة قبل وبعد الإجهاض هي جزء من عملها الروتيني انطلاقا من ولاية المنظمة والتزاماتها. وعموما، فقد أكد المشاركون أن هناك نقصا واضحا في المعلومات حول الإجهاض بين مقدمي الرعاية الصحية أنفسهم وهو ما يفسر عدم بذلهم الكثير من الجهد لتثقيف النساء، فضلا عن الرجال، في هذا الموضوع.

وفيما يتعلق بالحواجز التي تعيق الوصول إلى الإجهاض، تحدث المشاركون عن معيقات إجرائية تشمل الحواجز القانونية وأخرى واقعة خارج النطاق القانوني تضم جميع ما سواه. وبالإجمال، فقد أقرّ المجيبون بأن العديد من الحواجز المعيقة جلية وواضحة وبعضها الآخر أقل جلاءاً، وبمجموعها فهي تضم القيود المؤسسية والقانونية على المؤسسات (المستشفيات) التي تقدم خدمة الإجهاض، والاستنكاف الضميري تجاه خدمة الإجهاض بين مقدمي الرعاية الصحية، وضعف مستوى الممارسة المهنية المتعلقة بالإجهاض بين مقدمي الخدمات الصحية، واعتبار المعظم الإجهاض من المحرمات الإجتماعية والدينية بما في ذلك المهنيين الصحيين، ما كان مثيراً للقلق، وضعف التزام الحكومة بتأثير من الدين والرأي العام غير المقتنع بالحق في الإجهاض، وفرض شروط "إضافية" لإجراءه، وأخيراً الحواجز المعيقة الإستثنائية التي تواجهها المرأة الحامل خارج نطاق الزواج نتيجة للاغتصاب أو السفاح.

من حيث التعاون بين المؤسسات وجهوزية النظام الصحي، بداية، أكد المشاركون على ضرورة تناول ومعالجة موضوع الإجهاض ككل كامل وليس على نحو مجتزأ، بما يشمل الإجهاض التلقائي والمتعمد، وذلك لارتباط الموضوع برمته بوصمة العار المركبة والاتهامات بالكفر التي يتم استدعاؤها للتصدي لأي حراك يهدف الى تحسين المعلومات والخدمات والقوانين المتعلقة بالإجهاض. من هنا، فقد ذهب العاملون في مجال الإجهاض بحكمة لنهج جمعي في العمل بشكل بناء تحالف وطني ينبغي له أن يستمر بل ويتسع أيضا. وفي هذا السياق، فقد اتفق الفرقاء المشاركون في التحالف الذين تمت مقابلتهم بأنه هو المنصة التي تعظّم جدوى الجهود المبذولة في سبيل تحقيق

التغييرات المأمولة من خلال حملات المناصرة والإقناع والضغط على صانعي السياسات والقيادة السياسية لوضع مسألة الإجهاض على خريطة التنمية والخطط الصحية الوطنية الاستراتيجية. وقد شددوا على ضرورة أن يشمل ذلك دمج المؤشرات المتعلقة بالإجهاض في القاعدة الوطنية لبيانات الصحة الأمومية ليتم الإبلاغ عنها في المسوحات الصحية المستقبلية للجهاز المركزي للإحصاء الفلسطيني والتقرير السنوي لوزارة الصحة. هذا وقد اضاءت خبيرة على جدوى توظيف نموذج الحد من الضرر في تعزيز جهوزية النظام الصحي في التحقيق التدريجي لمفهوم الحق في الصحة للنساء بشأن المعلومات والخدمات وتحرير المواد القانونية المتعلقة بالإجهاض وذلك ضمن حدود الشريعة الإسلامية المستنيرة.

وأشار الخبراء بشكل خاص على أنه وباستثناء عمليات التوسيع والقشط أوالقشط والقحف التقليدية التي يتم تنفيذها كإجراء علاجي في المستشفيات لحالات الإجهاض غير المكتمل فإن موضوع الإجهاض غير مدرج على جدول أعمال وزارة الصحة بأي طريقة أخرى، فهو ليس جزءا من أي وثيقة سياساتية، أو خطة استراتيجية أو تشغيلية، أو بروتوكول فني أو حملة توعية أو نشاط تدريبي، أو أي برنامج خدماتي أو أي تقرير يعتد به حول الرعاية الصحية أو نتائجها. وهذا يعني أن وزارة الصحة بحاجة إلى أن تستثمر بشكل كبير في كل جانب من هذه الجوانب والمستويات لأن يكون متاحاً معالجة الرعاية الصحية بشان الإجهاض بشكل شمولي واستراتيجي كما ينبغي ويستحق، اتفق الجميع.

قدمت هذه الدراسة أدلة دامغة على الحاجة الى توفير علني وواسع لخدمات الإجهاض عالية الجوده؛ خدمات لا بد وأن تكون مقرونة بتدابير الرقابة المناسبة والبروتوكولات المهنية والإدارية الواضحة والمبادئ التوجيهية التقنية التي يجب أن تكون متاحة لجميع النساء بموجب قانون للإجهاض منقح ومستنير. وبالإضافة، فالبيانات النوعية والكيفية التي تولدت من هذه الدراسة بشأن الإجهاض عميقة التجذر في القوانين المتشددة والضيقة، ما من شأنه تحفيز الجهود الجدّيّة لإجراء التعديلات اللازمة لهذه القوانين الإقصائية مع الحساسية العالية للسياق والثقافة السائدة والتماشي مع التفاسير المتبصرة للمبادئ الإسلامية.

في ضوء ما سبق، تقع التوصيات التي خرجت بها الدراسة في مجالات أربعة واسعة من العمل؛ فعلى واجهة الرأي العام، هناك الدعوة والمناصرة للفهم الصحيح للقانون الإسلامي الليبرالي بشأن الإجهاض في إطار المشاركة الفعالة والكاملة للقادة الدينيين لتأمين الغطاء الديني اللازم لرفع مستوى مصداقية الحجج المبنيّة على الدين، ولعل الحضور والمشاركة النشطة للبرلمانيين خطوة استراتيجية للضغط نحو تحضير المشهد للتدخل القانوني المطلوب في هذا المجال.

أما على الواجهه القانونية، فإن الدعوة والتشبيك والضغط من أجل تحرير قوانين الإجهاض الحالية واللوائح ذات الصلة حاجة ملحة. فقد أكدت هذه الدراسة أن القوانين واللوائح الفلسطينية القائمة الخاصة بالإجهاض ضيقة ومقيِّدة للغاية سيما وأنها تحرم النساء من الحق الإنساني الأساسي في الصحة وتؤثر سلبا على صحتهن البدنية والنفسية. بالإضافة إلى ذلك، فإنها لا تكترث بحق "اصحاب الواجب" للحماية فيما يتعلق بدورهم كمقدمي الخدمات الرعائية بما في ذلك في مجال الإجهاض. لذا، فهناك توصية بمناصرة والدعوة الى إزالة الحواجز القانونية لوصول المرأة لخدمات الإجهاض، إذ يتوجب إخضاع الأحكام القانونية سواء في قانون العقوبات أو قانون الصحة العامة كلها لتعديلات تقدمية تهدف إلى احترام وحماية وإعمال حقوق الإنسان لأصحاب الحق الذين هم النساء وأسرهن كمتلقين للخدمات والقائمين بالواجب الذين هم الرجال والنساء من مقدمي الخدمات والرعاية الصحية . وهنا، قد يشكل خلق النقاش حول الموضوع مدخلا فعالا لإبقاء الموضوع في نطاق المرئي والمألوف والمثير للتساؤل حول القوانين والأنظمة القائمة سواء داخل الفضاءات المهنية أوالعامة بهدف القضاء النهائي على جميع الحواجز القانونية المعيقة للإجهاض الآمن.

على واجهة حقوق الإنسان، يختص مجال التوصية الثالث بسياسة وزارة الصحة وتمكين المؤسسات من إعمال الحق في الصحة بما يتوافق ويعزز من الإستثمار بأنشطة تحالف الإجهاض، الأمر الذي يُلزم وزارة الصحة بالمضي قدما بهذا الإتجاه بأكبر قدر من الفعالية باستثمار الحد الأقصى من الموارد المتاحة. في هذا السياق، من المهم التمييز بين عجز أوعدم رغبة الدولة في الامتثال لالتزاماتها الصحية بصفتها دولة موقعة على المعاهدات الدولية ذات الصلة. ومن المؤكد أن مراجعة وتعديل قانون الإجهاض الحالي هو أحد مجالات القدرة الممكن للوزارة العمل عليه بصفتها الجسم الوطني الذي يقود ويتحمل مسؤولية صحة جميع الفلسطينيين.

من حيث السياسات الصحية تحديداً، توصي الدراسة بتطوير وتنفيذ ومراقبة بروتوكولات تقديم الخدمات ذات الإسناد الحقوقي.وفي نفس الإتجاه، فهي توصي أيضاً بإجراء تدريب "توضيح القيم" لكافة أفراد الإدارة والمتطوعين والموظفين، بمن فيهم موظفو العيادات، لضمان دعم الجميع لحق المرأة في اختيار إنهاء الحمل غير المرغوب فيه والالتزام بتوفير خدمات الإجهاض بشكل يكفل الإحترام والكرامة للجميع. اعتماد وتنفيذ ورصد؛ سياسة واضحة بشأن الاستنكاف الضميري مع حقوق المرأة في القلب منه؛ وسياسة تسهل وصول المرأة إلى الإجهاض، بما في ذلك الإجهاض الطبي؛ وأخيرا تنمية ورصد فعالية شبكات الإحالة لخدمات الإجهاض، جميعها توصيات بالغة الأهمية بتدخلات على مستوى السياسات.

أما على واجهة الرعاية الصحية، فيجب على مقدمي خدمات صحة المرأة تدارك وتصويب معلومات وخدمات الرعاية الصحية فيما يتعلق بالإجهاض والصحة الإنجابية على نطاق أوسع، حيث من الضرورة بمكان ألا يحدث الحمل غير المرغوب فيه ليتسنى إنزال معدلات الإجهاض إلى أدنى مستوى ممكن ، وخصوصاً غيرالآمن منه. كما يتوجب معالجة مسألة خدمات تنظيم الأسرة غير الملباة. وهذا يعني أن حملات التوعية الشاملة والمستمرة لنشر المعلومات حول وسائل تنظيم الأسرة المتاحة مع التركيز بصفة خاصة على وسائل منع الحمل الطارئ والواقي الذكري يجب أن تكون هدفا مركزياً. وعلاوة على ذلك، يجب الحفاظ على القدرة على تحمل تكاليف وسائل تنظيم الأسرة والخيارات المتاحة ضمنها إلى جانب جعل المرأه واعية بهذه القدرة بالإضافة إلى تبليغها بمعدلات فشل كل وسيلة لتمكين النساء من اتخاذ قرار مستنير حول الوسائل الأكثر ملاءمة لهن.

في جميع المجالات، بينت الدراسة وجود قصور ونقص شديد في المعلومات، ما يعني أن هناك حاجة لتوظيف وسائل أكثر فعالية لتوفير المعلومات والتثقيف بشأن موضوع الإجهاض. كما أن التعاون بين اللاعبين الرئيسيين هو متطلب أساسي لضمان النجاح في ذلك عن طريق زيادة المعرفة كتدخل وقائي المستوى. فالإدراج المبكر للمعلومات ذات الصلة يتضمن إنهاء النهج التقليدي الانتقائي لطرح التعليم الخاص بالصحة الإنجابية والجنسية في برامج الصحة المدرسية، وذلك لرفع مستوى جهوزية الشباب (ذكوراً وإناثاً) للتعامل مع القضايا المتأتية عن الجهل فيما يتعلق بالجنسانية والاغتصاب والسفاح، والتي قد تعاني الفتيات/النساء في المدرسة او البيت عواقبها دون معرفة ما يجب عليهن القيام به.

ومن جهة أخرى، فقد أظهرت الدراسة عجزاً هائلاً في مجال الرعاية ما بعد الإجهاض ومعالجة المضاعفات الناجمة عن الإجهاض والتي هي استراتيجيات أساسية جدا لمنع والتقليل من عدد حالات الإجهاض غير الآمن. هناك حاجة ماسة لبروتوكولات ومبادئ توجيهية ملائمة للمهنيين العاملين في قطاع الخدمات الصحية لضمان العدالة في فرص الوصول وجودة خدمات الرعاية الصحية المقدمة. ولعل تعزيز وتوسيع التحالفات القائمة، مثل تحالف الإجهاض ووضع برامج جديدة مع المنظمات غير الحكومية الأخرى والمنظمات النسائية والقطاع الحكومي أن تدعم وصول النساء إلى خدمات الإجهاض، وخاصة تلكم اللواتي لا يستطعن تحمل تكاليف هذه الخدمات.

كما وقد كشفت الدراسة عن وجود عوائق إجرائية كبيرة (بما في ذلك القانونية) وغير القانونية لخدمات الإجهاض التي هي أصلا شديدة التقييد ومحدودة العرض، وهذه العوائق كلها موضوع فحص دقيق ومراجعة وتصحيح

بالإسترشاد بنموذج الحد من الضرر الراسي في مبادئ حقوق الإنسان. وحاليا، فهذه المبادئ لا تحترم ولا يتم حمايتها ولا الوفاء بها فيما يتعلق بمسألة الإجهاض الآمن وخدمات الإجهاض الشاملة للنساء في فلسطين، وقد وُجد أن هذا متصل بفقدان واضح من جهة مقدمي الرعاية الصحية للإعتراف والالتزام بالحق الإنساني للمرأة في الصحة ، الأمر الذي شكّل الاستنتاج الرئيسي في هذه الدراسة. وبالتالي، تحت حجة الاستنكاف الضميري على سبيل المثال، عبّر بعض المهنيين الذين تمت مقابلتهم في هذه الدراسة عن اعتقادهم "بحقهم" في رفض تقديم المعلومات بل والخدمات ايضا للنساء حول الإجهاض. فيما على العكس من ذلك، فإن الحجج التي استند اليها نهج تقديم الخدمة من منظور حقوقي بما في ذلك خدمة الإجهاض تنبثق عن المباديء الأساسية لحقوق الإنسان، وبالذات حق المرأة في السلامة الجسدية والإستقلالية. ونظرا للبيئة الاجتماعية والقانونية الفلسطينية المقيِّدة للغاية في هذا الصدد، فإنه يُنصح بشدة باعتماد و تعزيز نموذج الحد من الضرر في تنفيذ الرعاية الشاملة للإجهاض.

وختاما، فمن أجل تخطيط مستنير مبني على البيانات توصي هذه الدراسة بتكرار مثلها في المحافظات الأخرى لاستكمال الصورة. وبالإضافة إلى ذلك، فإن من شأن منهجيات بحثية تكميلية أخرى بما في ذلك الدراسات الاستقصائية الوطنية مع اختيار عينة عشوائية والدراسات النوعية المعمقة ان تشكل اختبارات ملائمة للجودة وتضيف إلى المصداقية والجدارة بالثقة في نتائج هذه الدراسة، أو تصحيحها. في كلا الاتجاهين، فالنتيجة هي لفائدة صحة المرأة ولتعزيز التقدم في تحقيق هدف الألفية الخامس الساعي لتحسين الصحة الأمومية.

List of Abbreviations

CAC	**Comprehensive Abortion Care**
D & C	**Dilatation and Curettage**
E& C	**Evacuation and Curettage**
ICPD	**International Conference for Population and Development**
IPPF	**International Planned Parenthood Federation**
MDG5	**Millennium Development Goal 5**
MOH	**Ministry of Health**
NOGs	**None Governmental Organisations**
PFPPA	**Palestinian Family Planning and Protection Association**
RTH	**Right to Health**

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Chapter I
Background and Significance

1.1 Introduction

Although maternal mortality rates in Majority Population Countries have declined in recent years, they remain unacceptably high. Achieving Millennium Development Goal 5—the reduction of maternal mortality by three-quarters between 1990 and 2015—remains a major public health, human rights and development challenge in regions like Western Asia and Northern Africa where unsafe abortion is a leading cause of maternal mortality(Singh, 2010). Over the past 15 years, the World Health Organization (WHO), with inputs from other international organizations, has focused attention on estimating abortion ratios and rates and maternal mortality caused by unsafe abortion at global, regional and sub-regional levels. However, fewer efforts have attempted to study abortion-related morbidity, especially at the individual-country level. Most such studies are small scale and have been limited to measuring the number of women who are hospitalized for abortion-related complications (Schiavon, Troncoso & Polo, 2010).

In Palestine and largely in the whole region, attention for abortion-related morbidity, in particular is missing. To date, the subject continues to go undetected as a priority health concern by the research community, women/human rights activism, and public health planners and policy makers. The situation is less harsh for maternal mortality despite the relatively recent attention only. This is where most countries are characterized by worn out health systems that are in utter need of ideological shifts in perspectives to be able to bring about revolutionary reforms and real quality of care improvements where the right holders including women are truly at the center. While this could be an expression of the sort of values governing society and the worth of human rights and realization of social justice within it, it clearly is an explicit gender precursor that points at the importance society grants for the safety and well being of women, ironically concerning what falls under her reproductive role that is perhaps the only recognized role for women in these societies. But yet even here they fail to protect women and ensure their freedom from harm or at least its reduction. One manifestation of this is that abortion laws are most restrictive while historical evidence and anecdotal observations suggest that women always resort to any form of abortion- safe or unsafe- when they want to terminate a pregnancy (Winikoff, 2012). Hence the interconnectedness between legality, incidence and safety may be strongly argued for here (Singh, 2010).

1.2 Background and Significance

Of the 213 million pregnancies that occurred worldwide in 2012, 40%—about 85 million—were unintended, about the same proportion as in 2008, when 42% of all

pregnancies globally were unintended. The recent study, "Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends," by Sedgh et al. (2012) found that the proportion of pregnancies that are unintended varied considerably by region. The highest proportions were in Latin America and the Caribbean (56%) and North America (51%), and the lowest were in Africa (35%), Oceania (37%) and Asia (38%); Europe's proportion was the closest to the global average (45%).The study also found that the average annual decline in the global unintended pregnancy rate between 2008 and 2012 was very small, compared with the average annual decline between 1995 and 2008. In 2012, there were 53 unintended pregnancies per 1,000 women aged 15-44, compared with 57 in 2008.

Box 1: Abortion Legality, Incidence and Safety

- After declining substantially between 1995 and 2003, the worldwide abortion rate stalled between 2003 and 2008. Between 1995 and 2003, the global abortion rate dropped from 35 to 29. It remained virtually unchanged at 28 in 2008.
- In 2008, six million abortions were performed in developed countries and 38 million in developing countries, a disparity that largely reflects population distribution.
- Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions occur in developing countries. In the developing world, 56% of all abortions are unsafe, compared with 6% in the developed world.
- Highly restrictive abortion laws are not associated with lower abortion rates. For example, the abortion rate is high, at 29 and 32 abortions per 1,000 women of childbearing age in Africa and Latin America, respectively—regions where abortion is illegal under most circumstances in the majority of countries. In Western Europe, where abortion is generally permitted on broad grounds, the abortion rate is 12 per 1,000 (Sedgh et al, 2012)
- Where abortion is legal on broad grounds, it is generally safe, and where it is illegal in most circumstances, it is generally unsafe. In the United States, where abortion is legal on broad grounds, induced abortion results in 0.6 deaths per 100,000 procedures. In Latin America and Sub-Saharan Africa, abortion results in 30 and 460 deaths per 100,000 procedures, respectively (WHO, 2011).

Sources: Guttmacher Institute webpage: http://www.guttmacher.org/media/presskits/abortion-WW/statsandfacts.html

According to Sedgh et al. (2012) findings, 50% of all 2012 unintended pregnancies ended in abortion, 38% in unplanned births, and 13% in miscarriage. Overall, the proportion of unintended pregnancies ending in abortion was higher in developed than in developing regions (54 vs. 49%). The authors note that each year in the developing world, thousands of women die and many more are seriously injured as a result of unsafe clandestine abortions.

However, measuring the level of unsafe abortion in countries where pertinent laws are highly legally restrictive remains difficult, since procedures are often carried out outside the formal health system and are not reflected in health records. Moreover, even when evidence points overwhelmingly toward an induced abortion, health

personnel may be reluctant to classify women as induced abortion patients because doing so often requires completing additional forms and it may expose patients and medical personnel themselves if they fail to report women to authorities to possible legal or moral sanctions. As a result, a significant number of cases that are not treated or documented accurately in formal facilities go missing (Banerjee & Clark, 2009).

In Western Asia and Northern Africa in particular, abortion remains one of the most neglected public health challenges. It is estimated that 1 in 4 pregnancies are unintended. WHO estimates that unsafe abortions contribute to 11% of total maternal mortality in the region and that 1.5 million abortions were performed in unsanitary setting or by unskilled provider or both(Singh, 2010).

Legal frameworks in countries of the region are; predominantly restrictive, defective in implementation, open to individual interpretations, and subject to multiple authorizations that are commonly hard to attain. Moreover, as drafted, these laws are shaped by and rooted in associated stigmas, sinfulness, shame and guilt attached to abortion. As a result women seeking abortion amid these predicaments find themselves in a maze of abortion procedural and access barriers including, prolonged waiting periods, providers' incompetence and poor knowledge and training, women inability to locate abortion services in health systems that are not equipped to deal with abortion and post-abortion care, and incomprehensive and poor quality services that are rarely declared even when existing. Furthermore, health providers themselves may have attitudes problems and so may decline serving an abortion-seeking women on the grounds of conscientious objection based on their own value system and religious convictions even in cases where abortion services are available, sought and needed by women.

In light of this depiction and as alarming as the facts on the grounds may be, data and evidence to inform policy in the region particularly in the Arab countries remain extremely lacking. Extensive literature search in grey literature, scholarly journal articles, available data sets, and technical reports took the investigator in this study but to a very few studies on abortion generally and unsafe abortion specifically, in the Arab countries.

On Palestine, only one relevant study was spotted and was completed by the Palestinian family Planning and Protection Association (PFPPA) in the form of a baseline survey on safe/unsafe abortion in selected refugee camps in West Bank. PFPPA the founding member and the lead organization of the Protect Women from Unsafe Abortion Coalition (PWUAC) since 2006 with the membership of 9 organizations active in the field, places the question of unsafe abortion high up on its agenda. The current study is meant to provide fresh insights that could facilitate the Association's informed planning in order to meet its two strategic objectives of strengthening public and political commitment to have access to information on safe abortion and expanding the provision of post abortion services as an integral part of sexual and reproductive health (SRH) services.

Recognizing the preventable nature of most maternal mortality and morbidity related to unsafe abortion, this study maintains that maternal mortality and morbidity due to unsafe abortions can be prevented when women have knowledge about and access to safe abortion services. Inter alia, this entails revisiting the highly restrictive abortion laws currently in effect in Palestine which may challenge social, moral and religious codes upon which these laws are laid and invoke social stigmas surrounding them. If invested intelligently, this could be a great opportunity for Palestinian human rights community, women health activists and public health planners to bring abortion laws and hence services to redress through discursive processes aiming for a strategic shift concerning it.

1.3 Harm Reduction Approach for Safe Abortion

This work is guided by the harm reduction approach with the central premise being creation of a discursive shift for safer abortion. According to Erdman (2012) harm reduction approach is one that supports the lessening of harms associated with an activity or behavior, without assigning any moral judgment to the behaviour itself.

A harm reduction and human rights approach, grounded in the principles of neutrality, humanism, and pragmatism, supports women's access to information on the safer abortion in diverse legal settings. With reference to unsafe abortion, this is as follows:

1. The neutrality principle refers to the focus on the health-related risks and harms of abortion, rather than its legal or moral status. This shift brings about a change in public policy responses to unsafe abortion, namely public health interventions rather than prohibition and punishment.
2. The humanistic principle refers to the entitlement of all women, regardless of their decision-making about pregnancy, to be treated with respect, dignity and worth. It recognizes that all women deserve to be treated as members of the community, whose health and lives matter.
3. The pragmatic principle accepts the inevitable reality that women engage in unsafe abortion for many reasons, and thus emphasizes the importance of meeting the needs of women were they are, which may include self-inducing abortion outside the health system.

In light of these three guiding principles, criminal law reform is a necessity to a harm reduction and human rights approach (Erdman (2012).

1.4 Study Aim and Objectives

This assessment learns about the status of abortion and estimates the extent to which unsafe abortion, in specific, is prevalent among women in reproductive age or passed it by no more than 10 years. Hence our targeted age group is women between 15-59 years, residing in Hebron Governorate-Southern West Bank, and seeking reproductive and sexual health (RSH) services at any PFPPA four service delivery settings being

two clinics located at the city of Hebron and the town of Halhul and two service delivery points in two vulnerable locations at various impoverished rural communities laying within the geographic boundaries of Hebron Governorate.

This is by meeting the following objectives;

1 Determine to what extent the experience of unsafe abortion exists among women in the targeted community.
2 Understand the methods used to induce unsafe abortion in the targeted community.
3 Investigate the reason/s behind women's resorting to unsafe abortion.
4 Determine the type of information women have about the availability of safe abortion related services.
5 Identify the barriers that prevent women from reaching existing safe abortion related services.
6 Define the challenges that limit local health organizations from providing essential abortion related services.
7 Provide recommendations to increase the provision of abortion related services at PFPPA service delivery points (SDP's) and to advocate for modifying present highly restrictive laws.

Chapter II
Literature Review

2.1 Introduction

Combating unsafe abortion is a pressing public health and human rights imperative. Worldwide, thousands of precious lives of young healthy women are unreasonably lost or become severely morbid/ impaired and many more thousands of children become orphans as a result; only because of avoidable abortion poor circumstances and repairable related laws. The high costs of unsafe abortions to individuals, families, societies and states remain a scourge of humanity. Women in majority population countries continue to be the prime victims of this calamity where nearly all (97%) unsafe abortions occur (Grimes et al, 2006).

The following pages will discuss the concept of abortion with emphasis being placed on the unsafe part of induced abortion including; its definition, main types, global incidence, religious and legal limitations, methods used to induce it, physical and psychological consequences, barriers hindering women's access to safe abortion related services, post abortion complications and challenges that face local health organizations in providing essential abortion related services.

2.2 Definition and Incidence of Abortion: An Overview

There are two main broad types of abortions; safe abortion and unsafe abortion. Safe abortion is defined as "a medical or surgical abortion performed by a well-trained professional with the necessary resourcesand in a suitable medical environment as the procedure involveslittle risk to the woman(Fau´ndes, 2010). TheWorld Health Organization defines unsafeabortion as "a procedure for terminating anunintended pregnancy carried out either by personslacking the necessary skills or in an environmentthat does not conform to minimal medical standardsor both (Grimes et al, 2006).

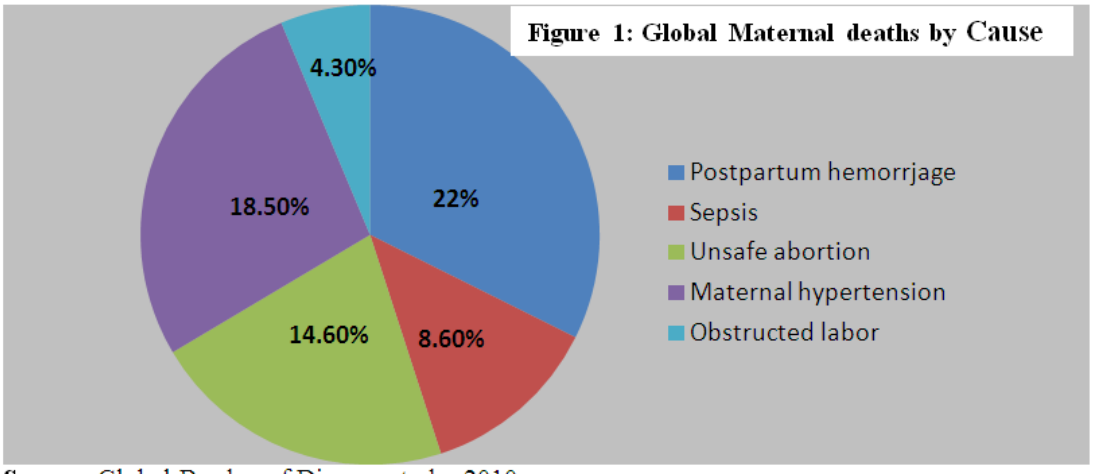
It is estimated that of the global 210 million conceptions each year, about 1 in 10 result in an unsafe abortion. An estimated 68 000 women die each year from unsafe abortion contributing to 13% of global maternal mortality and to significant morbidity among women, mainly in developing countries. Half of the global unsafe abortion deaths occur in Africa and one in four unsafe abortions occurs in teenagers (Shaw &Frcsc, 2010). The determinants of unsafe abortion include restrictive abortion legislations, lack of femaleempowerment, poor social support, inadequate contraceptive services and poor health-service infrastructure (Guttmacher Institute. 2008).

In the year 2000, the estimations indicated thatthere were 19 million unsafeabortions, almost all in developing countries.However, compared with 1995, the data from2000

appear to show a decrease in unsafeabortion rate for all developing country regionsexcept South-central Asia and northern Africa. The number of deaths from complications ofunsafe abortion also appears to have declined,from an estimated 78,000 in 1995 to an estimated68,000 in 2000(Shaw &Frcsc, 2010)

According to the United Nations, in 2003 the highestrates of unsafe abortions per 1000 women of 15–49 years of age were found in Africa and Latin America (29/1000), followed by Asia (11/1000), the highest rate is found in Eastern Africa (39/1000), followed by South America(33/1000) and Western Africa (28/1000), Central Africa (26/1000), Central America (25/1000)andSoutheast Asia (23/1000). The rate of unsafe abortion in the more developed regions is only 2 per 1000 (Cadmus &Owoaje, 2011).

World Health Organization estimated that about 47,000 women lose their lives annually due to the complications ofunsafe abortionalmost all of which could have been preventedthrough better access to sexuality education,access to contraceptive information and supplies,and safe abortion services where allowed by law (Dabash&Roudi- Fahimi, 2008).



Source: Global Burden of Disease study, 2010

In 2003, young women accounted for approximately45% of the estimated unsafe abortion-related deaths (WHO, 2007). The same organization estimated that the number of unsafe abortions in2008 reached 21.6 million, up from 19.7 million in2003. Such an increase was caused, almost entirely,by the increase in the number of women of reproductiveage. Between 2003 and 2008, the unsafeabortion rate remained unchanged at 14 unsafe abortionsper 1,000 women aged 15 to 44. Modest reductionsin the unsafe abortion rate are estimated tohave taken place in some regions. Furthermore, theincreases estimated for Middle Africa, Western Asiaand Central America are attributed primarily to bettercoverage and more reliable information in 2008 than in 2003 (Dabash&Roudi- Fahimi, 2008).

Statistics about **abortion incidence in Arab & Islamic countries** arealarming for the talk here is about preventable morbidities and mortalities of young women. As indicated in the table below, of the total number of women (1.4 millions) who had

induced abortions in Western Asia in the year 20008, 60% had unsafe abortions while by rate this was equivalent to 16/1000 women between the ages 15-44 years compared with 18/1000 of their counterparts in Northern Africa in the same year.

Table1: Estimates of Selected Abortion Indicators in the Majority Arab/Islamic Countries Sub-Regions, 2008

Sub-region	**Number of induced abortions in millions**	**% Unsafe**	**Abortion rate/1000 Women**	**Safe abortions rate**	**Unsafe abortions rate**
Western Asia	1.4	60	26	11	16
Northern Africa	0.9	98	18	†*	18

* † Rate less than 0.5.

Source: Sedgh et al., 2012. Guttmatcher Institute.

Statistics from Morocco indicates that the number of abortions had doubled during the last two years. Moroccan family planning experts estimate that 600 abortions daily are carried out in Morocco, most involving unmarried women. Only a small percentage is victims of rape or sexual abuse (Fawcus&Frcog, 2007).

A study by the International Planned Parenthood Federation estimated there were 7 million abortions in the Arab world from 1995 to 2000. A 1993 study showed that 14% of women in one rural Egyptian hamlet had had an abortion. Meanwhile, The Jordanian ministry of health estimated that about 6000 abortions are induced annually in Jordanian hospitals legally (Marge, 2004).

Researchers estimate that 100,000 abortions are performed annually in Iran, a non-Arab Moslem nation that stands out for its relatively progressive sex education and family planning policies. Moreover, the abortion statistics indicated that in 2009 more than 80000 Iranian women died as a result of unsafe abortions (Hourieh, Abolghasem & Feizollah, 2010).

The UN estimates that 10% of pregnancies in the Arab world ends in abortion. Moreover, between Western Asia and North Africa, one study estimates that up to 1.2 million unsafe abortions are carried out annually, given the lack of access to legal abortion services, and lack of knowledge of birth control(Marge, 2004).

In Western Asia and Northern Africa, officially, one in ten pregnancies end in abortion, and unsafe abortions constitute at least6% of maternal deaths in the region. In a 1998hospital-based study in Egypt, one in every fiveobstetric admissions was for post-abortion treatment,and over 1,000 unsafe abortions take placeevery day in Iran(Hessini, 2007).

Egypt's 2005 Demographic and Health Survey showed that 56% of married women use modern contraception, and yet one in five births are reported as unintended. Among women who reported their last birth as unintended, one-third wanted to have at least one more child at a later time, and two-thirds wanted no more children. As expected, the more children a woman has, the more likely she is to report her latest birth as unintended.

Few years later in Egypt, an abortion survey was conducted by MOH and UNFPAwhere 10,000 women in reproductive age were surveyed about if they had abortion and whether it was spontaneous or induced. They were asked about the period coving two years before the survey 2007 – 2009. The study revealed thatabortions represent 9.7% of all pregnancies in the surveyed women. Around 15% of abortions took place in pregnancies that happenedduring contraceptive use.Induced abortions accounted for 4% of all abortions (UNFPA, 2010).

Syria is a country in the region with restrictive abortion laws but where a nationally representative survey was conducted in 2006 asking women whether they have had an abortion. The survey revealed that 4% of married women ages 15 to 49 had at least one abortion. However, this figure is likely to be underreported as abortion is strictly forbidden.

Years before, in 1992, Syria hosted the first regional conference on unsafe abortion and sexual health, organized by the Syrian Family Planning Association and the International Planned Parenthood Federation's Arab World Regional Office. Bringing together health professionals, religious leaders, and women's health advocates, the conference raised awareness among health and family planning service providers about the dangers of unsafe abortion and the need to promote preventive measures. The participants concluded that unsafe abortion was a main public health problem in almost all countries in the region. They called upon their governments and family planning associations to review existing laws and provide better contraceptive services and treatment for women who seek post-abortion care.

The table below provides an indication about abortion and maternal mortality resulting from unsafe abortion in selected Western Asia and Northern Africa countries. This is in the form of a compilation of abstract numbers. The numbers clearly show that despite the very tight abortion laws in most of these countries abortions still happen, in line with the historical reality, and deaths caused by unsafe abortions are not insignificant and so deserve recognition and adequate attention by public health planners in all countries of the region.

Table (2): Number of Abortions and Maternal Mortality Due to Unsafe Abortions in the Western Asia and Northern Africa Region between1995-2000

Country	Number of Abortions	Deaths Due to Unsafe Abortions
Algeria	718670	1076
Bahrain	25754	16

Egypt	2079216	2542
Iran	2590681	5697
Iraq	893285	908
Jordan	196792	161
Kuwait	70160	52
Lebanon	177298	85
Libya	117050	190
Mauritania	116196	801
Morocco	699692	1084
Oman	80642	105
Palestine	98135	141
Qatar	20272	14
Saudi Arabia	699405	927
Sudan	702248	1893
Syria	653965	580
Tunisia	118102	256
Turkey	2301966	1536
United Arab Emirates	78770	49
Yemen	606339	842

Source: Global Health Council. Promises to Keep: The Toll of Unintended Pregnancy on Women in the Developing World. Washington, DC: Global Health Council, 2002. at: http://www.globalhealth.org/assets/publications/

In 1990, WHO estimated maternal mortality in Palestine at 92 per 100,000 live births, and reduced the estimate to 52 in 2000. In a report it published in 2009, maternal mortality for 2008 was estimated at 46 per 100,000 live births, reflecting a 3.8% decline per year. This is higher than the average worldwide reduction of 1.3% and lower than the target reduction according to MDG 5 (5.5%). Palestinian Ministry of Health Reports in 2010 indicates that maternal mortality ratio was 32 per 100,000 live births (MOH, 2011).

To strategize and prioritize MOH initiated setting up maternal mortality surveillance system by the formation of Technical Committee on Maternal Mortality tasked with creating a national-level system to provide a systematic monitoring with reliable data necessary for the measurement of maternal mortality in Palestine. The committee released its first and yet only report in 2011 whereby it reported on maternal mortality for the year 2009 in the West Bank and 2008 & 2009 in Gaza Strip (MOH, 2011).

According to the report, the number of registered maternal deaths for the year 2009 in the West Bank totaled 23 deaths. The ratio of maternal deaths to the number of live births therefore was 36.42/100,000 live births, considering that the total number of births in the West Bank in that year was 63,144 live births. This ratio falls within the range of WHO estimate for 2008, which was 46 (MOH, 2011).

All cases of death occurred in hospitals, except one case of a woman who died on the road to the hospital after being involved in a traffic accident. The largest number of

maternal deaths occurred in Hebron district compared to Rafah for the Gaza Strip. In 12 cases, women died in governmental hospitals (53%) and in 10, the death occurred in private sector hospitals (43%). Alongside, the analysis revealed that in 65% (15) of the cases, death occurred in the postpartum period. In 31% (7), death occurred during pregnancy and only one death (4%) occurred after abortion. In terms of the timing of postpartum deaths, in 10 cases (66.7%), death occurred during the first week, including 6 cases (40%) in which the women died during the first 24 hours after delivery that is to say while they were still at the health facility supposedly under the direct attendance of care providers . Not only that but also 74% of the deceased women were identified as law risk pregnancy and only 26% of them were identified as high risk pregnancies (MOH, 2011).

More than half (52%) of deaths in the West Bank were due to pulmonary embolism and severe pneumonia resulting from H1N1 infection.This is compared withpulmonary embolism (20%), heart diseases (20%), hemorrhage (16.7%) and septicemia (16.7%) in Gaza Strip (MOH, 2011).

As for Gaza Strip, in the review of all antenatal and hospital records of cases of maternal deaths, 11 and 19 maternal deaths in 2008 and 2009 were sequentially identified. Inaccurate underlying cause of maternal death, such as cardiac arrest and obstetric complication, was noticed in 40.7% of death certificates, while pregnancy status was not clarified in 44.4% of the certificates belonging to deceased women.

The deaths took place during the; post-partum period for 46.7%, ante-partum period for 33.3% and intra-partum for 16.7%. Only 3.3% of deaths took place after abortion. Of the deceased women only 4 died at home and the rest passed at hospitals, 80% of which were MOH hospitals (MOH, 2011).

2.3 Reasons for Abortion

In their study to assess the prevalence and determinants of unwanted pregnancy and induced abortion in Nigeria Friday, Patrick & Johnson (1999) revealed that "nearly 20% of the women reported having had an unwanted pregnancy. Of those, 58% reported that they successfully terminated the pregnancies; 32% continued the pregnancies; and nearly 9% stated that they had attempted termination but failed. Overall the prevalence of self reports of induced abortion was 11%. Moreover, nearly 19% of the respondents said they had become pregnant while they were using a family planning method. The other most important reasons respondents gave included the bad timing of these pregnancies, the respondents desire to remain in school, the high cost of rearing children and the feeling that the pregnancy was not socially acceptable.

According to Fawcus&Frcog(2007)reasons that lead to increased abortion include delayed marriage with premarital sex of both males and females due to the dramatic rise in marriage requirements coupled with sweeping unemployment and poverty.In addition, sex is becoming more tolerable in societies including in an embedded

manner, along with little or no education on birth control or sexuality and sexual health. More often family financial hardship, lack of social support, desertion by partner, sexualabuse, interference with studies/training, and contraceptive failure or non-availability are all key abortion determinants.

Aqualitative study of Nigerian adolescents indicated that many seeking abortion had notbeen motivated to use contraception, for example (Okonta, Ebeigbe, Sunday-Adeoye, 2010). In a study conducted by Mote, Otupiri and Hindin (2010) to detect the main factors influencing induced abortions in Ghana revealed that the most commonly given reasons for abortionis "not todisrupt education or employment" (35.6%) and "too young to bear a child" (28.7%), "could not cater for a baby" (19.4%), and"partner rejected the pregnancy" (19%)(Fau`ndes , 2010).

2.4 Reasons for Unsafe Abortion

DeJonget al. (2005) argues that there are many reasons that lead women to exercise and carry out unsafe abortion in Arab and Islamic countries in general and in Palestinian context in particular. These reasons include: women in the Arab world are caught between relaxed expectations of virginity, economic realities, the religious implications of abortion, a lack of information about and access to birth control and a lack of safe abortion services. Fau`ndes (2010) maintains that lack of information about contraceptive methods or not knowing how to access them are key reasons that lead to unsafe abortion.

Many women became pregnant against their will because they do not have sufficient information on how toprevent pregnancy. According to the Demographic and Health Surveys (DHS), a high proportion of women worldwide state that they have knowledge of at least one 'modern', highly effective contraceptive method, which includes all kinds of hormonal methods, intrauterine devices (IUDs), barriermethods such as the diaphragm and the male or female condom, and male or female surgicalsterilization(Cadmus&Owoaje, 2011).

The best indicator of access to contraceptive methods is the unmet need for contraceptives. 'Unmetneed' is defined as the proportion of women who do not want to get pregnant at that precise time orever again and who are not using any contraceptive method. It has been estimated that 125 millionwomen have unmet needs for family planning, mostly in the developing countries(Fau`ndes , 2010).

A study in Nepal, for example, found that for many women unsafe abortion was the only available method of fertility control. Several factors contribute to unmet need: lack of knowledge, lack of availability of contraceptive methods and lack of the resources needed to obtain contraceptives; however, opposition from a partner and family or cultural pressure towards high fertility represent additional factors.

Often women know about and have access to contraceptive methods but do not have control overtheir use every time they have sexual intercourse. Moreover, they may not

be using a method becausethey are not having sexual intercourse and are then without warning forced to have sex without the meanswith which to protect themselves or the time in which to do so.The vast majority of women who seek abortionsare either already mothers or not ready tobecome mothers. Some cannot afford to supportanother child; others have had pregnancyforced on them. Some cannot carry the burdenarising from fetal anomalies; others do not wishto be mothers at all. Every woman who seeksan abortion does so because for her it is necessary(Fau`ndes , 2010).

Fostera et al.(2005) revealed that "lack of information about services, fear of sideeffects and social taboos all contribute to thebarriers young people face in obtaining contraception. Unmarried young peopleare unlikely to be able to avail themselves ofservices and risk stigma in using family planning,but equally those who marry early often lack knowledge and access to services such asfor contraception".

When unintended pregnancy leads to a decision to terminate, then the reason that theprocured abortion is unsafe would be due to it being illegal and abortion providersbeing unskilled; or, in the context of legality, there being inadequate services, leadingto delays and late presentation when the pregnancy has advanced to the second trimester,which is associated with more complications (Okonofua, Odimegwu, Ajabor, 1999)

2.9 Traditional Methods for Unsafe Abortions

Seif Al-Dawla (2000) reported that projections have yielded an estimated induced abortion rate in Egypt of 14.75 per 100 pregnancies. A high proportion of such abortions 46% are either self induced or performed by lay healers, using traditional and often dangerous methods, e.g. beating or violent massage of the abdomen, introducing a plant stalk, catheter, feather or wire into the uterus, injecting substances into the uterus, drinking herbal preparations or taking various drugs(Grimes et al., 2006).

This was later confirmed by a report from the Ministry of Health and Population (2007). Egyptian Women who cannot afford appropriately equipped clinics are left with inexpensive but highly dangerous traditional methods, including drinking a combination of cinnamon, boiled onions and Coca Cola, and sometimes these are administered individually. Other unsafe methods used to terminate pregnancies include: ingesting high doses of malaria medication or measles vaccine; inserting sharp objects or a stem of a local herb into the vagina or cervix; and injecting cleaning agents into the vagina.

Out of 10,000 Egyptian surveyed women, 400 (4%) reported having had an induced abortion that was done by a doctor in 32% of cases, while the remaining were self induced. Only 12.9% of women who had abortion received some forms of counseling about FP after abortion (UNFPA, 2010).

Unsafe methods can be categorized into several broad classes: oral and injectable medicines, vaginal preparations, intrauterine foreign bodies, and trauma to the abdomen. As well as to detergents, solvents, and bleach, women in developing countries still depend on teas and decoctions made from local plant or animal products, including dung. Foreign bodies inserted into the uterus to disrupt the pregnancy often damage the uterus and internal organs, including bowel. In settings as diverse as the South Pacific and equatorial Africa, abortion by abdominal massage is still used by traditional practitioners. The vigorous beating of the woman's lower abdomen is designed to disrupt the pregnancy but sometimes bursts the uterus and kills the woman instead (Grimes et al., 2006).

The Government of Madhya Pradesh collaborated with Ipas to conduct a studytitled "Exploring the Pathways of Unsafe Abortion: A Prospective Study of Abortion Clients inSelected Hospitals of Madhya Pradesh, India". The study documents the first research initiativein India to interview 381 women with post-abortion complications selected from 10 secondary andtertiary hospitals. It provides interesting insights and information aboutthe pathways of unsafe abortion. The findings showed that 53% of women with post-abortion complicationsattempted abortion at home through medication, homemade concoctions, and traditional methods.Of those who accessed different providers, 47% women accessed chemists and 28% accessed privatedoctors. This study further emphasizes the need for informing women that abortion is legal up to20 weeks and should be availed from certified and trained providers (Banerjee & Clark, 2009).

In Pakistan, for a total of 100 women who were hospitalized for post-abortion complications, abortion provider was "lady health visitor" or nurse in 52% cases, TBA/Daya for 40%, doctors for 5% and traditional health care providers were the providers for 4% (e-Rehan, 2011).

The primitive methods used for unsafe abortion show the desperation of the women. Surveys done in New York City before the legalization of abortion on request documented the techniques in common use.Of 899 women interviewed, 74 reported having attempted to abort one or more pregnancies; 338 noted that one of their friends, relatives, or acquaintances had done so. Of those reported abortion attempts, 80% tried to do the abortion themselves. Nearly 40% of women used a combination of approaches. Invasive methods, such as insertion of tubes or liquids into the uterus, were more successful than were other approaches. Coat hangers, knitting needles, and slippery elm barks were common methods; the bark would expand when moistened, causing the cervix to open. Another widely used method was to place a flexible rubber catheter into the uterus to stimulate labor (Grimes et al, 2006).

2.10 Knowledge and Attitudes about Abortion

In a pioneer Palestinianstudy Sayej conducted for the PFFPA in 2007, a total of 333 women in reproductive age part took. Asked about their knowledge of the incidence

of abortion among relatives or others as well as among themselves; 54.4% knew of others had an abortion, and around 40% have experienced an abortion themselves; of those 21% had it once, 8% had it twice, 6% had it 3 times, and 1.2% had it for 4 times. The surveyed women were knowledgeable of the legal and religious laws, importance of following the health professional's advice, proper timing for abortion and for seeking abortion services from health professionals. Around 10% of the participants knew about women who seek abortion from traditional Dayas and 16% have agreed on the women themselves to induce abortion, which means around 26% of abortion practices are unsafe. Strikingly, these women have utilized the voluntary trauma method with serious maternal health consequences. In addition, the participants possessed a high level of knowledge about post abortion complications and consequences where over 90% agreed that women who experience abortion needed hospitalization, needed blood transfusion, and had vaginal bleeding. The participant's knowledge of consequences of abortion also indicated a high level of knowledge and awareness where 85% agreed on general weakness and body aches, 68% for weak uterus, 64% for the urinary tract infections and 50% for infertility (Sayej, 2007).

The Nigerian study where students of the University of Ibadan were targeted found that the major source of information about abortion for participants was their friends. Parents and teachers played only a minor role in this (Cadmus &Owoaje, 2011).

Few years earlier in a Kenyan study Mitchell et al. (2006) observed knowledge and perceptions of adolescents about abortion, where here too friends were the main sources of information participants cited. However, this result contrasts findings from another study which reported that adolescents consider their parents as useful sources of advice on sex matters (Adaji et al., 2010). Nevertheless, other investigators such as Correia et al. (2011) have shown that sexual matters are not discussed freely with parents. Investigating teenage sexual activity among secondary school girls in Brazil, Correia and colleagues found that the teenagers receive very little sex education from their parents which could be due to the fact that talking about sex is still regarded as a taboo in many societies.

A cross-sectional study about knowledge, attitude, behavior and practices of women on abortion conducted by Senbeto et al. (2005) in Ethiopia showed that awareness about complications of induced abortions was high among female youths with 75% of them knowing the complications of induced abortions. The most commonly cited complications were bleeding, infections and death.

When it comes to knowledge on Ethiopian abortion law there was some bewilderment among participants. Of those who have given responses regarding legal condition of abortion in Ethiopia, 172 (38.8%) replied that Ethiopian law allows abortion while 157 (35.5%) replied it did not and the remaining 114 (25.7%) answered that they did not know whether or not abortion is legally allowed in Ethiopia (Gelaye, Taye and Mekonen, 2014).

A study was conducted in Iran by Houriehet al. (2010) revealed that the majority of participants fairly knew about the prevalence of illegal abortions and their complications. There was strong agreement on abortion when health of the mother or the fetus was at risk. Abortion for reproductive health reasons was supported by a minority of the respondents. The majority disagreed with abortion when pregnancy was the result of a rape, temporary marriage or out of wedlock affairs. Making the decision for abortion by the pregnant woman, as a matter of her right, did not gain much approval.

Still in Iran, Milani, Pourreza, &Akbari (2010) looked into knowledge and attitudes of a Number of Iranian Policy-makers towards Abortion. The study revealed that the participants' overall knowledge was good. They knew the definition of abortion, its frequent practices in society, unhealthy conditions where abortions were carried out, and complications resulting from backyard abortions. But the dominant attitude of the participants towards abortion was "Disapproval"; a majority of the respondents agreed with abortion only when the health of the mother or the fetus was threatened.

Along the same lines, Singh (2010) maintains that negative attitudes of providers harm women seeking abortion care. Women's right to dignity is frequently violated by harsh and discourteous treatment by the staff at these facilities. For example, in one case in Egypt, an unwed young woman narrates:

"There were no preparations, ultrasound, equipment or nurse. He [the physician] didn't even ask me about my medical history or take any blood tests. He inserted the drip and I was shivering. He looked at me and said: It's a good thing you have blood [an Arabic maxim for shame]' I was very insulted, and if it wasn't an absolute necessity, I wouldn't have gone through with it. I stayed and proceeded out of terror because I just wanted it to be over" (Center for Reproductive Rights, 2009).

2.11 Health Consequences of Unsafe Abortion

Health consequences of unsafe abortion are physical, emotional and psychological. Immediate physical complications from unsafe abortions include; severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitals, intra-abdominal injuries and septicaemia. Medium and long-term complications range from reproductive tract infections (RTI) and pelvicin flammatory disease (PID) to chronic pain and infertility: 20 to 30 percent of unsafe abortions may lead to RTI, and of these, 20 to 40 percent result in PID and infertility. Late complications include increased risk of ectopic pregnancy, miscarriage or premature delivery in subsequent pregnancies (e-Rehan, 2011).

Most of deaths due to unsafe abortion occur in Sub Saharan Africa (about 36000) and south Central Asia (about 28400), while the number is insignificant in southern and western Europe, North America and China. In Tanzania, a recent review of 113 maternal deaths suggested that (12%)women had died following an unsafe abortion,

while inNigeria 12–13% of maternal deaths have been reported to bedue to unsafe abortion (Mote, Otupiri & Hindin, 2010)

A pilot study in three African counties has shown that in Kenya 28% of post-abortion patients experienced severe complications and among hospitalized patients in Nigeria; 1 in 3 had hemorrhage, 1 in 4 sepsis, and 1 in 10 had injury. One third of hospitalized cases in Ethiopia and Kenya and one fifth in Nigeria were in the second trimester (Singh, 2010).

In Malawi unsafe abortion has been documented to be responsible for 24% of all maternal deaths. Beyond the estimated 66500 annual maternal deaths from unsafe abortion, a far larger number of women experience short- and long-term health consequences. In a Nigerian study based on data from 586 patients admitted with abortion complications in 2002, the most common were infection (55%), bleeding (17%) and trauma to the genital tract (12%) (Jackson et al., 2011)

Less common but very serious complications are septicshock, renal failures, perforation of the intestines and peritonitis, chronic pain, inflammation of the reproductive tract and pelvic inflammatory disease, which may lead to secondary infertility, are other common complications.

The treatment of abortion complications in hospitals consumes a significant share of resources, including hospital beds, blood supply, medications, and often operating theatres, anesthesia and medical specialists (e-Rehan, 2011; Guttmacher Institute, 2008). The irony is that almost all of the occurring complications are preventable should women get access to safe abortion services in healthcare facilities.

In Pakistan, in a hospital-based study, e-Rehan (2011) interviewed a total of 100 women who were admitted with 7 different serious complaints that occurred post-abortion as illustrated in the table below. The health situation of all 100 women required surgical interventions of various severity including; D& C for 56%, Laparotomy for 30%, intestinal resection for 4% and abdominal surgery for 10% of the interviewed women. In many women, more than one procedure was performed.

Table 3: Complications at the Time of Admission (n-100)

Vaginal Bleeding	72
Uterine Perforation	13
Bowel Perforation	8
Acute Renal failure	1
Bowel fistula	1

Bladder injury	3
Sepsis	2

Source: e-Rehan N. (2011). Cost of the treatment of complications of unsafe abortion in public hospitals. Journal of Pakistan Medical Association. 61(2):169-172

In their study of knowledge and attitudes of Iranian Policy makers towards Abortion Hourieh et al. (2010) asserted that "unsafe and illegal abortions are the third leading cause of maternal death. It affects physical, emotional and social health of women and their families": an assertion that corresponds with the finding from the Global Burden of disease study (2010) where unsafe abortion was also found the third leading cause of maternal mortality, globally.

A study of trends in maternal mortality in public sector institutions in Algeria found that the most significant cause of maternal mortality was uterine perforation. It was estimated that about half of all uterine perforations resulted from poorly performed illegal abortions (UN, undated).

With regards to the psychological aspect, Major and colleagues (2000) examined women's emotions, evaluations, and mental health after an abortion. Women arriving at 1 of 3 sites for an abortion of a first-trimester unintended pregnancy were randomly approached to participate in a longitudinal study with 4 assessments—1 hour before the abortion, and 1 hour, 1 month, and 2 years after the abortion. Eight hundred eighty-two (85%) of 1043 eligible women approached agreed; 442 (50%) of 882 were followed for 2 years. Pre-abortion and post-abortion depression and self-esteem, post-abortion emotions, decision satisfaction, perceived harm and benefit, and posttraumatic stress disorder were assessed. Demographic variables and prior mental health were examined as predictors of post-abortion psychological responses.

Two years post- abortion, 301 (72%) of 418 women were satisfied with their decision; 306 (69%) of 441 said they would have the abortion again; 315 (72%) of 440 reported more benefit than harm from their abortion; and 308 (80%) of 386 were not depressed. Six (1%) of 442 reported posttraumatic stress disorder. Pre-pregnancy history of depression was a risk factor for depression, lower self-esteem, and more negative abortion-specific outcomes 2 years post-abortion. The study concluded that most women do not experience psychological problems or regret their abortion 2 years post-abortion, but some do. These tend to be women with a prior history of depression (Major et al., 2000).

Bradshaw& Slade (2003)discussed in their study the effects of induced abortion on emotional experiences and relationships where they have critically reviewed several studies that were conducted to assess the health consequences of unsafe abortions. They reported that following discovery of pregnancy and prior to abortion, 40–45% of women have high levels of anxiety and around 20% experience significant levels of

depressive symptoms. Distresses reduce following abortion, but up to around 30% of women continue experiencing emotional problems after a month. Women due to have an abortion are more anxious and distressed than other pregnantwomen or women whose pregnancy is threatened by miscarriage, but in the long term they do noworse psychologically than women who give birth. Self-esteem appears unaffected by the process.

The experience of twenty-one women who had emotional difficulties related to an abortion was investigated using a qualitative research approach in the form of semi-structured, in-depth telephone interviews in 2009. Negative outcomes were experienced when the woman did not feel that the abortion was primarily her decision or did not feel that she had clear emotional support after the abortion. Evidence pointed to a division of labor between women and men regarding pregnancy prevention, abortion and childrearing; as a result, the majority of abortion-related emotional burdens fall on women. The study concluded that supporting a woman's abortion decision-making process, addressing the division of labor between women and men regarding pregnancy prevention, abortion and childrearing, and offering nonjudgmental support may guide interventions designed to reduce emotional distress after abortion (Kimport, Foster and Weitz, 2011).

Overall, most substantive studies in the last 30 years have found abortion to be a relatively benign procedure in terms of emotional effect- except when pre-abortion emotional problems exist or when a wanted pregnancy is terminated, such as after diagnostic genetic testing (Adler, 1989; Adler et al., 1990; Russo &Denious, 2001; TFMHA, 2008;AMRC, 2011).

2.12 Costs of Unsafe Abortion

Guttmacher Institute (2008) has categorized the cost oftreating the complications of induced abortion into two components: (1) direct short-term health system costs oftreating complications resulting from unsafe abortion and (2)economic and social costs of unsafe abortion to individuals and households.

Costs of treating abortion complications in developing countries are burdensome to their governments given the limited budgets allocated to the healthcare sector. Direct costs that include health personnel, medications, blood, supplies and equipment, and overnight stays may be sharply reduced only by guaranteeing women's access to safe abortion services. In some low-income and middle-income countries, up to 50% of hospital budgets for obstetrics and gynecology are spent treating complications of unsafe abortion.

Post-abortion care cost about US $100 per patient in Africa (2006).Direct cost to health systems in Africa was an estimated $170 million in 2006. Post-abortion care is many times the cost of a safe abortion. Estimated $19 million spent annually in treating unsafe abortion complications in Nigeria. It would cost only $4.8 million to

provide the contraceptive services needed to prevent the pregnancies resulting in these abortions. This is a cost-benefit ratio of about 4:1 (Singh, 2010).

In Nigeria, for example, the average costs for women admitted with complications after an unsafe abortion were four times higher than for women who had a safe abortion within the hospital setting. Thus, the consequences of unsafe abortion place great demands on the scarce clinical, material and financial resources of hospitals in many low-income countries where abortion is restricted by law(Bradshaw & Slade, 2003).

A review of medical records in 569 public hospitals in Egypt during 1 month noted that almost 20% of the 22656 admissions to obstetrics and gynecology departments were for treatment of an induced or reportedly spontaneous abortion.The cost per woman to health systems for treatment of abortion complications in Tanzania is more than seven times the overall Ministry of Health budget per head of population (Guttmacher Institute, 2008).

In Pakistan, in a study of cost of the treatment of complications of unsafe abortion in public hospitals 100 women admitted with complications of induced abortion were interviewed. The average cost of abortion was Rs.1686/-. The cost varied from Rs.500/- to 7,000/- depending on the city, type of provider and facilities available at the clinic.The average cost of treating the complications was Rs. 4,197/- ranging from Rs. 1600- Rs 45,000 depending on the type and extent of complications. This is equivalent toUS$ 20- 560 when the average monthly income in Pakistan is 250 USD, The study concluded that treatment for abortion-related complications consumes a large portion of hospital budgets for obstetrics and gynecology and results in considerable mortality and morbidity (e-Rehan, 2011).

Estimates from Uganda comparing costs of treatment of abortion complications with costs of providing safe, elective abortion show the potential resource-savings to health systems. Post-abortion care offered in tertiary hospitals by physician providers was estimated to cost health systems ten times more than elective abortion services offered by mid-level practitioners in primary care (Johnston, 2004)

In sub-Saharan Africa, two studies attempted to estimate costs at the national level. A 1997 South African study estimated that the total yearly cost of treating unsafe abortion morbidity in public hospitals was ZAR 9·74 million (about US$1·4 million). A 2002 study in Nigeria estimated that the total national cost of direct medical care for treating abortion complication patients was NGN 1400 million ($11·7 million). A second study in Nigeria estimated that the national cost of treating unsafe abortion complications in 2005 was $19 million (AkinrinolaBankole, unpublished data).

The social costs of unsafe abortion are widespread and damaging. About 200,000 children lose their mothers each year due to abortion-related deaths, globally. Women's abortion-related ill-health affects their children and families. Internalized stigma -guilt and shame –negatively affects women's well-being. Perceived or actual

stigma arising from suspicion of infidelity weakens marital relationship (Singh, 2010). Other reasons established in a review of IPPF research and projects on abortion-related stigma include; women being thought to be deviating from the motherhood role which most societies consider as an intrinsic part of being a woman, humanization of the foetus as a living being and thus equating abortion with murder, and women misbehaving assumptions and being sin committer or even promiscuous (Walker, 2014)

2.9 Religion and Abortion

Islam: Textually Islamprohibits the killing of a human being except in very specific circumstances. However, it does not mention abortion as per se leaving the door open for Islamic theologians' interpretations.Most of the early Islamic theologians permitted abortion on very tight grounds given that the gestational age of the fetus does not exceed 120 days of pregnancy and some confined it to 40 days only. Most Islamic countries opted for the tightest conditioning in this permissibility arguing for the unborn child's life protection imperative and therefore embodied this view and reflected it in their laws ((Sayed, undated).

Embryonic development was central to all Muslim arguments on abortion. According to Muslim scholars, it is lawful to have an abortion during the first 120 days, but after the stage of ensoulment (after the soul enters into the fetus) abortion is prohibited completely except where it is imperative to save the mother's life.

Nonetheless, Islam's approach to birth control and abortion allows women to prevent pregnancy but forbids them from terminating it. *Shari'a* allows abortion when Moslem doctors declare with reasonable certainty that the continuation of pregnancy will endanger the woman's life. This permission is based on the principle of "the lesser of the two evils" known in Islamic legal terminology as the principle of the more important and the less important. In this case, one is faced with two forbidden cases: either abort the unborn child or let a living woman die. Definitely, the life of the mother is more important than the unborn child, so abortion is permitted to save the life of her person (Hessini, 2007).

"The Hanafi scholars, who comprised the majority of mainstream Muslims in later centuries, permitted abortion until the end of the four months. According to them, a pregnant woman could have an abortion without her husband's permission, but she should have reasonable grounds for this act. One reason, which was mentioned frequently, was the presence of a nursing infant. A new pregnancy put an upper limit on lactation, and the jurists believed that if the mother could not be replaced by a wet nurse, the infant would die" (Sayed, undated).

With no explicit statement on abortion in Quran, Islamic scholars made *fatwas (religious edict)*thatprovided the foundations for subsequent pertinent laws in effect in today's Moslem countries. For example, a 1991 *fatwa* in Saudi Arabia permitted

abortion in the four months after conception in the case of fetal impairment. In Iran both the Grand Mufti and the Ayatollah Ali Khameni issued two *fatwa* in 2005 permitting abortion under specific conditions; the first provided for abortion in cases of genetic disorder in the first trimester and the second allowed abortion in the first trimester if a woman's health and life were at risk (Rasch, 2011).In Algeria, the Islamic Supreme Council issued a fatwa in 1998, stating that abortions were allowed in cases of rape, as rape was being used by religious extremists as a weapon of war. However, neither of these *fatwas* was translated into law.

Christianity: Abortion is never mentioned in the Bible, despite the fact that it has been practiced since ancient times by a variety of means. However, a number of Bible passages have been cited as being relevant to the abortion issue. The Roman Catholic Church says that deliberately causing an abortion is a grave moral wrong. The Church says that human life begins when the woman's egg is fertilized by a male sperm. The Church condemned abortion as early as the 2nd century after Christ. Pope John Paul II took a very strong line on abortion, describing it as murder (Christian Bible Reference Site Website)

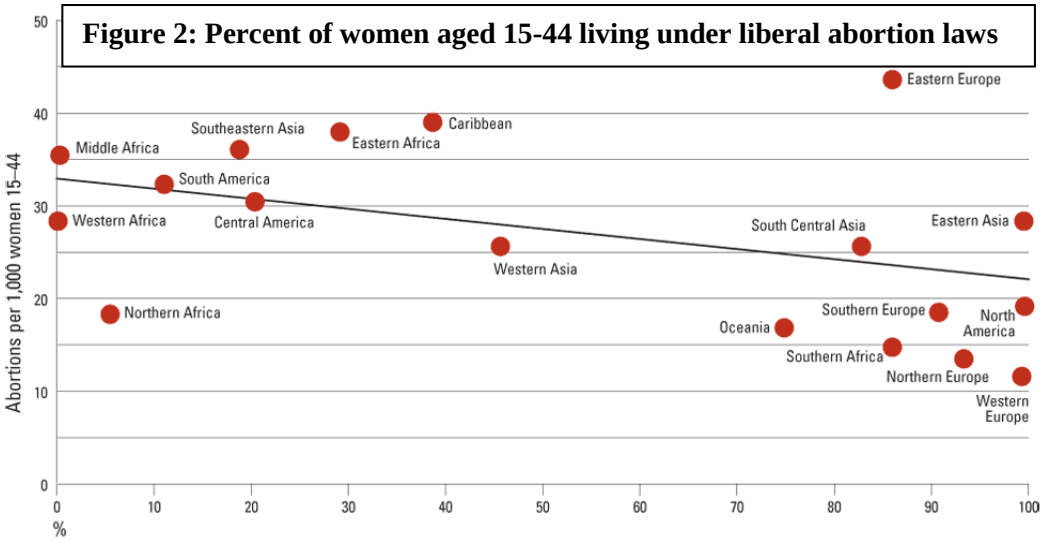
In the USA; a country with a Christian reference in Law, prior to 1973, abortion was legal in some of the 50 states, usually with restrictions. In 1973, the United States Supreme Court ruled that a woman has a right to an abortion during the first trimester of pregnancy. However, the states are still allowed to regulate abortion during the second trimester and prohibit it during the third trimester. Since that time, abortion has become one of the most controversial and divisive issues within America.

Overall, people of both faiths have deep and serious doubts about the morality of abortion. At the same time, they believe abortion may be the lesser of evils in some cases. Situations thought to justify abortion include, with varying degrees of acceptance, danger to the mother's life, defective fetus, rape, incest, risk to the mother's physical or emotional health, unstable family situations and mental retardation of the mother.

2.10 National Laws and Unsafe Abortion

As can be read in the figure below, it appears that global abortion rates are lower in sub-regions that have liberal abortion laws. Nevertheless, compared to the sburegions with less liberal laws Northern Africa seem to be faring best followed by Western Asia in terms of the abortion rate per 1000 women at 15-44 years of age.

Figure 2: Percent of women aged 15-44 living under liberal abortion laws



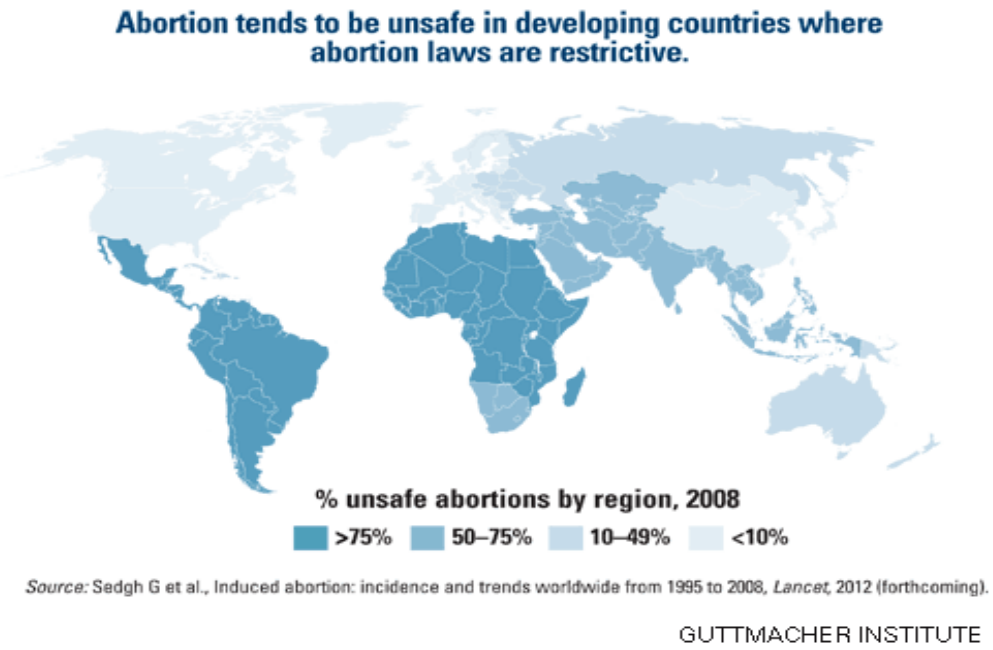
Source: Sedgh et al, 2012. Guttmacher Institute.

Laws of 197 countries governing the practice of induced abortion across the world are divided into five main categories; to save a woman's life or prohibit pregnancy altogether, to preserve physical health, to preserve mental health, socioeconomic grounds and no restriction. In 68 countries, abortion is illegally allowed on any reasons or only to save the woman's life, and 26% of the world's population are living in countries with such restrictive laws. In 36 countries, about 10%of the world's population, abortion is permitted merely to protect a woman's physical health and in another 23 countries, nearly 4% of the world's population, also to protect her mental health. Eventually, 21% of the world's population lives in the14 countries that allow abortion on socioeconomic grounds and another 39% are living in the remaining 56 countries, where abortion is available without restriction as to indication, albeit not gestational length(Rasch, 2011).

Induced abortion is allowed by most countries on the world. In 2009, 97% ofall countries permitted abortion to save a woman's life. Nowadays, there is high tendency toward increasing the scope of the permission of abortion, abortion laws and regulations are sharply more restrictive in developing countries where abortion tends to be unsafe as the figure below clearly shows.

Canada is unique in not having a law regulating abortion after the Supreme Court of Canada struck down Canada`s abortion law as unconstitutional in 1988 since it infringed upon a woman`s right to life, liberty and security of the person, So, violating Section 7 of the Charter of Rights and Freedoms. During an attempt to place abortion in the criminal code again, a tied vote in the Senate in 1991 resulting in defeat of the Bill C-43 and abortion is now treated like any other medical procedure, with no special laws governing it.

Figure 3



Before the legalization of abortion throughout the USA in 1973, abortions were allowed in some of the states. In 1972, 586,800 legal abortions were performed in those states. It is estimated that between 200,000 and 1,200,000 illegal abortions were also performed each year. Many women living in areas where abortion was not allowed simply traveled to states or countries where abortion was legal to terminate their pregnancies. Those who could not afford that option often sought out someone to perform the procedure illegally. Some sympathetic doctors were willing to help. But many illegal abortions were performed by unqualified practitioners, and many women suffered exploitation, sexual abuse, injury, infection, sterility and even death at the hands of these "back alley" practitioners (Lowenstein, 1996).

The majority of Western Asia and Northern Africa countries recognize Islam as the state religion. Most have dual systems of law. Secular codes, often based on colonial law, regulate most legal matters, while Islamic law covers the family, marriage, divorce, inheritance and custody. Turkey is the one fully secular country in the region, while only Iran, Saudi Arabia and Sudan apply Islamic law to all matters of jurisprudence, including abortion.

However, with the increasing expansion and developments in the public health field and given the growing pressure on countries to observe their progress in meeting the MDGs where bringing down maternal mortality figures is a pillar, countries endorsed abortion laws including provisions that secure its legal permissibility. Even if this was on very tight grounds most often in Arab/Islamic countries these laws contributed to

improving access to safe abortion services in countries where social stigma including among healthcare providers themselves is less of an access barrier.

Overall, the laws of 13 of the 21 countries in the region are very restrictive, only permitting abortion if the woman's life is at risk. Under colonial penal codes, abortion was prohibited in Lebanon, Libya, Mauritania and Syria in all circumstances; those laws now allow abortion only in case of risk to the woman's life. Abortion in Yemen is governed by the 1994 penal code, based on restrictive Islamic law, which prohibits abortion except to save the life of the woman. Similarly, in Algeria, Egypt, Iran, Pakistan and Turkey abortion is forbidden except if the pregnancy endangers the mother's life. The Turkish law that was mandated in 1983 allowed abortions during the first 10 weeks of the pregnancy.

The Jordanian law under article 13 about public health stated that "it is prohibited for any doctor to prescribe anything that leads to aborting a pregnant woman, or to make an abortion for the pregnancy, unless the abortion was necessary to protect the woman from the threat to her health or exposing her to death, and that this is done in a public hospital or in a maternity hospital". In addition, this law requests documented approval from the woman, or the approve of her husband or her guardian and the certification of another two doctors that the intended abortion is a necessity for the women`s life and safety.

Tunisia was the first Muslim country to legalize abortion on 2 stages in 1965 and 1973, sequentially. In 1964, Tunisia established its first population policy, whose main goals were to improve the health of women, ensure the fullest development of families, control population growth and reduce the negative health results of unsafe abortions. At the time, women suffering from complications of illegal abortions occupied 25% of all Tunisian hospital beds. In1965, the 1940 penal code was replaced. The new code permitted abortion on request if the abortion was performed before the end of the first trimester, the woman had at least five living children and the written agreement of both husband and wife was obtained. Unsafe abortions continued, however, because many women could not meet the parity requirement that basically was a law- embedded barrier to Tunisian women access to safe abortion. Conversely, subsequent to the 1973 law, maternal mortality from abortion dropped and a decrease in abortion between 1990 and 2003 (from 11 to 7/1000) was recorded (ElAdawy, 2010).

Lebanese law that was drafted in 1943 based on the French penal code at the time (Hessini, 2007) comprises articles 539-546 where abortion is illegal under all circumstances. It wasn't until October 1969, that the Presidential Decree No.13187 allowed abortion only to preserve the woman's life, if in danger (United Nations, 2001). "The Lebanese law that is governed by eight articles prohibits the dissemination of information on abortion or methods used to facilitate it, the selling or accusation of objects that are designed to perform it, in addition to punishing any woman who induces abortion and any other person who aids her to do so" (United

Nations, 2001). Even with the woman consent, under the law, the person who performs an abortion is subjected to one to three years of imprisonment and the woman herself is subjected to six months to three years imprisonment.

The Algerian Criminal Code of 8 June 1966 (Articles 304-313) prohibits abortion unless it is performed as an indispensable measure to save the life of the mother. The Public Health Code of 1976 (Articles 28 and 414), however, specifies that abortion is lawful when performed before foetal viability as an essential therapeutic measure to save the life of the mother or to safeguard her seriously endangered health. The Law on the Protection and Promotion of Public Health(Article 72) permits abortion to be performed as an essential measure to preserve a woman's mental equilibrium when it is seriously jeopardized. A woman inducing or agreeing to the inducement of her own abortion is subject to imprisonment for a period of 6 to 24 months and a fine. The person who performs the abortion is subject to imprisonment for one to five years and a fine. If that person is a medical practitioner, he or she can also be suspended from practicing his or her profession(United Nations,undated).

Under the Penal Code of Qatar of 1971, abortion is generally illegal. A pregnant woman who performs an abortion on herself or consents to its performance is subject to up to five years' imprisonment. A person who intentionally performs an abortion on a pregnant woman is subject to the same penalty if she consents, or to up to ten years' imprisonment if she does not consent. The Code also provides, however, that the performance of an abortion to save the life of the pregnant woman is legal. Law No.2/1983 governing the practice of the professions of physician, surgeon and dentist, contains a similar provision. Moreover, it provides that if the pregnancy is of less than four months' duration an abortion may be legally performed: a) if continuation of the pregnancy would cause certain and serious harm to the mother's health; or b) if there is evidence that the child would be born with serious and incurable physical malformations or mental deficiency, and both spouses consent to the abortion.

Under Law No. 3/1983, a medical commission consisting of three medical specialists must recommend the procedure before an abortion can be performed. All abortions must be performed in a government hospital (United Nations, undated).

Legalization of abortion saved lives. In South Africa, between1994-2000, severity of abortion related complications dropped manifesting in fewer post-abortion infections, larger gains by young women and a decline in deaths due to unsafe abortion by at least 50% (Jewkes et al., 2004 in Singh, 2010).

A recent study that was conducted by the "World Public Opinion" organization revealed that 53% of Egyptians, 57% of Palestinians and 55% of Iranians are in opposition to their governments' policies of criminalizing abortion (Megam , 2014).

2.11 Criminalization of Abortion in Palestine

In Palestine, abortion is criminalized under Articles 321-324 and 325 of the Jordanian Penal Code of 1960. Penalties are extended to the pregnant woman& to all individuals and healthcare staffs who assist her in performing the abortion. This intimidating legal approach makes it hard for a woman to secure a safe abortion if a pregnancy occurred as a consequence of a sexual crime and forces her, as a substitute, to resort to the risky method of unsafely inducing an abortion. Abortion is also addressed in the Penal Code of 1936 where Articles 175, 176, and 177 offer similar arguments for criminalization as the Jordanian Penal Code of1960. Moreover, the above stated Articles of the Jordanian Penal Code of 1960 and Article 175, et al. of the Penal Code of 1936 do not fully concord with the United Nations Millennium Declaration, in particular Millennium Development Goal 5(MDG5), which seeks to reduce unsafe pregnancy rates, and improve maternal health and access to reproductive health services (Jallad, 2012).

The Palestinian Authority is actively seeking to meet the MGDs and has monitored progress accordingly. Fortunately, Article324 of the Jordanian Penal Code of 1960 affords a mitigating excuse for a woman and family members up to the third degree who obtains an abortion for "honor" related reasons. In cases of extra-marital pregnancies, law provides for a more lenient punishment for abortion if the motive is to cover the woman's perceived "dishonorable" conduct and to protect her and her family's reputation (Jallad, 2012). So, the reduced penalty is not about female reproductive health, women's human rights, individual dignity or harm reduction to the woman's person but rather about the culture of honor and shame in the service of patriarchy.

In light of this literature, in Western Asia and Northern Africa women's health advocates must promote liberalizing abortion laws ensuring that laws are implemented to the fullest extent possible and in a dignified manner to women and their families. Advocates may cite local and international evidence of the potential impact on reducing maternal deaths and disabilities, and the resulting psychological and financial burdens that unsafe abortions pose for women, families, and healthcare systems.

Where abortion laws have become more liberal, unsafe abortion and related maternal deaths have declined. Following the legalization of abortion in South Africa, for example, deaths due to unsafe abortion decreased by 90 percent from 1994 to 2001 (Berer, 2004)

Chapter III
Study Methodology

3.1 An Introductory Note on Abortion Categories.

Conceptually and operationally, in this study, an important distinction was made between a miscarriage which is spontaneous abortion and induced abortion because of the choice element inherently embedded in miscarriage but not in induced abortion. Miscarriage, by its very definition, is a spontaneous abortion. The elective ending of a pregnancy is a completely different situation than the loss of a wanted pregnancy, both medically and emotionally. The second made distinction was between safe and unsafe induced abortion due to the huge vulnerability gap between the two abortion categories.

3.2 Study Design

This assessment utilizes a descriptive cross-sectional exploratory mixed-method approach to address the question of abortion with particular emphasis on unsafe abortion in Hebron governorate known to be a highly conservative community in Southern West Bank- State of Palestine.

Triangulation principle espoused several data sources, research techniques and data collection methods and tools were employed to validate findings, pinpoint issues of interest and construct the most comprehensive and solid depiction of the assessment in order to enable planners and policy makers within PFPPA, interested donors, partners from other NGOs or the government of Palestine correct pitfalls and capitalize on achievements. Triangulation is a strategy that controls bias and helps to establish valid conclusions because it uses at least three (tri) different types of methods or tools to collect data from which conclusions are drawn. Therefore, it strengthens the study by combining methods. In this needs assessment both quantitative and qualitative data collection methods and tools were utilized. By so doing, multiple diverse perceptions of the single concept of abortion are obtained. Cross-checking of data gathered across multiple sources of information was conducted for its further validation.

3.3 Target Population

In this assessment different complementary population groups were targeted. At the user end, women attending the PFPPA clinics and service delivery points at four urban and rural sites were targeted with a questionnaire. This is between 19 October and 10 November 2014. The sample was purposively chosen from women who visited the clinics during the mentioned period and have experienced abortion at least once in their

lifetime. At the qualitative part of the study specific stakeholders were interviewed using different interviewing format. Two focus groups interviews were conducted; the first was with health and social work professionals selected from MOH and NGOs while the second was with the PFPPA staff solely. At the macro policy and strategic levels, expert opinion was solicited through a small group interview with selected stakeholders being senior service providers, managers, policy makers or planners in the areas of; healthcare, human rights, law and social work.

3.4 Sampling Methods

Purposive none-random sampling method was used in the quantitative part of the study where the questionnaire was completed. Purposive (also known as judgmental) sampling is a non-probability sampling technique where the researcher selects units to be sampled based on her knowledge and professional judgment. Purposive sampling is used if the researcher knows a reliable professional or authority that she thinks is capable of assembling a representative sample. However, that the selection is made none-randomly, the findings are then non general is able, which makes it a limitation in this study. Befitting the purpose of this assessment, this sample selection was made jointly by the researcher and the executive director of PFPPA based on its expected usefulness for employing the subsequent data collection methods. A total of 560 women partook in the study and filled up the questionnaires. Of these, 19 were dropped out for inappropriate completion bringing the total number of the valid questionnaires to 541.
As for the qualitative part, stakeholder sampling is found to be particularly useful in the context of this assessment. It involves identifying the major stakeholders who are involved in designing, giving, receiving, or managing the service being assessed, and who might otherwise affect or be affected by it. Participants in this part both in focus groups and experts meeting totaled 21 individual.

3.5 Data Sources

Data sources were secondary and primary as follows.

A) *Desk review for secondary data analysis from documented evidence:* Primarily of relevant documents, laws and studies including the PFPPA and the IPPF documents and previous reports in addition to other information obtained from ministries and NGOs

B) *Primary data from direct sources:*

1) **Quantitative data** was collected using a specially tailored and validated questionnaire targeting women who had at least one abortion experience and receive reproductive health services from any of the four PFPP different service locations in Hebron governorate being Hebron or Halhoul clinics, and any of its

two outreach service points. Between 19 October and 10 November, 2014 a total of560 eligible women participatedafter being invited to participate using a purposive sample selection method from the four service locations.

2) **Qualitative data was collected from three different stakeholder categories**.
   a. **Two Focus Groups Discussions** (7-10 participants each); the first was with PFPPA staff of the service delivery points who are involved in designing, giving, or administering the program or service being assessed. The second was with relevant stakeholders from MOH and NGOs serving within Hebron governorate in the area of RH to gauge their views, practices and own assessment of the existing and lacking services in relation to safe/unsafe abortion as well as abortion service access barriers.
   b. **One Experts Group Interview:** A small group of 7 experts were interviewed together to explore in-depth stakeholder opinions, similar or divergent points of view, or judgments about abortion-related services and information, in addition to their recommendation for improvements in service provision.
   c. **Debriefing Workshop** involving key internal and external stakeholders with the view of strengthening the quality of the collected data and validate it in addition to promoting stakeholder engagement. This will take place after the completion of first draft of the report.

3.6 Questionnaire Construction and Administration

Guided by the extensive literature review the investigator carried out to this purpose, she developed a special questionnaire to collect information rich data from the service users in the four reproductive and sexual health service sites of PFPPA in order to examine the abortion experience of the study participants. The questionnaire consisted of the following four sections: demographic characteristics, reproductive history, the woman and her confidents' abortion experience and the woman's knowledge about abortion and related information. These sections were covered in a total of 40 questions the vast majority of which is closed ended with only few open ended ones. Questionnaire completion time was 15-20 minutes on average per participant.

The questionnaire(Appendix II) was administered by PFPPA staffs working in the targeted locations after being trained by the principal investigator. The data collection process was overseen by a fieldwork supervisor; a senior PFPPA staff who referred to the principal investigator in close consultation and follow up as needed. All women who attended the services between 19 October and 10 November, 2014 were invited to participate after being informed about the study, its purpose, use of the yielded information and the importance of their contributions in improving the services on offer. In addition, ethical considerations of anonymity, confidentiality, right to refuse participation or withdraw from it at any point without having to explain about the reason were all stated at the cover page of the questionnaire and read to each participant by the fieldworker who closes by enquiring if the woman have any question to ask before beginning the questionnaire administration process. This is to ensure the participant readiness, willingness and satisfaction with the participation.

3.7 Validation of the Questionnaire: Reliability & Validity

Reliability refers to the consistency and stability in the results of a test. The conducted split-half reliability estimation method divides the scale into two halves, so that the first half forms the first part of the entire test and the second half forms the remaining part of the test. Both halves are normally of equal lengths and they are designed in such a way that each is an alternate form of the other. Estimation of reliability is based on correlating the results of the two halves of the same test. If the two halves of the test are parallel forms of one another, the Spearman Brown prophecy formula is used to estimate the reliability coefficient of the entire test. In the SPSS program used here, the 'split–half' model for reliability analysis is conducted on the assumption that the two halves of the test are parallel forms.

Reliability Coefficients Output: Split-half model using 12 items

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Correlation between forms= .7328	Equal-length Spearman-Brown= .8458
Guttman Split-half= .8439	Unequal-length Spearman-Brown= .8458
CronbachAlpha for part 1= .7911	Cronbach Alpha for part 2= .7167
6 items in part 1	6 items in part 2

The above SPSS output contains the results of reliability analysis based on the split-half model. The correlation between the two halves (or parts), labeled on the
output as "Correlation between forms", is .7328. This is an estimate of the reliability of the scale if it has twelve items. The equal length Spearman-Brown coefficient, which has a value of.8458 in this case, tells us what the reliability of the entire scale would be if it was made up of two equal (or parallel) parts that have a twelve-item reliability of .7328. Since the two parts of the scale are of equal length, the two Spearman-Brown coefficients are identical and indicate high reliability. The Guttman split-half coefficient is another estimate of the reliability of the overall scale that was conducted. It does not assume that the two parts are equally reliable or have the same variance; hence the reliability coefficient produced is smaller. Finally, separate values of Cronbach's "are also shown for each of the two parts of the scale in the output. Results of all conducted reliability tests are high in statistical terms and indicate strong data collection instrument (the questionnaire).

As for validity which is the amount of systematic or built-in error in measurement, the questionnaire's face and content validity were established before data collection first by consulting panel of experts and second by pilot testing. Based on the panel's reading and feedback, some questions were omitted, some modified, and others were added for comprehensiveness. The rest showed relevance and adequacy. Then a second draft questionnaire was ready for pilot testing with 20 women who were not included in the study sample but who experienced abortion at least once in their life time. Examples on the addressed questions included; is the questionnaire comprehensive enough to collect all the information needed to address the purpose and goals of the study? Does the instrument look like a questionnaire? And does it represent the content?

3.8 Data Analysis and Synthesis

Two types of data were gathered in this assessment; quantitative and qualitative. Quantitative data yielded from the questionnaire after being completed from service users were entered into the computer using the statistical Package for Social Sciences (SPSS), coded, cleaned and statistically analyzed using basic descriptive statistics. These were presented in frequency tables and interpreted in a narrative manner.

Analysis of qualitative data from focus group discussions and group interview transcripts, or open-ended questions helped identify similarities and differences across several accounts, as well as directions, trends and tendencies. For interpretive content analysis, data was categorized into recurrent themes and topics that are relevant to answer the study questions. The reasoning logic was therefore a deductive one. It worked from the more general content, which were the transcripts and open ended questions and ended more specifically thru conclusions that were made from available facts and observations.

Chapter 1V
Presentation and Analysis of Findings

4.1 Introduction

This chapter presents analysis and interpretation of the quantitative data results collected by use of a specially tailored questionnaire and the qualitative data collected in focus group discussions and experts meeting. The quantitative part is presented first followed by the qualitative one. Descriptive statistics were utilized to analyze the socio-demographic variables in frequencies and percentages. Statistical analysis procedures were utilized for questionnaire items which are ranked in ordinal measure of frequency and percents and presented in interpreted tables. The qualitative data are then thematically presented, content analyzed and discussed.

4.2 The Quantitative Part: The Questionnaire

4.2.1 Socio-Demographic Characteristics

The profile of the participants' socio-demographic variables was obtained for the participants' age, living place, education level, work, as well as their husbands' work and size of the family. The socio-demographic variables were not manipulated or correlated with the dependent variables. The findings are presented below to give an idea about the participants' socio-demographic background.
The age of the women who participated in this study ranged from 18 - 59 years**,** and the highest percentage was for those aged 18 – 29 years.

Table (4): Age of Respondents

Age	Frequency	Percent
18 - 29 year	177	32.7%
30 – 39 years	176	32.5%
40 – 49 years	125	23.1%
50 – 59 years	63	11.7%
Total	**541**	**100.0%**

As illustrated in table 5 below, 39.2% of the respondents live in cities, 35.5% live in towns, 24.2% in villages and very few (1.1%) live in camps.

The question on the highest attained level of education shows that 3% of the respondents are uneducated or illiterate, 23.1% completed elementary school compared to 41% who completed secondary school, 12.2% hold a diploma, 19.2% are Bachelor's degree holders, and 1.5% hold a Masters degree as can be seen in table 6 below.

Table (5): Respondents' Living Place

Place	Frequency	Percent
City	**212**	**39.2%**
Town	**192**	**35.5%**
Village	**131**	**24.2%**
Camp	**6**	**1.1%**
Total	**541**	**100.0%**

Table (6): Respondents' Highest Attained level of Education

Age	Frequency	Percent
Uneducated/illiterate	16	3.0%
Elementary Education	125	23.1%
Secondary Education	222	41.0%
Diploma	66	12.2%
Bachelor's Degree	104	19.2%
Master Degree	8	1.5%
Total	**541**	**100.0%**

Comparatively, the husband's highest attained level of education is shown in table 4 below. It indicates that 1.8% are uneducated or illiterate, 32.7% completed elementary school education compared with 36.2% who completed secondary school including the Palestinian School leaving exam (Tawjihi) that qualifies them for higher education entry. However, of these the majority appear to have opted for direct entry into the labour market. Only 7.9% of the husbands reported having a diploma, 19.6% a Bachelors and 1.7% reported having a Masters degree.

Comparing the data in tables 6 and 7 it can be observed that only 7.9% of the husbands completed a diploma vs. 12.2% of the women. Meanwhile, around the same percent of both hold a bachelor degree being 19.6% for husbands vs. 19.2% for women. This reflects "formal equality" among the study respondents and their spouses in higher

education in terms of access and participation but not beyond that especially in qualitative terms.

Table (7): Spouse Highest Attained level of Education

Age	Frequency	Percent
Uneducated/illiterate	10	1.8%
Elementary Education	177	32.7%
Secondary Education	196	36.2%
Diploma	43	7.9%
Bachelor Degree	106	19.6%
Master Degree	9	1.7%
Total	**541**	**100.0%**

About whether the attained higher education serves as an asset to women employment, figures in tables 8 and 9 below point at the obvious gender gap whereby the Palestinian education system fails to provide for equal opportunities for women and men to transition into the labour market, despite having achieved gender parity in higher education.

Table (8): Respondents by Employment Status

Employment status	Frequency	Percent
Yes	111	20.5%
No	430	79.5%
Total	**541**	**100.0%**

Around 80% of the study respondents (women) are not employed compared to 20.5% who are. Conversely, 74.5% of the spouses (men) are employed vs.25.5% who are not.

Table (9): Spouse by Employment Status

Employment status	Frequency	Percent
Yes	403	74.5%
No	138	25.5%
Total	**541**	**100.0%**

The majority of the study respondents (n=412=77.8%) live in households with 4-9 members while 57 (11.5%) reside in households with 10 or more members.

Table (10): Number of Family Members

Number of family members	Frequency	Percent
1-3	63	11.64
4-6	225	41.59
7-9	196	36.22
10-12	32	5.91
13-15	17	3.13
16 & more	8	1.46
Total	**541**	**100**

4.2.2 Reproductive History

The study participants' age at marriage ranged between 14 and 40 years. Around half (49%) were married early between the ages 14-18 years while 40.9% were married between 19-23 years. As to the remaining 10%, 7.2% were married at 24 – 28 years and 2.7% were married at 29 - 40 years of age.

Table (11): Respondents by Age at Marriage

Age at Marriage	Frequency	Percent
14 – 18 years	265	49%
19 – 23 years	221	40.9%
24 – 28 years	39	7.2%
29- 33 years	10	1.8%
34 – 40 years	5	0.9%
Total	**541**	**100.0%**

Table 12 below indicates that the respondents' age at first pregnancy ranged between 14 - 42 years; 40.7% were pregnant for the first time as early as the ages 14-18 years. Around 47%, 10.2% and 2.7% were pregnant at the ages; 19 -23, 24 -28 and 29 – 42 years, sequentially.

Table (12): Respondents by Age at First Pregnancy

Age at 1st pregnancy	Frequency	Percent
14 – 18 years	220	40.7%
19 – 23 years	252	46.6%
24 – 28 years	55	10.2%
29- 33 years	10	1.8%
34 – 42 years	4	0.7%
Total	**541**	**100.0%**

As illustrated in tables (13) & (14) below, the respondents' age at first childbirth ranged between 14- 42 years. Around a third (28.3%) went through their first childbirth between the ages 14-18 years. More than a half (52.7%) went through it at 19 -23, 14.4% at 24 -28 and 4.60% did so at 29 – 42 years of age. The number of living children for the participating women ranged between 0–15 children with around equal percent sitting at the 0-4 (48.8%) or 5-9 (47.2%) categories. Of the later, 30.3% have 5 or 6 living children.

Table (13): Respondents by Age at First Childbirth

Age at first childbirth	Frequency	Percent
14 – 18 years	153	28.3%
19 – 23 years	285	52.7%
24 – 28 years	78	14.4%
29- 33 years	17	3.1%
34 – 42 years	8	1.5%
Total	**541**	**100.0%**

Table (14): Respondents by Number of Living Children

Number of Children	Frequency	Percent
0-4	264	48.8%
5-9	256	47.2%
10 -15	21	3.9%
Total	**541**	**100.0%**

The study results revealed that 65.4% of the surveyed women use family planning methods compared to 34.6% who do not use any method. This does not necessarily reflect the overall family planning utilization rate in Palestine for the sample selection bias embedded in targeting women at the FPPA service facilities as explicated under the methodology chapter.

Table (15): Respondents by Use of a Family Planning Method

	Frequency	Percent
Yes	354	65.4%
No	187	34.6%
Total	541	100.0%

Those who declared using a family planning method where asked about what method they use. Table (16) below indicates that the most widely used method is the Intrauterine Device (IUD) reported to be used by more than two thirds of the women (64.5%) followed by 14% using the oral pills with a considerable gap in the frequency of its use and the IUDs. Condoms are used only by 7.7% of the women. This is less than the 10.9% who use the natural contraceptive methods. Some negligible percentages of women: 1.4%, 1.1% and 0.3% use the injections, bags and suppositories, sequentially. Few women chose not to report on the type of their used methods.

Table (16): Respondents by Type of the Used Family Planning Methods

Type of the family planning method used	Frequency	Percent
Oral Pills	49	14.0%
Injections	5	1.4%
Suppositories	1	0.3%
Bags	4	1.1%
Condom	27	7.7%
Intrauterine Device	225	64.5%
Natural Contraceptive methods	38	10.9%
Total	**349**	**100.0%**

These findings indicate that women still endure the major burden and responsibility for family planning. Despite the highest safety, effectiveness and none-invasiveness of the male condom its utilization remains pretty low compared with the invasive women used

methods particularly noting the IUDs. In spite of the obvious gender element inherent in this utilization pattern it also rings the bell as to the role and usefulness of the relevant health education and awareness raising efforts that have been going on for a good number of years now with the outcomes still being far from acceptable. This deserves some serious in-depth examination of the matter with special emphasis on the current utilization level of the male condoms.

Women who reported not using a family planning method were asked about the reasons. Table (17) below clearly shows the gender inequity in decision making power within the Palestinian family even with regards to matters that relate to and directly impact the women's life, body and wellbeing in the first place. In more than 40% of those who do not use a family planning method, the husbands' unwillingness to use a method or let the wife use one is the reason for the none-use. Fear of contraceptives side effects such as obesity, cancer or bleeding ranked second (20%) distantly followed by 5.70% who reported the couple inability to withstand the extended family pressure for having a lot of children. Lack of family planning services, not knowing about family planning services places of availability, the woman inability to comply with the instructions for the use of contraceptives, closely followed with the percentages of 3.40% for the first two and 2.80% for the third. The remaining percentage of 22.70% chose not to declare their reasons and so reported them as others.

Table (17) Reasons for the None-use of Family Planning Methods

Reasons for not using a family planning method	Frequency	Percent
Husband unwilling to use a male-used family planning method	54	30.7%
Husband unwilling to allow his wife use a female-used family planning method	18	10.2%
Couple's inability to withstand the extended family pressure for having a lot of children	10	5.7%
Lack of family planning services	6	3.4%
Do not know where family planning services are available	6	3.4%
I can't comply with the instructions for the use of contraceptives	5	2.8%
I fear the symptoms of contraceptives side effects (obesity, cancer or bleeding)	37	21.0%
Other reasons	40	22.7%
Total	**176**	**100.0%**

4.2.3 Women Experience with Abortion

Participating women were asked about if they experienced an abortion ever, regardless of type. More than 70% responded positively compared to 28% who responded negatively as shown in figure (4) below.

Figure (4): Respondents by Having Ever Experienced an Abortion

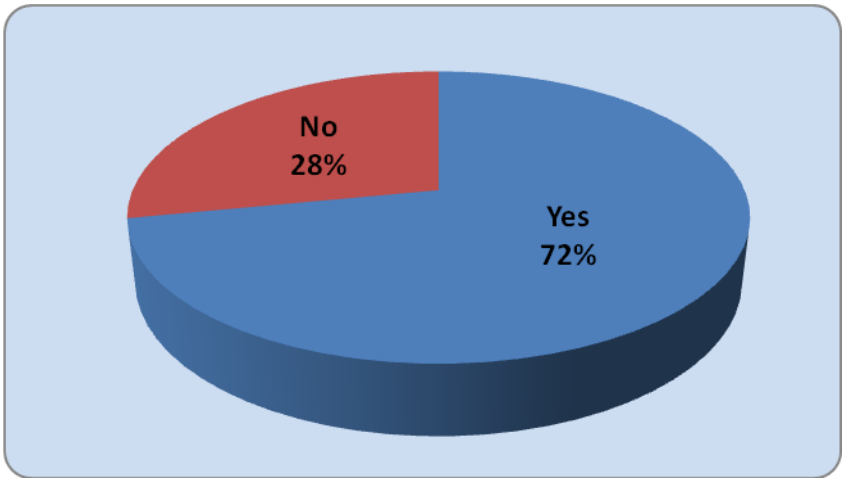

Table (18): Number of Abortions Experienced by Each Woman

Number of abortions	Frequency	Percent
1	182	33.6%
2	109	20.1%
3	48	8.7%
4	26	4.8%
5	14	2.6%
6	4	0.7%
8	5	0.9%
11	1	0.2%
Total aborted	389	71.7%
Not aborted	152	28.3%

Grand Total	**541**	**100.0%**

Those who responded positively were then asked about the number of times they endured an abortion. More than the half (53.7%) reported having experienced it once or twice. Another 16.1% experienced abortion between 3-5 times while a negligible 1.8% experienced it 6, 8, and 11 times. The details are presented in table 15 above.

Table (19) indicates that 60.5% of the women who experienced abortion reported their abortion as being spontaneous abortion that occurred against their will. But then spontaneous does not necessarily imply complete abortion. On the contrary, in the case of these study participants it appears that the majority have been incomplete abortions. This is compared with 11.3% who said their abortions were induced.

Table (19) Type of the Experienced Abortion

Experiencing abortion		**Frequency**	**Percent**
Type of abortion	Spontaneous/miscarriage	327	60.5%
	Induced	61	11.3%
Total aborted		389	71.9%
Not aborted		152	28.2%
Total		541	100.0%

When asked about the gestational age of the foetus 37% of the aborted women said it was during the first or second trimester of the pregnancy. Of these 25.9% occurred within the first trimester, in specific, while more than a third could not remember this piece of information

Table (20): Identity of Individuals with Prior knowledge About the Abortion

Individuals with prior knowledge about the abortion	**Frequency**	**Percent**
Nobody at all	263	67.6%
My husband only	75	19.3%
My husband and mother-in-law	17	4.4%
My husband, mother-in-law and own mother.	29	7.5%
Close friend only	5	1.3%
Total	**389**	**100.0%**

Women were asked about who had prior knowledge about the abortions they underwent. Table (20) above indicates that 67.6% of the abortions occurred with the prior knowledge

of nobody expect the woman herself. In 19.3% of the abortions only the husband knew. In 4.40% the husband and mother-in-law did while in 7.5% the husband, mother-in-law and own mother knew. In 1.30% only a close friend had a prior knowledge about the abortion to happen.

Of these, the most alarming remains the first and highest (67.6%) where the woman is alone by herself in an extremely vulnerable position with the approval and support of nobody. This means that she is alone with the consequences too. What follow from this is the question as to the reasons why a woman chooses this risky path in an issue that is a fundamental human right to her: the right to choice and the right to bodily integrity.

As to the reasons for the conducted abortion, the most frequently stated one was "ultrasound scan has shown congenital defects in the feotus". This was followed by "immediate pregnancy after recent childbirth". Serious chronic illness of the woman such as diabetes, heart disease, anemia, cancer or others came third. Other reasons appeared less frequently. Of these the most alarming was because the woman "expected that the sex of the fetus is female": a confirmation about the existent son preference believed to have been over with more progressive social changes, more equitable gender relations, and the growing modernization in Palestine, some argue.

In terms of the place where abortions were done, table (21) below indicates that more than a third (31.2%) was done by the woman herself at her own home and in around one fifth (18.5%) they were done by the *Arab Daya* at her home. Combined these un/inappropriately attended abortions constitute around 50% of the reported abortions whereby these women were subject to all associated risks and complications. Not to forget those who chose not to respond to this question totaling 75 of the women who reported having gone through an abortion procedure. On the other hand, 43.6% of the abortions were done at a health center or hospital while 6.7% were done in a private medical/doctor clinic.

Table (21): Abortions by person and place of completion

Person and place of induced abortion	Frequency	Percent
By myself at home	98	31.2%
By the Arab *daya* at her home	58	18.5%
By a doctor in his private clinic	21	6.7%
By a doctor in a health center or hospital	137	43.6%
Total	**314**	**100.0%**

When asked about the method used in undertaking the abortions, in their vast majority, women who responded to the question reported having done it using therapeutic methods. Around half (49.40%) said it was done by intra-vaginal placement of special plastic

tubes[1]. Use of intramuscular injection came next (22.9%) with a substantial difference between the two. A combination of both methods was used in7.20% of the cases followed by 5.70% who used oral pills. The remaining percentage was fragmented between other abortion methods used individually or combined. This included the non-therapeutic traditional methods such as taking herbs or natural teas or jumping from heights and lifting heavy objects that induce abortion as table (22) below shows.

Table (22): Methods used in conducting abortion

Abortion method	Frequency	Percent
Intramuscular injection	89	22.9%
Oral pills	22	5.7%
Dilatation and curettage	22	5.7%
Intra-vaginal placement of special plastic tubes	192	49.4%
Intramuscular injection plus dilatation and curettage	6	1.5%
Intramuscular injection & intra-vaginal placement of special plastic tubes	28	7.2%
Dilatation and curettage & placement of special plastic tubes inside the vagina	2	0.5%
Oral pills & dilatation and curettage	5	1.3%
Insertion of a foreign body in the vagina such as a sharp instrument, wooden stick etc	5	1.3%
Insertion of cloth or cotton soaked with some special salts in the vagina	2	0.5%
Taking herbs or natural teas that induce abortion	5	1.3%
Jumping from heights and lifting heavy objects	1	0.3%
Taking herbs or natural teas, jumping from heights, lifting heavy objects & other methods	1	0.3%
Oral pills & intra-vaginal placement of cloth or cotton soaked with some special salts	7	1.8%
Other methods	2	0.5%
Total	**389**	**100.0%**

Table (23) below indicates that only 6.70% experienced no post-abortion complications while; 52.20% had severe vaginal bleeding, 22.9% experienced general weakness and mild persistent pain lasting for a long period of time, 6.70% experienced infection and high temperature, 2.80% was not able to conceive and bear children thereafter and the remaining 7.70% had other post abortion complications they did not declare.

[1]Vacuum for uterine aspiration is a surgical technique carried out for first-trimester abortion. It can be produced with either an electric pump or a hand-held syringe (manual vacuum). In the procedure, a plastic cannula known to women as “special plastic tubes” is placed into the uterus and its contents are sucked out by negative pressure created in a syringe.

Table (23): Respondents by Post-Abortion Complications

Experienced post-abortion complications	Frequency	Percent
No complications at all	26	6.7%
General weakness and mild persistent pain lasting for a long period of time	89	22.9%
Severe vaginal bleeding	203	52.2%
Infection and high temperature	26	6.7%
Need hospitalization for few days	4	1.0%
Was not able to conceive and bear children thereafter	11	2.8%
Others	30	7.7%
Total	**389**	**100.0%**

About post-abortion healthcare services, as illustrated in table (24) below, around half of the women (49.60%) who experienced abortion received treatment of incomplete abortion, 30.30% received counseling on family planning methods, 12.60% received awareness on the subject of abortion, such as the risks of induced and unsafe abortion, 4.90% had counseling and psychological support and 2.6% didn't receive any kind of services.

Table (24): Participants Receipt of Healthcare Services Post-Abortion

Received healthcare services post-abortion	Frequency	Percent
Treatment of incomplete abortion	193	49.6%
Counseling on family planning methods	118	30.3%
Awareness on the subject of abortion, such as the risks of induced and unsafe abortion	49	12.6%
Counseling and psychological support	19	4.9%
Others	10	2.6%
Total	**389**	**100.0%**

Women who reported having conducted an abortion were asked about their feelings post-abortion. Table (25) indicates that 44% of the women felt free post abortion, 20% said they felt like they committed a sin, 6% felt they had killed their baby, 7% felt they made the right decision, 20% felt guilt and remorse, 2% said they had treated themselves as if it wasn't there. Notably, in a total of 46%, respondents articulated having experienced

negative feelings of sin, guilt, regret and self blame implied in killing their own babies. This could be understood within the framework of the socially imposed dichotomous position of either her or the baby a woman finds herself in considering abortion which in itself is another form of gender inequity and injustice against women. It even contradicts such religion instructions about the need for the availability of capability in all human endeavors. This concept of capability includes all physical, emotional and psychological aspects of a human being.

Table (25): Feelings of Women Post-Abortion

Feelings of women post-abortion	Frequency	Percent
I felt free	173	44%
I felt like I committed a sin	79	20%
I felt that I had killed my baby	22	6%
I felt that I made the right decision	27	7%
I felt guilt and sorrow	78	20%
I treated myself as if it was not there	7	2%
Others	3	1%
Total	**389**	**100%**

Respondents who underwent an abortion were asked about if they encountered any obstacle in relation to the abortion/s they had. The question was posed using an open ended format. They all stated different obstacles they encountered including: compelled home abortions due to the presence of military checkpoints. Continuous bleeding, absence of any form of support, lack of awareness about abortion altogether, prolonged hospitalization days until full recovery from post-abortion complications, fear from psychological effects, financial difficulties in relation to covering pertinent expenses and strike in hospitals. Surprisingly, none of them mentioned anything related to abortion service availability as per se although abortion is not a service on offer.

Beyond themselves, study participants were asked about if any female relative or friend confided to them about a personal experience of abortion and if yes how many times they were told this had happened. Table (26) indicates that 48.98% responded positively to the question compared with 51.02% who responded negatively. Of the former, 40.11% said their confidants told them about having gone through abortion only once, 4.07% twice, and 4.81% said their confidants told them about having experienced abortion more than three times.

This presents further evidence that suggests that the extent to which abortion is prevalent in Palestine is not insignificant. This is despite prohibitive laws and traditions of blame, sin and guilt. The question that remains then is to whose benefit existing barriers to

appropriate services are safeguarded and how does this impact women and child wellbeing and human rights.

Table (26): Participants by the Number of Female Confidants about a Personal Abortion Experience by Frequency of Occurrence

Shared information on abortion		Frequency	Percent
Yes		265	48.98%
No		276	51.02%
Total		**541**	**100.00%**
Number of abortions confidants told about	**At least once**	217	40.11%
	Two or three times	22	4.07%
	More than that	**26**	4.81%

Study participants were then asked about those of their confidants who told them they had an induced abortion/s. Table (27) shows that 81.1% (215 out of 265) of the confidants said their abortion/s was induced. Of these, more than half (50.7%) had one induced abortion, 21.86% had two, 33.49% had three while .0.93% had six induced abortions.

Table (27): Number of Confidants' Induced Abortions

Number of induced abortions	Frequency	Percent
1	109	50.70%
2	47	21.86%
3	72	33.49%
6	2	0.93%
Total	**215**	**100.00%**

Answers to the question about if study respondents know about women who died as a result of abortion are shown in table (28) below. Expectedly, the vast majority (92.31%) did not know about any such women. However, 3.99% said they know 1 women, 1.99% know 2 women, 0.57% know 3 women, 0.28% know 4 women, and 0.85% said they know 5 women who died as a result of abortion. While these reporting do not necessarily

reflect an accurate depiction of abortion-resulting maternal deaths they certainly draw attention to the need for a methodological investigation of this area to obtain accurate information rich data that can guide relevant planning and policy decisions particularly concerning maternal health improvement and MDG5 progress.

Table (28): Abortion-Resultant Deaths of Women Known to Respondents

Number of abortion-resultant deaths	Frequency	Percent
0	324	92.31%
1	14	3.99%
2	7	1.99%
3	2	0.57%
4	1	0.28%
5	3	0.85%
Total	**351**	**100.00%**

4.2.4 Women Knowledge about Abortion

Table (29) in the following page comprises the study findings on the respondents' knowledge about abortion and related information. The main findings are the following;

- The majority (83.5%) thinks that abortion is often spontaneous and not induced.
- Around a half (49.5%) thinks that appearance of signs like high temperature, pain, and persistent bleeding for a long period of time is considered normal post-abortion and so don't warrant concern.
- A little more than a half (54.7%) thinks that the rate of abortion increases with the woman progress in age and is less in her the early life.
- Around 15% said that a woman who experiences abortion must get pregnant immediately.
- A little more than a fourth (26.40%) agrees that negative consequences of abortion are limited to the physical health side only.
- A vast majority (94.60%) agrees that post-abortion, the woman must pay utmost attention to personal hygiene because the likelihood of infections and diseases is very high.

- Around two thirds (56.90%) agree that pregnancy does not happen but after 40 days of abortion. Therefore using a family planning method can be started any time during that period.
- A majority (90.90%) agrees that pregnancies that occur too close may cause uterine fatigue and loose uterine cervix leading to frequent abortions and its associated health risks to the mother.
- A majority (95.40%) said that traditional prescriptions and practices, such as jumping and carrying heavy objects may lead to abortion but possibly also to; severe bleeding, endanger the life of the mother and weaken her fertility in addition to serious infections if parts of the pregnancy remain.
- A majority (93.0%) agrees that abortion is absolutely prohibited religiously except in cases where continuing the pregnancy poses a risk to the woman's life.
- A substantial percent (82.10%) agrees that a woman who had an abortion is preferred to wait at least six months prior to the subsequent pregnancy.
- Around a half (46.40%) agrees that the hormonal method of contraception known as "the morning after pill" is an emergency contraception method that can be used to avoid unplanned pregnancy.

Interpreting the percentages above, it should be observed that the responses come from PFPPA service users. Given that abortion services including education is part of PFPPA mandate, these respondents have a particularly biased exposure to information on abortion. Therefore, responses can't be considered standard responses regarding women's knowledge on abortion. Nor could they be dealt with as a benchmark for estimating the wider public knowledge and other audiences PFPPA and other similar NGOs don't cater for.

In spite of this comparative advantage these women have concerning information on abortion a closer look into the percentages above signifies the extent to which there is a need for more awareness raising campaigns amongst women. With particular reference to statements number; 2-5, 7, 10 and 12 responses are especially negative and indicative of the extent to which women are uninformed or misinformed about abortion. This holds significant implications for the direction, intensity and focus of any future awareness raising campaign on abortion.

Table (29): Respondents Knowledge about Abortion and Related Information

		Yes		No	
No.	**Statement**	**frequency**	**%**	**frequency**	**%**
1	**Abortion is often spontaneous and not induced.**	452	83.5%	89	16.5%
2	**Appearance of signs like high temperature, pain, and persistent bleeding for a long period of time is considered normal post-abortion and so don't warrant concern.**	268	49.5%	273	50.5%
3	**The rate of abortion increases with the woman progress in age and is less in her the early life.**	296	54.7%	245	45.3%
4	**A woman who experiences abortion must get pregnant immediately.**	80	14.8%	461	85.2%
5	**Negative consequences of abortion are limited to the physical health side only**	143	26.4%	398	73.6%
6	**Post-abortion, the woman must pay utmost attention to personal hygiene because the likelihood of infections and diseases is very high.**	512	94.6%	29	5.4%
7	**Pregnancy does not happen but after 40 days of abortion. Therefore using a family planning method can be started any time during that period.**	308	56.9%	233	43.1%
8	**Pregnancies that occur too close may cause uterine fatigue and loose uterine cervix leading to frequent abortions and its associated health risks to the mother**	492	90.9%	49	9.1%
9	**Traditional prescriptions and practices, such as jumping and carrying heavy objects may lead to abortion but possibly also to; severe bleeding, endanger life of the mother & weaken her fertility in addition to serious infections if parts of the pregnancy remain.**	516	95.4%	25	4.6%
10	**Abortion is absolutely prohibited religiously except in cases where continuing the pregnancy poses a risk to the woman's life.**	503	93.0%	38	7.0%

11	**A woman who had an abortion is preferred to wait at least six months prior to the subsequent pregnancy.**	444	82.1%	97	17.9%
12	**The hormonal method of contraception known as "the morning after" pill is an emergency contraception method that can be used to avoid unplanned pregnancy.**	251	46.4%	290	53.6%

4.3 The Qualitative Part: Focus Groups and Experts Meeting.

Qualitative data was collected in two different focus groups discussions with the participation of a total of 15 women and men professionals practicing in the area of reproductive women health, psychosocial and legal counseling both in the government and NGOs. These group discussions were carried out late October, 2014 and lasted for 2-2:30 hours each. After obtaining the participants' permission in light of the information they were provided about the intended discussions, each was tape recorded alongside being transcribed by a trained note taker. Later in November, one expert group meeting was done with participants occupying lead decision making positions in their respective human rights and healthcare institutions. This later component was exceptionally useful in filling up remaining information gaps, furbishing the study findings by emphasizing key results, drawing conclusions and making appropriate recommendations.

4.3.1 Women's Knowledge about Available Abortion Services is Poor

There is no information given by health professionals to women about available abortion services because such services are not openly available at the first place, most participants agreed. Hence women rarely come to health institutions for abortion. *"They know abortion isprohibited by law and religion"* one participant said. In addition, by customary law that is mirrored in traditions, accepted social norms and expected conduct, women are taught that an abortion is never welcome. So they resort to *dayas* who do not tell them or even know the difference between safe and unsafe abortion. Furthermore, women have no clue about psychosocial counseling they are entitled to as part of post-abortion service. What they think is that once they have a dilatation or evacuation and curettage done that is all the service they are entitled to. This indicates their lack of recognition of their RTH. In addition, women do not know anything about emergency contraception and its role in preventing an unwanted pregnancy. Some women believe that abortion is the woman's own business to handle and do not bother about legal requirements or health system aspects. If they want it they get it done or do it themselves safely or else, one midwife confirms.

The widely shared information amongst women is that there is no doctor who would take a woman for an abortion service including of an unwanted pregnancy occurring in marriage. Abortion is not an accepted or encouraged practice; not by healthcare providers themselves or by the wider public. There is no clinic known to women where they can get an abortion, if they need. Therefore, rather than being guided by professional information

and practice, women abortion experiences are largely shaped by *dayas* or traditional healers' remedies, advices and harmful unsafe practices, one social worker asserts. Furthermore, advice coming from female older family members and friends about spontaneous abortion aligns with the predominant abortion denial and rejection thinking whereby an aborting woman is advised that *"if she goes to the toilet and sees that everything came down she should be fine and facility-based professional assistance need not to be sought",* a participating midwife explains. There is no information about incomplete spontaneous abortion among women, she continues. Therefore, resorting to the advice of other women, aborting women don't take signs of incomplete abortion seriously until they become too grave. At this point women would have developed serious post-abortion complications including the most commonly reported one of sever vaginal bleeding, that compel their long hospital stay for recovery as they themselves pointed out speaking about key obstacles they encountered in the abortion/s they experienced.

4.3.2 Lack of Efficient Human Rights-based Approach and Gender Sensitive Comprehensive Abortion Services

Participating service providers and experts' narrations of women experiences with spontaneous and induced abortions suggest the presence of serious gaps and deficits in human right based approach to service provision alongside utter gender insensitivity. They also reveal significant legal, extra-legal and procedural barriers to women access to dignified abortion information and services that deserve utter professional attendance. Below is only a selection of these narrations.

At 14 years of age 15 years ago a newly married woman didn't know she was pregnant until her husband told his parents that she was five months pregnant. She did not accept the pregnancy and jumped off a high wall. She bled for three days until she went unconscious which took her to the emergency department of a private hospital that happened to be the nearest to her place of residence. There she had a D&C performed without any anesthesia as if it was childbirth. As she was screaming banging her head against the wall from the severe pain she was having her mother went to the doctor asking about her situation. His response was that this is none of your business and asked her to go back to her seat and let them do their job. This is without informing her anything about what was going on with her daughter. In addition, the woman herself was not informed that she is Rh negative and that she needs to take a special injection so that her next child does not develop any health problems. As a result her second child was born deformed because of Rh incompatibility[2] . In the process a total of seven units of blood were transfused to her. This woman reported that she hates all about marriage and reproduction especially when she becomes pregnant. This and other similar information

[2]Rh incompatibility develops only when the mother is Rh-negative and the infant is Rh-positive.If the mother is Rh-negative, her immune system treats Rh-positive foetal cells as if they were a foreign substance and makes antibodies against the foetal blood cells. These anti-Rh antibodies may cross back through the placenta into the developing baby and destroy the baby's circulating red blood cells. Because it takes time for the mother to develop antibodies, firstborn infants are often not affected unless the mother had past miscarriages or abortions that sensitized her immune system.However, all children she has afterwards who are also Rh-positive may be affected

is documented nowhere, the reporting expert argues and proceeds by asking the following key questions;

"Do we know how many women come for post-abortion counseling, harm reduction or family planning services? Did we ever question the relatively high numbers of D&C admissions and how do women end up having them? The answer is definitely no because these are women issues …gender issues and the significance attached to them continues to be minimal".

Participants agreed that an important number of women choose to risk a self induced home abortion so that they can get a "dignified completion of an incomplete abortion" instead of having to receive all forms of negative judgments, attitudes and stigmas they experience when they seek termination of pregnancy from healthcare providers, if this was even a possibility. This is because the slightest mentioning of abortion elicits accusations of faithlessness and reminders about penalties.

Experts argued that spontaneous abortion which gets often taken lightly, is more worrisome than an induced one because it is indicative of illnesses or defects that could range between viral infections, major trauma, chromosomal, immunologic, and uterine abnormalities. But they also were inclined to believe that women who get these abortions completed therapeutically rarely get followed up with the needed post-abortion care. A case in the point is a woman living in the old city of Hebron where services are inaccessible and the Palestinian population right to mobility is almost fully confiscated by the Israeli occupational measures in effect. One participant reported that this woman had a total of 16 abortions. Of these, 9 were spontaneous, 7 were induced 4 of which were self home induced. The reasons for these repeated abortions were never subject for examination.

In another case a woman with nine living children from Tarqoumya –south west Hebron was pregnant with a twin that she did not want but could not avoid because of the husband objection to her contraceptives use. She beat herself strongly until she started bleeding and aborted her two feotuses at Halhoul clinic bathroom. An ambulance was called, the bleeding was stopped and her life was saved. Then communication with and counseling the husband he approved of her use of a contraceptive method.

4.3.3 Abortion, Post-abortion Care and Referral

Legally and practically, only hospitals are entitled to conduct abortions and only under tight grounds of religious permissibility and medical necessity that is restricted to pregnancy posing a threat to the woman's life. Evacuation & curettage (E&C) or dilatation & curettage (D&C) are the most commonly used methods for abortion once it's legal and approved or as a therapeutic measure in case of incomplete abortion. Cytotec which is a Prostaglandin tablet administered orally is given only in hospital under close observation and medical supervision of a specialist. If no bleeding follows taking the tablet the woman gets released, if bleeding happens then she undergoes a D&C. This later option is far less frequently used and its availability is kept at a very low profile to

prevent its easy access and hence uncontrolled use. Albeit, some participants particularly noted its clandestine availability in the market, purchase from under the table and independent usage by women at home without any professional supervision or care, regardless of all potential harms.

In one focus group discussion, participants working at the Northern Hebron Directorate Health Center agreeably estimated that in September 2014, a total of 12 women arrived to their center with spontaneous incomplete abortion and were referred to Alia Government hospital for D&C. This is a center where 40% of the total pregnant women in Hebron are routinely registered. Documented in one month only, this number suggests the presence of many other such cases that could probably fetch the service in private sector establishments. Moreover, it also tells about a potential self home induced abortion that didn't terminate fully and so compelled professional intervention.

As for referrals, it was reported that in case of incomplete abortion women are offered the option to have a medication abortion by taking the abortion pill to help the expulsion of the remaining parts. If need be it, the woman is referred to appropriate health facility whether in the government or other NGOs usually from the Coalition partners.

4.3.4 Counseling and Education regarding Abortion

As for counselling and education regarding abortion, focus groups participants agreed that psychological counselling for women is nonexistent expect in few NOGs where pre and post abortion counselling is part of the routine work in line with the mandate of the organisation. Overall however, participants confirmed that there is an obvious lack of information about abortion among healthcare providers themselves which explains the reason why they do not exert much effort to educate women let alone men about the subject. In this regard, participants emphasised the role of the Coalition for the Protection of Women from the Dangers of Unsafe Abortion PFPPA founded in 2006 in awareness raising where schools and other community settings are targeted. Interestingly nonetheless, participants pointed out the need of all involved organisations to place more emphasis on cities instead of the currently predominant emphasis on rural areas. The fact that targeting rural communities is easier and more fulfilling as people are more receptive compared to city dwellers has incrementally yielded systematic neglect of urban communities. Eventually, they ended up having significant information gaps including about abortion while at the same time are more exposed to modern life influences and access to modern media including all sorts of information that is not necessarily always useful or accurate.

4.3.5 Family Planning and Emergency Contraception.

The discussions showed that family planning methods despite being on offer with high affordability for women yet the margin of unmet needs remains attention drawing, participants confirmed. This is either because information about their availability is lacking or because women are reluctant to use a method due to distrusting the effectiveness of the methods as the case was for a woman who came wanting an abortion

in one PFPPA clinic, it was said. A third point that reiteratively kept appearing was that many women do not use any family planning method because of the spousal objection. As a result, in cases of unwanted pregnancy these women resort to home induced abortion using risky homemade procedures and remedies such as drinking a washing liquid soap, ginger and cinnamon mix or placing a wooden stick into the uterus to induce abortion which three different women actually did, it was reported. This is compared to women who use family planning methods without the spousal knowledge.
As a pro-choice association these told women stories present PFPPA with qualitative indicators on its need for considering alternative approach hes for promoting gender in family planning use by placing emphasis on men, perhaps more than women.

Across the board, participants believed that information and therefore use and service provision with emergency contraception is minimal at best. Women barely know about it and only some service providers have the needed information and actually prescribe it. Given its harm reduction effectiveness in handling unwanted pregnancy substantial efforts must be invested in promoting this method with adequate visibility, intensity and duration.

4.3.6 Barrier to Access Abortion

The barriers participants and experts talked about are categorized below into procedural that include legal and others and extra-legal that include all others. According to the IPPF (2008), extralegal barriers in particular are part of abortion-related practices and/or the country's socio-cultural and economic situation.

4.3.6.1 Institutional and Legal Restrictions on Abortion performing Institutions

One key procedural barrier to abortion is institutional and legal restrictions on abortion performing institutions or personnel. A senior midwife explains it like this;

"Even if a married women comes seeking abortion without having any justifiable health situation we cannot abort her, first, because the service is not in offer and second because we are not legally protected. If we do we are subject to legal accountability and criminalization for violating the law. However, if she comes with incomplete abortion we are covered institutionally and legally".

This piece of evidence shows how law serves as a deterrent to the women human right to health realization. Penalties extended to the pregnant woman & to all individuals and healthcare personnel who assist her in performing the abortion makes it hard for a woman to secure a safe abortion if a pregnancy occurred both intra or extra martially. Consequently, this forces her, as a substitute, to resort to the risky method of unsafely inducing an abortion with all associated risks and adverse health outcomes that are all unnecessary costs that she, her family and the healthcare system pay.

4.3.6.2 Conscientious Objection toward Abortion among Care Providers

Not only that abortion law is fairly restrictive but also healthcare providers themselves have a substantial conscientious objection stemming in their religious and moral convictions. A nurse from the government sector clinging to her strongly held pro-life beliefs has expressed it like this;

"It is impossible that I can kill a human being. Only if the woman's life is endangered by the pregnancy I would. And for this she will have to provide me with the fatwa. What I can do is to give her health education on the risks associated with abortion. But if she is not convinced after all I am not her only option". Linking this to the client right to choice, the same nurse did not see any connection and went back to the legally imposed restrictions, but notably, participants in the same discussion group expressed no alternative views that could challenge this one.

4.3.6.3 Lack of Providers' Professional Practice regarding Abortion

Abortion as a taboo both normatively and religiously was a strongly held notion amongst most focus group participants who are all health professionals from different disciplines. Some even argued for its absolute prohibition in Islam including where the pregnancy gestational age is at less than 120 days. Few others claimed its only 40 days while a couple of them claimed that the said 120 days conditioned permission of abortion is not subject to full agreement between Islamic scholars to date.
In the context of this obvious confusion about gestational age of pre-ensoulment abortion permissibility, explaining about their abortion related services; participants reported that when the woman approaches them for abortion they provide her with counseling with religion being the chosen entry point. They tell her that abortion is prohibited in Islam and advice her to reconsider her decision. This means they refer to their own believes and not professional code of practice whereby they being the duty bearers are accountable to respect, protect and fulfil the women's right to health.

Along the same lines, reflecting rather judgmental attitudes, participants voiced serious concern and strongly warned against the risk of promoting abortion in an open uncontrolled manner because as such it could encourage sex and extramarital pregnancy in contradiction with Islamic instructions and principles alongside challenging customary law and Palestinian societal norms.

4.3.6.4 Lack of Government Commitment by Influence of Religion &Unconvinced Public Opinion

In their mindset and consequently service planning and delivery as well as policy decisions abortion is located outside the domain of reproductive health. One senior nurse stated it thus: *"For us focus both in service delivery or health education is on reproductive health and not abortion. This includes; pregnancy, childbirth and postnatal care and family planning issues".* As such the approach, orientation and emphasis are still as selective, traditional and gender insensitive as they have always been. Women reproductive childbearing role is still sitting at the heart of women reproductive health concept in programmatic and practical terms. Confined to this role, women's own

personhood and human rights did not materialize and reflect in the national development agenda.

There was a wide agreement among the two focus groups discussions that there is no mention of abortion anywhere in the MOH operational protocols, rules and regulations. If there is no health condition that is acceptable on religious grounds for conducting an abortion, a woman seeking it is forced to look for alternative illegal unsafe methods to end a pregnancy she does not want or cannot keep. Doctors are not entitled or protected legally to conduct an abortion because it is criminalized by law exceptwhen a Moslem doctor declares with reasonable certainty that the continuation of pregnancywill endanger the woman's life. This is translated by a detailed medical report from a recognized gynecologist along with a formal certificate of approval from the *Mufti* for Islamic law *(Shari'ah)* authorization for conducting the abortion, participants explained. Yet, it remains within the discretion of the Mufti to accept the medical report and approve of the abortion or not. Often times, it happens that he tells the woman to *"trust Allah, accept His will and keep the baby".* The woman would then feel and appear an infidel if she chooses otherwise.

4.3.6.5 Imposition of 'Extra' Requirements

One senior nurse asserted that the imposition of 'extra' and unnecessary requirements that are absent in the national law, for women seeking abortion services is an act of harassment against women. Such requirements were actually addressed to this nurse friend who sought an abortion because she was on medications for a clinically diagnosed depression. At the hospital the doctor requested a medical report from her treating psychiatrist that the medication could cause congenital malformation/s to the feotus. She did. When she brought the report the same doctor requested letter of approval from the Mufti who when addressed with the request was reluctant and did not approve the abortion. He maintained that he can do that only if the said malformation is subject of certainty and not suspicion or if proceeding with the pregnancy endangers her life.

4.3.6.6 Additional Barriers faced by Women with Extramarital Pregnancy: Attitudinal, Procedural including the Legal

Complete denial of access to abortion for pregnancies resulting from rape or incent was brought up as one prime barrier to the victim's human right to health. Participants viewed it as a compound perpetual tragedy that a woman is forced to endure largely because of this denial of her human right to health.

Obstacles are peculiar, multiple and compounded for those who become pregnant as a result of rape or incest. Because of the extreme legal and social strictness regarding abortion these victims are confronted with attitudes and procedures that trap them into no choice situation where they are forced to continue with their extramarital pregnancies to full term. The only help they get is that in coordination with the police and the Ministry of social affairs these women are housed at "Women Refuge Homes" until they finish 28 weeks of their consent to the following conditions; give birth by caesarian section,

relinquish the newborn, accept not to see, know the sex or even attempt to reclaim the child anytime in future.
This inhumane humiliating approach to extramarital pregnancy management was described by one participant who works in a women rights nongovernmental organization. This course of action is taken despite the fact that even under the very tight laws on abortion Article 324 of the Jordanian Penal Code of 1960 affords a mitigating excuse for a woman and family members up to the third degree who obtains an abortion for "honor" related reasons. In cases of extra-marital pregnancies, law provides for a more lenient punishment for abortion if the motive is to cover the woman's perceived "dishonorable" conductand to protect her and her family's reputation. It can then be argued that the above depicted approach stems in prevalent judgmental attitudes and perceptions of policy makers, planners and service providers more than the law itself.

4.3.7 Inter-organisational Collaboration and Health System Preparedness

Focus groups participants and interviewed experts stressed the point of cultural sensitivities surrounding the question of abortion. They first emphasized the needs to tackle it as a whole and not in a fragmented manner; both spontaneous and induced abortion side by side. Because of all the associated compounded stigma and infidelity accusations that could be brought to the table to combat activism for improved abortion information, services and laws those who work on the subject have wisely gone for the collective approach and should continue to do so in expansion, one expert explains.

The previously mentioned Coalition for the Protection of Women from the Dangers of Unsafe Abortion was discussed as an effective model in this direction. Capitalising on existing partnerships and networking, the coalition serves as a platform that augments all efforts for achieving the changes aspired for through lobbying, persuasion and pressuring policy makers and political leadership to put the question of abortion on the development map and national strategic health plans, participants agreed. This includes integration of abortion related indicators into national maternal health database to be reported on in the PCBS future health surveys and MoH annual report, one expert said.

Beyond the Coalition, networking and collaboration between key players from civil society and government including; Ministry of Health, UNRWA, Ministry of Social Affairs, Police Child and family Protection Unit, Union of Health Work Committees, Palestinian Medical Relief Society and Women Center for Legal Aid and Counseling manifest in such joint activities like in areas of staff capacity development and sensitisation to key models where human rights principles are anchored. Of these harm reduction model is a prime one for its great potential to enhance the health system preparedness to the gradual realisation of the women RTH as regards to abortion information, services and legal liberalization within the boundaries of enlightened Islamic Shari'a, one lead expert elucidated.

That said, experts particularly noted that except for the conventional D&C/E&C that is therapeutically performed in hospitals for incomplete abortions, for the Ministry of Health abortion is not on the agenda in any other way. It is not an included part of any

policy document, any strategic or operational plan, any technical protocol, any awareness campaign, any training activity, any service program, or any recognized healthcare/outcomes report. Basically abortion is treated with full denial as if it does not happen. This means that MoH needs to substantially invest in every aspect and level of these so that it can appropriately and effectively address abortion care as comprehensive and strategic as it should rightly be.

Chapter V
Conclusions and Recommendations

This pilot study sheds some light and provided insights on the question of abortion among Palestinian women. Abortion experience spontaneous and induced; safe and unsafe were considered. The study evidently showed that abortion is not a rare experience for Palestinian women in Hebron- Southern West Bank. The overall percent of women who experienced abortion at least once in their lifetime was more than 70 % of the total of 541 study participants. Around 49% of their confidants told them they too underwent the same experience. Of the total, around half were married, more than 40% had their first pregnancy and 28% had their first childbirth all at18 years of age or less.

Albeit these figures are all alarming yet the health burden of unsafe abortion being 11.3% in this study must be confronted, recognised and put high up on the agenda of health programmers, planners and policy makers. More alarmingly, of the 314 women who aborted, around 50% did it by themselves at home or had the *daya* do it at her home. In both cases this was done using harmful traditional non-therapeutic remedies, prescriptions and procedures. This means that open and increased provision with quality abortion related services is an imperative need. Abortion services with appropriate control measures, clear professional and administrative protocols and technical guidelines in place must be made universally available to women under a revised enlightened abortion law.

The complications of unsafe abortion this study documented are not only risky for women and their families, but also cause untold costs to the already burdened Palestinian health care system. This being brought about by the extremely tight relevant laws must also be recognized and elicit sincere efforts for the amendments and redress of these exclusivist laws with full sensitivity to the culture and in line with the insightful interpretations of Islamic principles.

5.1 At the Public Opinion Front: Advocacy for Accurate Understanding of Liberal Islamic Abortion Law

Perceptions about women's capacities andlimitations placed on their sexual and reproductive rights and health are often embodied in the norms and attitudes largely rooted in and shaped by religion texts, teachings, interpretationsand the people's understanding of them all. This understandingthen dictates what'acceptable' behaviour is in society.

The study findings revealed a universal misunderstanding of the Islamic theological interpretations of gestational age and pre-ensoulmentabortion permissibility. This applies to women at the recipient end of the services as well as women and men at its provider

end. In this study not even one single voice uttered the correct Islamic interpretation in this regard. All spoke about prohibition of abortion in Islam starting from the onset of pregnancy regardless of the stage of gestational age or ensoulment. This is when Muslim theologians have concluded that killing a feouts is not permissible as soon as it can be spoken of as a "child"- a person whose parts are fully formed and into whom a soul has been breathed (IPPF, 2008). From then on, they declared, abortion can be permitted only if the continuation of pregnancy will endanger the woman's life (AlQuds, 2013). This is indicative of the need to re-educate the public and health care providers too about accurate understanding of the Islamic law (Shari'a) to rectify the predominance of the current misunderstanding and confusion regarding this very sensitive aspect that generates tremendous unnecessary sense of guilt and sinfulness among women including those who abort prior to the end of the pre-ensoulment gestational age and fear among care providers who may help them. Strategically, this concrete corrective step must aim at a shift in public opinion regarding this whole matter. This advocacy endeavour requires the full all-embracing active engagement of religious leaders to secure religious coverage and optimize credibility of such critical religion based arguments. Presence and active participation of Parliamentarians could be a strategic lobbying move toward setting the scene for the anticipated legal intervention.

5.2 At the Legal Front: Advocacy, Networking and Lobbying for Liberalization of the Present Abortion Laws and pertinent regulations

In any given context behaviors are perpetuated through laws and policies; all of which have a real impact on access to timely and safe abortion services. Spousal consent laws, even when unwritten yet in effect, is an example of laws that inhibit women's access to family planning services and fail to consider the potentially harmful impact that it might make on the woman . What is worse is that often, laws and policies relating to sexual and reproductive health translate into a denial of access to information and/or services. In the case of abortion, the delay and denial of safe abortion services means that women are placed at higher risk of suffering, disability or even death.

This study emphasized that existing laws and regulations on abortion are extremely tight and restrictive depriving women of their basic human right to health and impact their physical and psychological health adversely. In addition, these laws are totally inconsiderate of the duty bearers' right to protection in relation to their role as service providers including in the case of abortion services and care. Therefore, advocacy for the removal of legal barriers to women's access to abortion is strongly recommended. New legal provisions whether in penal law or public health law or else are all subject to progressive amendments aimed at respecting, protecting and fulfilling the human rights of right holders who are women and their families at the recipients and duty bearers who are men and women at the provision end of the care giving process. Discourse creation is one effective entry point to create and encourage visibility, familiarity and questionability about existing laws and regulations both within professional and public spaces with the view of eventual elimination of all legal barriers to safe abortion.

5.3 At the Human Rights Front: MoH Policy and Institutional Strengthening to Conform to RTH Realization and Enhance Synergy with Abortion Coalition Activism

MoH as a the prime government instrument in health must take steps forward in conformity with the principle of the RTH progressive realization, legal amendments and synergy with abortion coalition activism. This imposes an obligation to move forward as effectively as possible, individually and through international assistance and cooperation, to the maximum of available resources. In this context, it is important to distinguish the inability from the unwillingness of the State to comply with its right to health obligations as a signatory to relevant international treaties. Review and modification of existing abortion law is certainly one ability domain for the Ministry to act upon as the lead national body in charge of health of all Palestinians.

The start is recommended to be with the development, implementation and monitoring of service delivery protocols that are rights-based, taking into account the medical history and capacity of each individual client, and following the latest WHO technical guidelines on the provision of safe abortion. What may follow from this is conducting values clarification training with all management, volunteers and staff, including clinic staff, to ensure all support a woman's right to choose to terminate an unwanted pregnancy and commitment to the respectful dignified provision of abortion-related services for all.
Adoption, implementation and monitoring of ; a clear policy on conscientious objection with women's rights at the heart of it, a policy that facilitates women's access to abortion, including to medical abortion, and development and monitoring the effectiveness of referral networks for abortion services are three highly recommended policy level response interventions.

5.4 At the HealthCare Front: Redress Information and Healthcare Service Delivery with Respect to Abortion and beyond

The International Conference on Population and Development (ICPD) of 1994 noted in its consensus statement that *''All Government and relevant intergovernmental or non-governmental organizations are urged to deal with the health aspects of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services''*.

No unwanted pregnancy should happen so that abortion, especially the unsafe, is brought to a minimum. Unmet family planning must be addressed. This means that consistent universal awareness campaigns for information dissemination about available family planning methods with particular emphasis on emergency contraception for its preventive role in unwanted pregnancy and subsequent potential abortion and male condom promotion for its gender equity value in shouldering reproductive burden must be a prime target in reproductive health service delivery and planning.

Furthermore, affordability of family planning services and choices within them must be maintained alongside making women informed about this affordability as well as about

contraceptive methods failure rates to enable women make an informed choice about the most convenient method and be prepared to deal with it.

Across the board, lack of information was a major finding in this study. More effective means of providing information and education on the subject of abortion are required. The collaboration between key players is a basic requirement to ensure success by increasing knowledge as a preventive level intervention. Early introductions of these information suggests ending selective traditional approach to offering reproductive and sexual health education in school health education to raise the level of youth preparedness to deal with issues arising from ignorance in relation to sexuality, rape, incest where school girls could suffer the consequences without knowing what to do about them.

The study showed important deficits in post-abortion care and the management of abortion complications which are very essential strategies to prevent and reduce the number of unsafe abortions. The 1994 ICPD statement noted that *''in all cases, women should have access to high quality services for the management of complications arising from abortion''*. Appropriate protocols and guidelines for health service professionals are much needed for ensuring equity of access and qualityof care. Strengthening and expanding existing alliances such as the abortion coalition and development of new ones with other NGOs, women and governance organizations can support women's access to abortion services, particularly those who cannot afford the services.

One successful model with strong evidence on high efficiency and effectiveness was developed and adopted in a number of majority population countries is the comprehensive abortion care (CAC) program championed by the Bixby Center for Population, Health & Sustainability at the University of California at Berkeley.
CAC program with the four pillars of ; safe termination, treatment of incomplete abortion, contraceptive counseling and advices and referral shown in the figure below is strongly recommended to be studies, culturally suited and proposed as an integral component of reproductive health service package for achieving more progress in MDG5 in Palestine.

Figure 5: The Four Pillars of Comprehensive Abortion Care (CAC)

Source: Bixby Center for Population, Health & Sustainability. University of California, Berkeley (2014)

The proposed CAC should aim to decrease abortion-related morbidity and mortality in conjunction with family planning to reduce unwanted pregnancy. The goal of the CAC program is to provide safe, high-quality services that are affordable and acceptable to women as close to their homes as possible including in outreach via mobile clinics, with the long-term goal of reducing the number of unplanned pregnancies and abortions. The services are designed to effectively reach the majority of women in need of care, by tailoring available services to the existing capacity of the health care system at various levels of care. The program offers a feasible modality for delivering safe post-abortion care, making appropriate referral linkages within the health system, and offering family planning counseling and services, even under the current context where abortion is still illegal and criminalized in Palestine

Bringing abortion services out into the open is a precondition for ensuring quality of care, accessibility, availability and affordability, especially for the poor women. This encourages health professionals to provide a defensible service. Widespread public awareness is an important component in making abortion safe; women need to know that safe abortions are not only permitted but available and staffs at pertinent health facilities are welcoming and respectful of women and their needs. A carefully structured information, education and communication strategy with the central message of "harm reduction" as its niche where a combination of media outlets is extensively used would be an important asset in this direction. Using innovative strategies such as hotlines, mobile and web-based platforms to provide information on abortion in a quick and anonymous way may be a worthwhile exploration here. In addition, the usefulness of linking to educational institutions, such as medical, nursing and midwifery schools, to develop the capacities of future health professionals can't be overlooked.

The study revealed the presence of significant procedural (including legal) and extralegal barriers to the already restricted abortion services and care on offer. These are all subject for thorough inspection, revision and rectification guided by the harm reduction model anchored in human rights principles. Currently, these principles are not respected, protected or fulfilled vis-à-vis the question of safe abortion and comprehensive abortion care for women in Palestine. This was found to be connected to the evident lack of healthcare providers' recognition of and commitment to the woman human right to health which was a key finding in this study. Hence, under the conscientious objection argument for example, some professionals interviewed in this study articulated their perceived entitlement to refuse to provide the needed information let alone services to women in relation to abortion. Conversely, the rights-based arguments for the provision of abortion services are founded in basic human rights, namely a woman's right to bodily integrity and autonomy. Given the Palestinian highly restrictive social and legal environment in this regard, it is strongly recommended to adopt and promote the harm reduction model in implementing comprehensive abortion care (CAC).

According to the IPPF (2014), the model refers to public health interventions that seek to reduce the dangers and risks associated with a particular activity, like unsafe abortion or abortion more generally, rather than prohibit the activity itself. In general terms, the harm

reduction model ensures and realizes respect for the right to information, the right to health and the concept of autonomy. Women obtain the information they need to make informed decisions and adequately manage their own health. The model also serves as an empowerment tool that mobilizes health professionals, turning them into human rights and social change agents and advocates.

In closure, for more informed data driven planning, replicating this study on the other governorates is recommended for a fuller picture. In addition, other complementary methodologies including national surveys with random sample selection and in-depth qualitative research would serve as appropriate quality checks and add to the credibility and trustworthiness of this study results, or rectify them. Both ways, the outcome is that women's health benefits and progress in MDG5 is enhanced.

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Annex 1: Study Questionnaire

Assessment of Safe and Unsafe Abortion among Palestinian Women in Hebron Governorate in Southern West Bank- Palestine

Hello, my name is .....and I am working on a study for the Palestinian Family Planning and Protection Association at its reproductive health service provision sites located within the boundaries of Hebron governorate in Southern West Bank. The study aims at improving maternal health for women of childbearing age by raising the level of response to their unmet needs of reproductive health and family planning services. To this purpose, it specifically seeks to assess the women experience of safe and unsafe abortion, the reasons that push them to resort to unsafe abortion, the methods used, the extent of their awareness of its serious complications and the need to avoid its risky consequences.

In addition, the study is interested to uncover the nature of information women possess about abortion, the type of services available to them for safe abortion and the obstacles that prevent them access and receive these services. It is also concerned with the disclosure of the challenges that hinder local health institutions in the provision of basic safe abortion services for women to ensure protecting their health and lives.

Participation in the study by answering this questionnaire is completely voluntary. You may answer some or all of the questions, as you can withdraw if and when you want. However, we appreciate your full participation because your answers will play an important role in our understanding of the subject and will enable us provide the services women need in light of their own articulations of the expressed needs.

Your answer on the whole questionnaire requires between 10-15 minutes noting that the information will be treated with strict confidentiality and will not be shared with anybody except the research team members for scientific purposes only. The results will help providers of reproductive health services in planning to improve the quality and scope of these services and to meet the unmet needs in order to reduce the incidence of abortion and avoid its complications and negative consequences on the health and lives of women.

We appreciate your participation and respect it and wish you all the very best health and the fullest enjoyment of wellness.

Researcher
Dr. Ayesha AlRifai

Section I: Demographic Information

1. Your current age in completed years is .....

2. You live in the:

2.1 City .....
2.2 Town .....
2.3 Village .....
2.4 Camp .....

3. The highest level of education you attained is .....

4. The highest level of education your spouse attained is .....

5. Are you employed? Yes No

6. Is your spouse employed? Yes No

7. The number of family members, including all residents of your household .....

Section II: Reproductive History of the Respondent

8. Age at marriage in completed years .....

9. Age at first pregnancy in completed years .....

10. Age at first childbirth in completed years.....

11. Number of your living children is .....

12. Are you using any family planning method? Yes No

13. If yes, your used method is .....

14. If not, your reason for not using a family planning method is (can combine more than one reason)

1) Husband unwilling of the use of birth control
2) Husband unwilling to allow the wife's use of contraceptives
3) Couple's inability to withstand the extended family pressure for more children
4) Religion prohibition of contraception
5) Lack of family planning services
6) Do not know where family planning services are available
7) I can't comply with the instructions for the use of contraceptives
8) I fear the symptoms of contraceptives side effects (obesity, cancer or bleeding)

Section III: Respondents and her confides experience with abortion

15. Have you ever had an abortion? Yes No

16. If yes, how many times? .....

17. The abortion/s you had was/were

17.1 Spontaneous?	Yes	Number of times.....	No
17.2 Induced?	Yes	Number of times.....	No

18. Gestational age when abortion occurred was (in weeks).....

19. When you aborted, this was with the prior knowledge of

19.1 Nobody at all
19.2 My husband only
19.3 My husband and mother-in-law
19.4 My husband, mother-in-law and own mother.
19.5 Close friend only

20. In the event of induced abortion, the reason was (can combine more than one reason)

1) It was found out that I have a serious or chronic disease (such as diabetes, heart disease, anaemia, cancer, etc.
2) Immediate pregnancy after a recent childbirth
3) I knew or expected that the sex of the foetus is female
4) Ultrasound scan has shown congenital defects in the foetus
5) Severe marital problems
6) Lack of financial resources needed to raise more children
7) Have enough children and no desire for more
8) Pregnancy impacts my job negatively (job loss or opportunities for advancement are overthrown)
9) Others, specify please .....

21. Where was the abortion completed?

1) In my own house by myself
2) In the Arab *Daya's* home
3) In a private medical clinic
4) At the health canter or hospital
5) Somewhere else, please specify.....

22. What method was used to induce the abortion/s (can combine more than one answer)

1) Intramuscular injection
2) Oral pills
3) Dilatation and curettage operation
4) Introduction of special plastic tubes inside the vagina

5) Insertion of a foreign body in the vagina (a sharp instrument, wooden stick etc)
6) Insertion of cloth or cotton soaked with some special salts in the vagina
7) Taking in herbs or natural teas that induce abortion
8) Jumping from heights and lifting heavy objects
9) Other methods, specify .....

23. Complications you experienced after abortion were

1) No complications at all
2) General weakness and mild persistent pain lasting for a long period of time
3) Severe vaginal bleeding
4) Infection and high temperature
5) Needed blood transfusion/s
6) Need hospitalization for few days
7) Was not able to conceive and bear children thereafter

24. Did you receive any form of post-abortion care? If yes, what services did it include?

1) Treatment of incomplete abortion
2) Counselling on family planning methods
3) Awareness on the subject of abortion, such as the risks of induced and unsafe abortion
4) Counselling and psychological support
5) Others please specify.....

25. Feelings you experienced post-abortion were (you can combine more than one answer)

1) I felt free
2) I felt like I committed a sin
3) I felt that I had killed my baby
4) I felt that I made the right decision
5) I felt guilt and remorse
6) I felt ashamed and embarrassed by myself
7) I treated myself as if it was not there
8) Others please specify.....

26. Did you encounter any obstacles in you quest to get an abortion? If yes, what are they?

1) .....
2) .....
3) .....
4) .....

27. Did any of your female relatives or friends confide to you about her experience of abortion? If yes how many of them did so:

1) At least once .....
2) Two or three times .....
3) More than that .....

28. How many of these women had an induced abortion/s? .....

29. How many of these women informed you that they self aborted or did their abortions outside health institutions? .....

30. Do you know about women who died as a result of abortion, if yes how many? .....

Section IV: Respondents knowledge about abortion and related information

Please answer with True or False next to each statement below.

1. Abortion is often spontaneous and not induced.

2. Appearance of signs like high temperature, pain, and persistent bleeding for a long period of time is considered normal post-abortion and so don't warrant concern.

3. The rate of abortion increases with the woman progress in age and is less in her the early life.
4. A woman who experiences abortion must get pregnant immediately.

5. Negative consequences of abortion are limited to the physical health side only

6. Post-abortion, the woman must pay utmost attention to personal hygiene because the likelihood of infections and diseases is very high.

7. Pregnancy does not happen but after 40 days of abortion. Therefore using a family planning method can be started any time during that period.

8. Pregnancies that occur too close may cause uterine fatigue and loose uterine cervix leading to frequent abortions and its associated health risks to the mother

9. Traditional prescriptions and practices, such as jumping and carrying heavy objects may lead to abortion but possibly also to; severe bleeding, endanger the life of the mother and weaken her fertility in addition to serious infections if parts of the pregnancy remain.

10. Abortion is absolutely prohibited religiously except in cases where continuing the pregnancy poses a risk to the woman's life.

11. A woman who had an abortion is preferred to wait at least six months prior to the subsequent pregnancy.

12. The hormonal method of contraception known as "the next morning" pill is an emergency contraception method that can be used to avoid unplanned pregnancy.

Section V: Is there anything you would like to add?

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END OF QUESTIONS

Annex 2: Focus Groups Discussion Guide

Opening note: WHO estimates that unsafe abortions contribute to 11% of total maternal mortality in this region.

1. What type of information do you think women have about the availability of safe abortion related services?

2. What are the Services offered through your centre/institution to women in reproductive aged (15-49) years regarding:
    - Family planning and emergency contraception
    - Abortion and post abortion care
    - Counselling and education regarding abortion
    - Referral

3. Is there a cooperation and collaboration between your organisation and other providers of abortion related care? What are the difficulties and the advantages of it?

4. To what extent do you consider the health system is equipped to deal with abortion and post-abortion care?

5. Do you face difficulties and constraints in dealing with the issue of abortion, if so, at what levels (eg. the women and community) and how do you tackle them?

6. What are the barriers that prevent women from reaching safe abortion related services?

7. What are the challenges that limit local health organizations from providing essential abortion related services?

8. What are your recommendations to increase the provision of abortion related services?

9. What are your recommendations to advocate for modifying present laws on abortion?

END