

منتدى السياسات الصحية في الشرق الأوسط وشمال أفريقيا  
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM



# Addressing unintended pregnancy in the Arab region

## **Disclaimer**

The views expressed in this publication are those of the author(s), and do not necessarily represent those of the United Nations, including UNFPA, or the UN Member States nor reflect the views of the Middle East and North Africa Health Policy Forum (MENA HPF), its staff, or its trustees.

# **Addressing unintended pregnancy in the Arab region**

December 2018

## **Contributors and acknowledgments**

### **Steering committee:**

Dr. Maha El Rabbat (MENA HPF), Dr. Shible Sahbani (UNFPA/ASRO) and Dr. Mohamed Afifi (UNFPA/ASRO)

### **Synthesis and drafting:**

Dr. Farzaneh Roudi, Population and Development Expert

### **Review:**

Dr. Maha El Rabbat (MENA HPF), Dr. Shible Sahbani (UNFPA/ASRO), Dr. Mohamed Afifi (UNFPA/ASRO) and Dr. Naglaa El Tiganni (MENA HPF advisory committee)

### **Financial support:**

United Nations Population Fund Arab States Regional Office

# Preface

---

Abortion continues to be a key contributor to maternal mortalities and morbidities in the Arab states region. With zero preventable maternal deaths and zero unmet need for family planning clearly articulated as strategic priorities of UNFPA at global, regional and national levels, UNFPA Arab States Regional Office (ASRO) in partnership with Middle East North Africa Health Policy Forum (MENA-HPF) launched this desk review and analysis that scanned available data and literature to analyze the situation of abortion-related legislations and practices, the magnitude of unsafe abortion and its root causes in the Arab states region.

The analysis looks at the consequences of unsafe abortion, attempts to address the challenges related to unsafe abortion and the necessity of fulfilling women's and adolescents' right to accessing family planning information and services as an effective measure to preventing the recourse to abortion and reducing subsequent mortalities and morbidities. The analysis highlights that respecting women's rights particularly in accessing quality reproductive health and family planning information and services is an effective measure to curb the burden of disease and mortalities related to unsafe abortion as well as a plethora of other contributors to maternal mortalities.

MENA HPF

UNFPA/ASRO

---

## Contents

Preface .....	1
Acronyms and abbreviations .....	3
1. Overview .....	4
2. A global perspective .....	6
3. Abortion laws in the Arab states .....	8
4. Unintended pregnancies .....	10
5. Abortion in the Arab region .....	13
6. Special needs of girls and women in humanitarian situations .....	14
7. Demographic realities and challenges of inequality .....	16
8. Avoiding unsafe abortion .....	19
9. International agreements and development goals .....	22
10. Conclusion .....	24
References.....	25

## List of Figures

<b>Figure 1:</b> Nearly 2 million abortions occurred each year in Northern Africa between 2010 and 2014: more than two-thirds were unsafe .....	5
<b>Figure 2:</b> Arab region's population distribution by countries' abortion laws.....	9
<b>Figure 3:</b> Percent of currently married women aged 15–49 who have two living children and want no more, by wealth quintile, Egypt, 2014 .....	11
<b>Figure 4:</b> Percent of pregnant women who reported their pregnancy was unintended.....	13
<b>Figure 5:</b> Total number of women aged 15–49 in the Arab region, 2015–2045.....	16
<b>Figure 6:</b> Arab countries with the largest increase in their female population of reproductive age, 2015–2045.....	17
<b>Figure 7:</b> Percent of pregnant women whose pregnancies were unintended, by wealth quintile, Egypt, 2008 .....	18

## List of Tables:

<b>Table 1:</b> Legal ground under which abortion can be permitted .....	9
<b>Table 2:</b> Contraceptive use and unmet need for modern contraception among married women in selected countries.....	12

## Acronyms and abbreviations

---

<b>DHS</b>	Demographic and Health Survey
<b>EmOC</b>	Emergency obstetric care
<b>ICPD</b>	International Conference on Population and Development
<b>MDGs</b>	Millennium Development Goals
<b>MVA</b>	Manual vacuum aspiration
<b>PAC</b>	Post-abortion care
<b>SDGs</b>	Sustainable Development Goals
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization

---

# 1 Overview

Unsafe abortion is a serious and often neglected public health challenge in the Arab region, as unintended pregnancies are widespread, placing a burden on individuals, families, and socioeconomic development. Rates of unintended pregnancy are relatively high in the Arab region, where one-third of married women of reproductive age have “unmet need” for family planning: they either want no more children or want to delay a pregnancy but are not using a modern contraceptive method. Universal access to quality family planning information, services, and methods of choice is key to reducing unintended pregnancies and therefore the need for abortion.

Women and couples around the world, including the Arab region, are increasingly choosing to have a smaller family by relying on modern contraception to avoid unintended pregnancy. As a result, rates of both pregnancy and unintended pregnancy have declined globally. However, the percentage of unintended pregnancies that end in abortion remains almost unchanged. In the Arab region, two in five pregnancies are still unintended and one-half of unintended pregnancies end in abortion.<sup>1</sup> Such a high rate of unintended pregnancies is largely preventable through expanding and investing in family planning, women’s empowerment and behavior change.

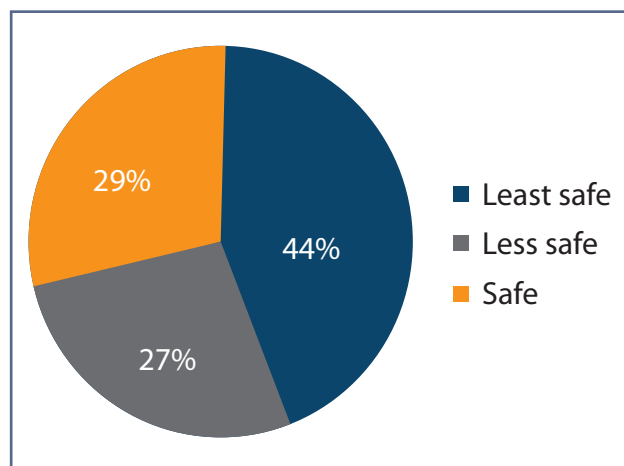
In the Arab region, women who decide to terminate their unintended pregnancy largely

seek clandestine abortions that are potentially unsafe. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy carried out by individuals lacking the necessary training or performed in an environment not conforming to minimal medical standards, or both.<sup>2</sup> Women having an unsafe abortion are likely to face life-threatening complications and put heavy demand on already scarce resources when they seek post-abortion care (PAC). It is estimated that in Northern Africa alone, close to 2 million abortions occurred each year between 2010 and 2014, more than two-thirds of which were unsafe. In all, 44 percent were “least safe,” meaning that both criteria were present: individuals performing the abortions lacked necessary training and they did it in a substandard medical setting (Figure 1). This percentage is three times higher than that of the world average: 44 percent versus 14 percent.<sup>3</sup>

Globally, unsafe abortion is a major cause of maternal death, despite the fact that the vast majority of maternal deaths are generally preventable. Nearly all unsafe abortions (97 percent) occur in developing countries, where almost all abortion-related deaths occur.<sup>4</sup> For every woman and adolescent girl who dies from unsafe abortion, many more are left with serious injuries or permanent disabilities, including infertility. In the Arab region, 10 percent of maternal deaths are resulted from from unsafe abortion.<sup>5</sup>



Figure 1: Nearly 2 million abortions occurred each year in Northern Africa between 2010 and 2014: more than two-thirds were unsafe



**Source:** Guttmacher Institute, *Abortion Worldwide 2017: Uneven Progress, Unequal Access*.

**Note:** Abortion is safe when done by a trained person using WHO-recommended methods, less safe when one of those conditions is met, and least safe when neither is met.

The great majority of abortions are unsafe in the Arab region in part because abortion is largely illegal and countries with high rates of unintended pregnancies generally have weaker health care systems that are less equipped to deal with the complications of unsafe abortion. Too often, countries lack community health care providers who are trained and equipped to meet women's reproductive health care needs, including family planning information and services that could help women avoid unintended pregnancy in the first place and even more so in the case of PAC when needed. Other factors also play a role, such as the stigmas surrounding reproductive health issues—particularly for unmarried women—and women's socioeconomic status. Women from the poorer segments of society are at higher risk of unintended pregnancy and unsafe abortion, as they are less likely to have the knowledge, power, and means to seek reproductive health services, including family

planning, instead having to go through unsafe abortion services.

The Arab region is hugely diverse socially and economically. It includes some of the richest and some of the poorest countries in the world. At the same time, in the least developed countries of the region, such as Somalia, Sudan, and Yemen, where the majority of the population lives in rural areas, women have limited access to reproductive health care services including family planning. Furthermore, the Arab region is home to the largest refugee and displaced population in the world. Ongoing conflicts in the region have forced people to flee their homes in huge numbers, exacerbating the already poor state of reproductive health care at both the service delivery and policy level. Whether in a humanitarian situation or not, effective family planning is a critical part of the effort to reduce unintended pregnancies and therefore the need for abortion. However, high rates of contraceptive use alone do not eliminate unintended pregnancies and other services such as counselling, emergency contraceptives, should be included in any reproductive health package provided to women.

The challenge of meeting the region's need for quality reproductive health services is exacerbated by its rapid population growth.<sup>A</sup> While reproductive health services have expanded and improved to varying degrees throughout the region over the past few decades, progress has largely been uneven within and across countries. The Arab region's

<sup>A</sup> Rapid population growth represents an immense challenge on reproductive health services quality; as migration and urbanization increase demand and pressure on RH resources and services, in addition to increasing the consumption pattern and decreasing the efficiency as per Hakkert, R., Guzmán, J. M., Hermann, M., & Schensul, D. (2012). Impacts of population dynamics reproductive health and gender on poverty.

maternal mortality ratio has dropped by nearly one-half since 1990, but thousands of women still die due to pregnancy-related causes each year. Disparities in the risk of women dying due to pregnancy-related causes are unacceptably wide across Arab countries: women's lifetime risk of dying from a pregnancy-related cause ranges from 1 in 22 in Somalia to 1 in 10,300 in Kuwait.<sup>6</sup>

Furthermore, these and other national averages mask disparities within countries that are unfair—or inequitable. For example, disadvantaged population groups such as young girls, illiterate women, unmarried individuals, or displaced persons are less likely to have access to reproductive health services or to be empowered to use the available services, resulting in their experiencing higher rates of unintended pregnancy. An “equity approach” to meeting the family planning needs of all couples would help reduce or eliminate differences in reproductive health outcomes resulting from structural and individual factors, such as gender inequality and lack of opportunity or access, which are avoidable and unfair. Reducing or eliminating inequities in reproductive health requires policies and interventions that address the so-called social determinants of health by specifically targeting poor and marginalized people. Experiences from the region and other parts

of the world, however, have demonstrated the complexities of social, cultural, political, legal, and financial factors influencing reproductive health outcomes.

Since the United Nations' (UN) 1994 International Conference on Population and Development (ICPD), the call for universal access to sexual and reproductive health care services and their integration into national strategies and programs has been central to international development agreements, namely the ICPD's Programme of Action, the Beijing Declaration and Platform of Action of the Fourth World Conference on Women (1995), the Millennium Development Goals (MDGs, 2000), and the Sustainable Development Goals (SDGs, 2015). Prior to the 2015 SDGs, however, the indicators used in these agreements to measure countries' progress in achieving the goals fell short of taking into account disparities among subgroups, because national averages could simply reflect gains mainly among the more privileged groups of the population, while the less privileged continued to lag behind. The SDGs tried to fix this gap in measuring progress by requiring countries to apply the principle of “leaving no one behind” and to show indicators disaggregated by wealth, age, geography, and education, among other factors, so that they can monitor their progress toward equity on specific targets.

## 2 A global perspective

Abortion is one of the oldest medical practices. Evidence of abortion dates back to ancient Egypt, Greece, and Rome. It is believed that

during the Middle Ages, abortion techniques were adopted and accepted by Western Europe and later diffused across the globe.<sup>7</sup> The term

“abortion” generally refers to induced abortion, although technically it includes spontaneous abortion (miscarriage) as well. Induced abortion was traditionally synonymous with surgical abortion procedures until recently, when medical (nonsurgical) abortion became available.<sup>B</sup>

WHO first recognized unsafe abortion as a serious public health problem in 1967. A number of UN agreements have since highlighted the public health impact of unsafe abortion, calling on governments to reduce the need for abortion and protect women’s health in the event abortions do occur. The 1994 ICPD held in Cairo was the first UN meeting to forge a global consensus on abortion. The ICPD Programme of Action states that “in no case should abortion be promoted as a method of family planning” and urges “all governments and relevant intergovernmental and non-governmental organizations to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services.”<sup>8</sup>

Since the 1990s, WHO has produced a series of technical reports and guidance on safe abortion and PAC for health systems, with periodical updates to ensure that new scientific evidence is taken into account.<sup>C</sup> Although treatment of complications has improved as a result, complications from unsafe abortions are still

common in developing regions. Guttmacher Institute, the leading research organization compiling and analyzing data on abortion, estimates that:<sup>10</sup>

- 56 million abortions occurred each year worldwide during 2010–2014; 25 million of them (45 percent) were unsafe, of which 31 percent were less safe and 14 percent were least safe.
- Women in developing regions have a higher likelihood of having an abortion than those in developed regions. Between 1990–1994 and 2010–2014, the abortion rate declined markedly in developed regions, but remained roughly the same in developing regions.
- The number of crude abortions declined in developed regions, but increased in developing regions largely due to population growth. As a result, the proportion of abortions worldwide that occur in developing regions rose from 76 percent in 1990–1994 to 88 percent in 2010–2014.
- During 2010–2014, one-quarter of all pregnancies ended in abortion. Between 1990–1994 and 2010–2014, the proportion of pregnancies ending in abortion rose in developing countries while it fell in developed ones.
- During 2010–2014, nearly 100 million unintended pregnancies occurred each year worldwide. Of these, more than one-half (56 percent) ended in abortion. In developing countries, 84 percent of unintended pregnancies occurred among women who had an unmet need for modern contraception.

<sup>B</sup> Medical abortion is defined as a procedure that uses medication to end a pregnancy. A medical abortion doesn’t require surgery or anesthesia and can be started either in a medical office or at home with follow-up visits to your doctor» as Sokol, A. I., & Sokol, E. R. (2007). *General Gynecology: The Requisites in Obstetrics and Gynecology*. Elsevier Health Sciences.

<sup>C</sup> UNFPA also produced a link to technical guidance on safe abortion <https://www.unfpa.org/frequently-asked-questions#abortion>

### 3 Abortion laws in the Arab region

Nearly one-third of the region's population lives in 11 countries that do not allow abortion or allow it only to save a woman's life; Sudan falls in the latter group, which also allows it in case of rape (Table 1 and Figure 2). In countries such as Comoros, Djibouti, and Mauritania, abortion is not legal on any grounds. In Qatar and the United Arab Emirates, abortion is permitted in case of foetal impairment and in Iraq for

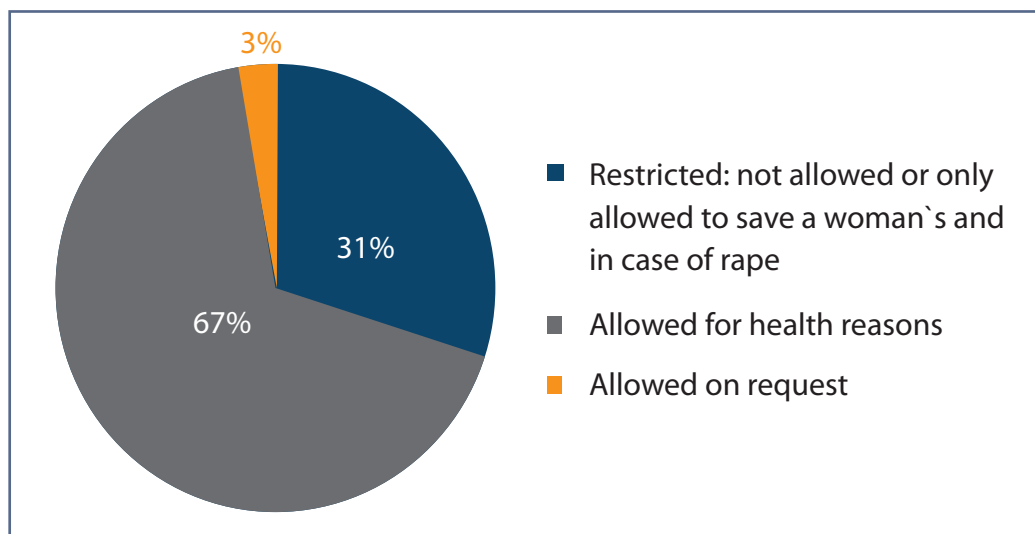
both foetal impairment and a woman's mental health. Countries such as Egypt, Jordan, and Saudi Arabia allow abortion for "health reasons" without being specific. All Arab countries, regardless of their law, require authorization from one or more doctors for abortion to be performed. Spousal consent is required in Kuwait, Morocco, Qatar, Saudi Arabia, Syria, the United Arab Emirates, and Yemen.

**Table 1: Legal ground under which abortion can be permitted**

Country	On request	Fetal impairment	Rape	Incest	Mental health	Physical health	Health of women	Life
Algeria	-	-	-	-	+	+	-	+
Bahrain	-	-	-	-	-	-	-	+
Comoros	-	-	-	-	-	-	-	-
Djibouti	-	-	-	-	-	-	-	-
Egypt	-	-	-	-	-	-	+	+
Iraq	-	+	-	-	+	-	+	-
Jordan	-	-	-	-	-	-	+	+
Kuwait	-	+	-	-	-	-	+	+
Lebanon	-	-	-	-	-	-	-	+
Libya	-	-	-	-	-	-	-	+
Mauritania	-	-	-	-	-	-	-	-
Morocco	-	-	-	-	-	-	+	+
Oman	-	-	-	-	-	-	-	+
Qatar	-	+	-	-	-	-	+	+
Saudi Arabia	-	-	-	-	-	-	+	+
Somalia	-	-	-	-	-	-	-	+
Sudan	-	-	+	-	-	-	-	+
Syria	-	-	-	-	-	-	-	+
Tunisia	+	+	+	+	+	+	+	+
UAE	-	+	-	-	-	-	-	+
Yemen	-	-	-	-	-	-	-	+

**Source:** Global Abortion Policies Database [online database]. World Health Organization, 2018 (<https://srhr.org/abortion-policies/>, access date 20 April 2018); and Jocelyn DeJong and Hyam Bashour, *Sexual and Reproductive Health laws and Policies in Selected Countries*. UNFPA and the Middle East and North Africa Health Policy Forum, 2016.

Figure 2: Arab region's population distribution by countries' abortion laws



**Source:** The percentages are calculated based on 2015 population data from UN Population Division's World Population Prospect 2017, and abortion laws shown in Table 1 of this report.

**Note:** The percentages do not add up to a 100 due to rounding.

Except for Tunisia, Arab countries' criminal codes generally criminalize abortion. Examples of such codes are:

- Section 2 of Algeria's Criminal Code criminalizes abortion and those who contribute to its realization.
- Sections 260–264 of Egyptian Penal Code of 1937 prohibit abortion in all circumstances.
- Articles 539–546 of the Lebanese Penal Code, drafted in 1943 based on the French Penal Code at the time, make abortion illegal under all circumstances. A woman who induces her own abortion or allows another person to do so is subject to six months to three years imprisonment. In 1969, Presidential Decree 13187 was issued, allowing abortion only to preserve a woman's life if in danger. A person who performs an abortion with the woman's consent is subject to one to three years' imprisonment, unless the woman dies, in which case the imprisonment is four to seven years.
- Articles 525–530 of Syria's Criminal Code criminalize any act leading in a direct or indirect way to abortion and the person committing those acts and anyone assisting a woman to abort.
- Articles 321–325 of the Palestinian Criminal Code (Law 16/1960) criminalize the woman and any person who assists her. The law differentiates between abortion with or without the woman's consent.
- Sudan's Criminal Code of 1991 stipulates punishments for illegal abortion. If the pregnancy is of less than 90 days' duration, the person who performs the abortion is subject to up to three years in prison and/or payment of a fine. If the duration of the pregnancy is of more than 90 days, the penalty for performing an abortion increases to up to five years' imprisonment

and payment of a fine. However, Sudan is the only country in the Arab region to allow abortion in the case of rape or incest.

In 1965, Tunisia became the first Arab country to legalize abortion as part of an effort to end unsafe abortion and improve women's health. In the same year, it established the *Office National de la Famille et de la Population* (ONFP), which has since successfully promoted a strong family planning program while simultaneously creating access to safe abortion and other reproductive health services. In 2001, Tunisia was also the first Arab country to authorize the use of medical abortion as an alternative to surgical methods, after conducting a series of clinical studies that demonstrated its effectiveness, safety, and acceptability.<sup>7</sup>

In 1998, the Grand Imam of al-Azhar in Egypt issued a fatwa calling for access to abortion for unmarried women who had been raped. Later in 2004, he approved a draft bill that would permit abortion in the case of rape, but the bill

was not passed.<sup>13</sup> In Morocco, however, in 2015, King Mohamed VI ordered the government to amend abortion laws. A year later, the government approved an amendment to the Moroccan Penal Code, liberalizing abortion law to allow it in cases of rape, incest, and birth defects.<sup>14</sup> In addition to the mother's mental disorder and when there is a risk for the mother's life.

In short, reforming reproductive health-related laws and policies, as well as strengthening services to meet all women's family planning needs—including unmarried—must be considered in all efforts aimed at eliminating unsafe abortion in the Arab region, where unmet need is high and discontinuation and method failure are prevalent. Experiences in the region and other parts of the world have shown time and time again that correct use of effective family planning methods is critical to reducing unintended pregnancies and therefore the need for abortion.

## 4 Unintended pregnancies

Despite increased use of modern contraceptives, unintended pregnancies are still widespread in the Arab region, jeopardizing women's and their children's health and well-being. Too often, women who either want to delay a pregnancy or want no more children are faced with an unintended pregnancy. An estimated 14.5 million pregnancies occurred in the region in 2017: 40 percent were unintended, of which 50 percent

were terminated by induced abortion and 11 percent through miscarriage.<sup>1</sup>

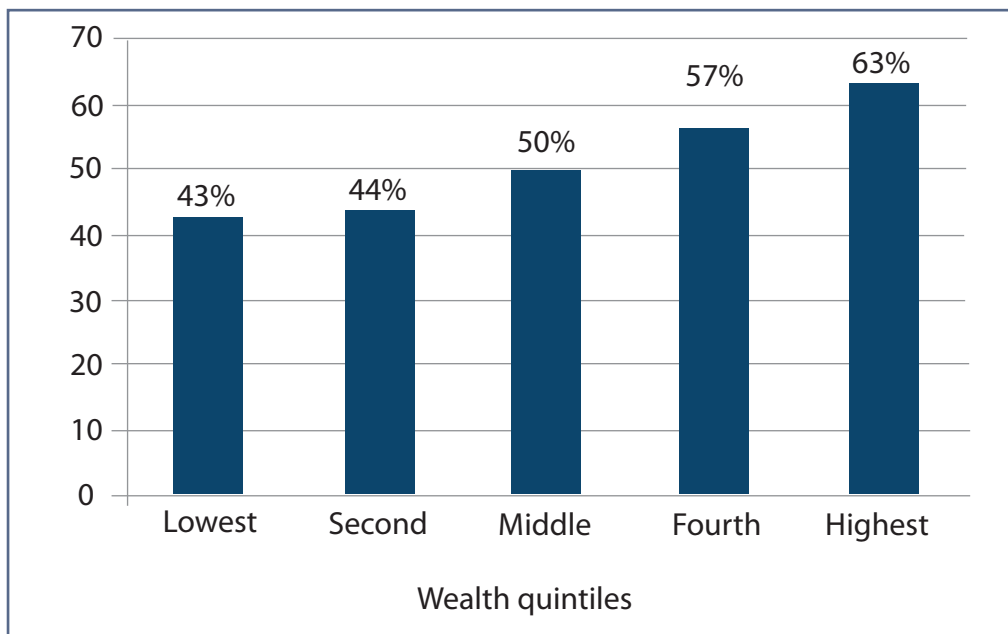
Egypt's 2014 Demographic and Health Survey (DHS) shows that on average women give birth to 3.5 children, which is higher than 2.8 children they on average declare to want to have.<sup>15</sup> The majority of Egyptian women who already have two living children want no more. Like their other beliefs and actions, however, women's



desire to have a specific number of children—and whether to practice an effective method to determine when to have them—is affected by their socioeconomic characteristics. Among the richest fifth of the population, three in five women (63 percent) who already have two children want no more, compared to two in five women among the poorest fifth or the second

poorest fifth of the population (43 percent and 44 percent, respectively) (Figure 3). The desire to have a small family size among the poorest 40 percent of the population is still substantial. Thus, meeting their family planning needs is crucial to efforts aimed at achieving Egypt's SDGs.<sup>D</sup>

Figure 3: Percent of currently married women aged 15–49 who have two living children and want no more, by wealth quintile, Egypt, 2014



**Source:** 2014 Egypt DHS report, Table 5.2.

**Note:** Wealth quintiles (five population groups of equal size) were created using an index of household assets.

Family planning services have expanded in the Arab region, and a growing number of women are using modern contraception. On average, about one-half (47 percent) of married women of reproductive age use modern contraception, ranging from 59 percent in Egypt and 57 percent in Algeria to 16 percent in Mauritania and 15 percent in Sudan.<sup>16</sup> In all, about one-quarter (23 percent) of married women have unmet need for modern family planning—they want no more children or want to have a child later but are not using a modern method.<sup>17</sup> These women are at risk of having unintended

pregnancies, which can jeopardize the health of the women and their children and also burdens health systems and society as a whole.<sup>E</sup> Table 2 shows rates of contraceptive

<sup>D</sup> Family planning is one of the targets around universal access to sexual and reproductive health found in the SDGs (3.7 and 5.6) as per Dockalova, B., Lau, K., Barclay, H. and Marshall, A., 2016. Sustainable Development Goals and Family Planning 2020.

<sup>E</sup> Unmet family planning needs affects the whole society through hindering women to participate in economic and educational activities necessary to overcome the cycle of poverty and ill-health. Consequently, this is considered a crucial factor in affecting gender inequality and poverty, high female illiteracy as per PATH, U. (2006). Meeting the Need: Strengthening Family Planning Program.

use and unmet need for modern family planning methods among married women of reproductive age in selected countries (based on national surveys). It is worth noting that throughout the region such data are not

collected for unmarried women due to cultural and religious sensitivities around sexual relationships outside marriage-leaving it all to anecdotal evidence.

**Table 2: Contraceptive use and unmet need for modern contraception among married women in selected countries**

	% of Married women ages 15 to 49 wanting to avoid pregnancy			
	Total need for contraception	Need met: using modern method	Unmet need	
			Using traditional methods	Using no method
Algeria 2013	76	54	9	13
Egypt 2014	73	58	2	13
Iraq 2011	62	36	17	9
Jordan 2012	73	42	19	12
Oman 2014	45	16	11	18
Palestine 2014	68	44	13	11
Tunisia 2012	73	53	12	8
Sudan 2014	40	12	1	27
Yemen 2013	63	30	4	29

**Source:** Guttmacher Institute, Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017 — Estimation Methodology. Table 15.

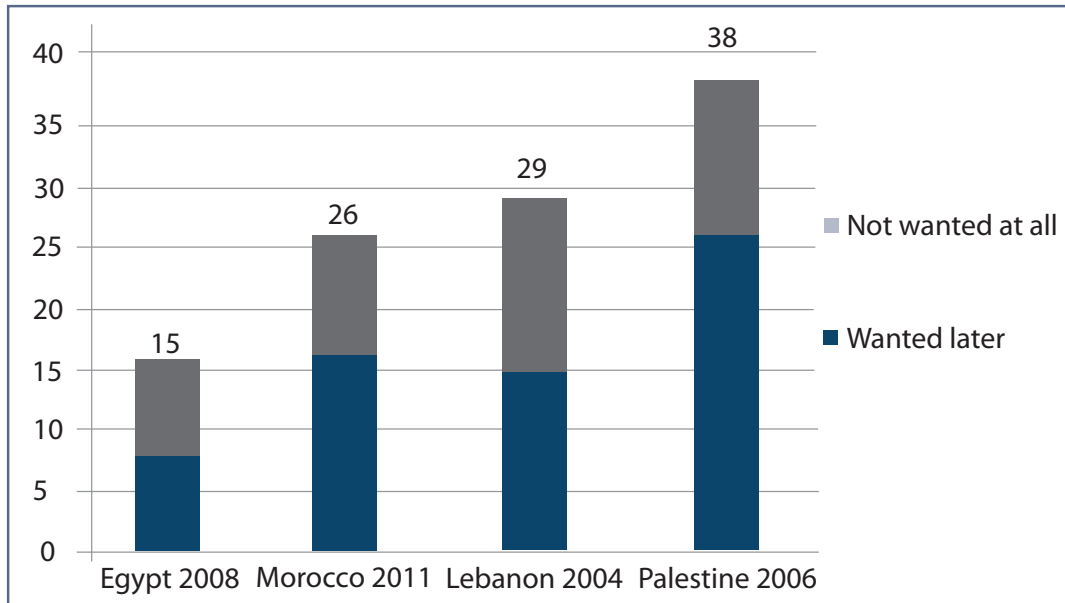
In the region as a whole, one in four births are the outcome of an unintended pregnancy.<sup>18</sup> Figure 4 shows the percentage of pregnant women who reported their pregnancy as unintended in select countries. Although couples may treasure a child born as the result of an unintended pregnancy as much as one born from a planned pregnancy, international studies have shown that unintended pregnancies are associated with poorer maternal health behaviors and infant health outcomes.<sup>19</sup> A woman with an unintended pregnancy is more likely to delay seeking prenatal care or to receive inadequate care,

which can affect the health of both mother and child. In addition, children born as the result of an unintended pregnancy are at a higher risk of illness because they are more likely to be born with a low birth weight, be breastfed for fewer months, and experience developmental problems. These children are particularly at risk when they are born soon after a sibling.<sup>F</sup>

<sup>F</sup> pregnancies that start less than 18 months after birth are associated with poor birth outcome such as delayed prenatal care, preterm birth, neonatal morbidity, and low birth weight as per Gibbs, C. M., Wendt, A., Peters, S., & Hogue, C. J. (2012). The impact of early age at first childbirth on maternal and infant health. Paediatric and perinatal epidemiology, 26, 259-284.



Figure 4: Percent of pregnant women who reported their pregnancy was unintended



**Source:** Farzaneh Roudi and Ahmed Abdul Monem, Unintended Pregnancies in the Middle East and North Africa. Population Reference Bureau, July 2010. Figure 1.

Unintended pregnancies can result from not using contraception, using a method incorrectly, or using a less effective method more prone to failure, such as withdrawal. In 2006, Syria conducted a nationally representative survey assessing the unmet need for family planning, the incidence of unintended pregnancies, and the prevalence of abortion in women. The survey, covering ever-married women aged 15–49, revealed that one-half of the women who had an unintended pregnancy were using a family planning method when they became pregnant. Of the family planning users, 45 percent were relying on traditional methods.<sup>7</sup> Both discontinuation and method failure are prevalent in the region, demanding a program and policy response.

Having access to family planning services – living reasonably close to a facility that provides convenient and affordable services – is one factor in preventing unintended pregnancies. Other factors include people’s willingness to

seek available services and consistent and correct use of birth control methods. Quality of services is also an important factor. Health providers play a critical role in informing women and couples about the method most appropriate for their particular circumstances (for example, whether a woman is breastfeeding or wants no more children), how to use the methods correctly, and the possible side effects of modern methods and how to treat them.

Moreover, aside from the capabilities of health systems in meeting women’s family planning needs, a range of obstacles and constraints – stemming from individual beliefs to women’s socioeconomic conditions, and to broader cultural, social, legal, and political factors – can also undermine a woman’s ability to act on her childbearing preferences. These circumstances systematically put the poorest and most vulnerable girls and women at disadvantage in meeting their reproductive needs, including family planning.

## 5 Special needs of girls and women in humanitarian situations family planning information and services

Women and children in crisis and humanitarian settings need special protection because of their heightened vulnerabilities. Refugee women and girls have unique needs beyond what have traditionally been considered basic in relief programs: food, clean water, shelter, security, and primary health care. They are at higher risk of unintended pregnancies and sexual violence. They often face serious and even life-threatening reproductive health-related situations, largely because of their lack of access to modern contraception, emergency obstetric care (EmOC), and post-abortion care. Comprehensive EmOC that includes PAC is critical for preventing pregnancy-related death and disability in addition to providing care necessary for women in conflict situations. Relief programs should include family planning services that include post-coital oral contraceptive pills (emergency contraception) for victims of sexual violence and manual vacuum aspiration (MVA) kits for the treatment of septic and incomplete abortions.

Attending to the reproductive health care needs of refugee and displaced women and girls is particularly important in the Arab region, home to the largest refugee and displaced population ever in the world. Recent conflicts and wars in Iraq, Libya, Syria, and Yemen have forced the largest number of people ever to flee their homes. This only adds to the region's existing large refugee populations; most well-known among them are the Palestinians,

Somalis, and Sudanese. The ongoing conflict in Yemen is affecting the country's already weak and fragile health infrastructure, making it increasingly difficult to have functioning delivery of family planning services and other reproductive health services.

According to the 2018 Humanitarian Needs Overviews, nearly one-half (46 percent) of the 136 million people requiring humanitarian assistance globally are located in the Arab States.<sup>20</sup> The ongoing conflict in Syria has created the biggest wave of displacement ever. Since the start of the crisis in 2011, one-half of Syria's population has been forced to flee their homes; the majority—6.5 million people—are displaced inside the country. With 5.4 million refugees mainly in Iraq, Jordan, Lebanon, and Turkey, Syrians constitute the largest refugee population in the world.<sup>21</sup>

The fresh plights of Syrian refugees covered in the news and social media put a spotlight on the fact that in crisis and humanitarian situations, too often the whole family is on the move—among them pregnant women. Indeed, the Syrian refugee camps in bordering countries are largely filled with women and children. Access to family planning services and PAC is a continuing need for these women, who do not know when or if they will return home. For refugees in Turkey, mobility should be less of an issue when seeking reproductive health services because they do not live in

camps and have the freedom of movement. Nevertheless, most refugees in the region are poor and rely on assistance for their basic needs. Finding extra money to spend on their health does not come easily. In 2015 in Jordan, 73 percent of Syrian refugees were living below the poverty line, a figure that had risen to 93 percent by June 2017.<sup>22</sup>

While host countries and communities are trying to cope with pressures put on their health system and services by refugee and displaced populations, none could be found to have the capacity to deal with the situation. Zaatari camp in Jordan, a model refugee camp and the second largest in the world, has effectively become the fourth most populous city in Jordan. It is home to around 80,000 Syrians, who rely on health providers recruited from surrounding communities.<sup>23</sup> Operated by Jordan Health Aid Society and supported by the United Nations Population Fund (UNFPA), the camp has four health clinics staffed by a wide range of cadres including midwives and obstetrician/gynecologists. The clinics provide services across the whole continuum of sexual, reproductive, maternal, and newborn health care. Their programs also target refugee girls to help them find the courage to resist early marriage in favor of school or work.

Rates of child marriage in the refugee communities are alarmingly high and increasing. According to a survey conducted in 2017 by UNFPA, the American University of Beirut, and Sawa for Development and Aid, among the Syrian refugee populations in some areas in Lebanon, one-quarter of girls aged 15–17 were married. Among women aged 20–24, more than one-third were married before age 18. Similar statistics are emerging from Sudan, Somalia, Yemen, and Iraq.<sup>25</sup>

Despite efforts to prevent early pregnancy in humanitarian settings, through multi-sectoral effort and, in particular, through S-GBV and family planning programming and awareness campaigns, few girls are able to attend reproductive rights sessions and access services, and even when they do, their choices and ability to make decisions remain limited. Many refugee girls already face steep challenges to continue their education due to economic and social barriers, and early marriage and motherhood virtually ensures the end of educational opportunity.<sup>24</sup>

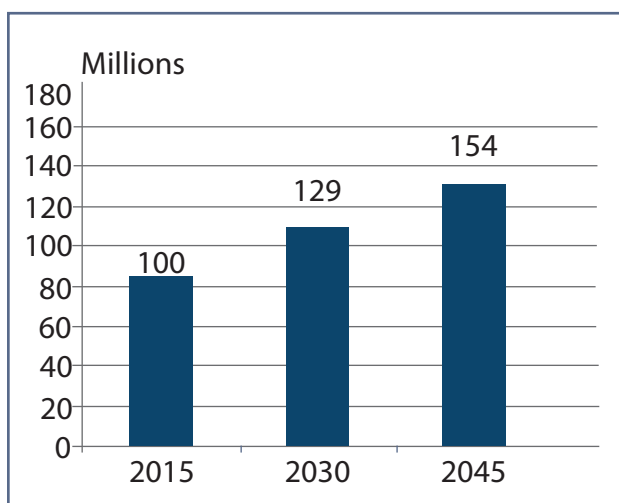
More than 20 million Yemenis are in need of some form of humanitarian assistance as the result of the ongoing conflict that has left over 14 million people without adequate health care. Girls and women – especially pregnant women and women in rural areas – are particularly disadvantaged by the lack of female health service providers. More than 500,000 pregnant women lack access to reproductive health services.<sup>26</sup>

In all, improving capacities of local communities is key to building their resilience in coping with the situation so that they can provide family planning services as well as basic and comprehensive EmOC at primary, secondary and tertiary health care locations that refugees and displaced people can access. Strengthening host communities' ability to deliver health care is a cost-effective and relatively quick way to ensure refugees' equitable access to reproductive health care and services, including family planning and PAC, without compromising the needs of local communities.

## 6 Demographic realities and challenges of inequality

The Arab region's demographic challenges go beyond its large refugee and displaced populations. Rapid population growth is exacerbating the region's economic, social, and health disparities. The UN Population Division estimates that in 2015, there were 100 million women aged 15–49 in the Arab region, a figure expected to reach nearly 130 million by 2030 and over 150 million by 2045 (Figure 5). A recent UNFPA analysis concludes that to achieve universal access to sexual and reproductive health services, the region's health systems would require a total capacity of providing approximately 400 million health service encounters per year.<sup>27</sup> The extent to which reproductive health services keep pace with increasing demand is of key importance. If rates of unintended pregnancies are not reduced substantially, the number of abortions and the demand for PAC are expected to increase as the number of women of reproductive age increases.

Figure 5: Total number of women aged 15–49 in the Arab region, 2015–2045

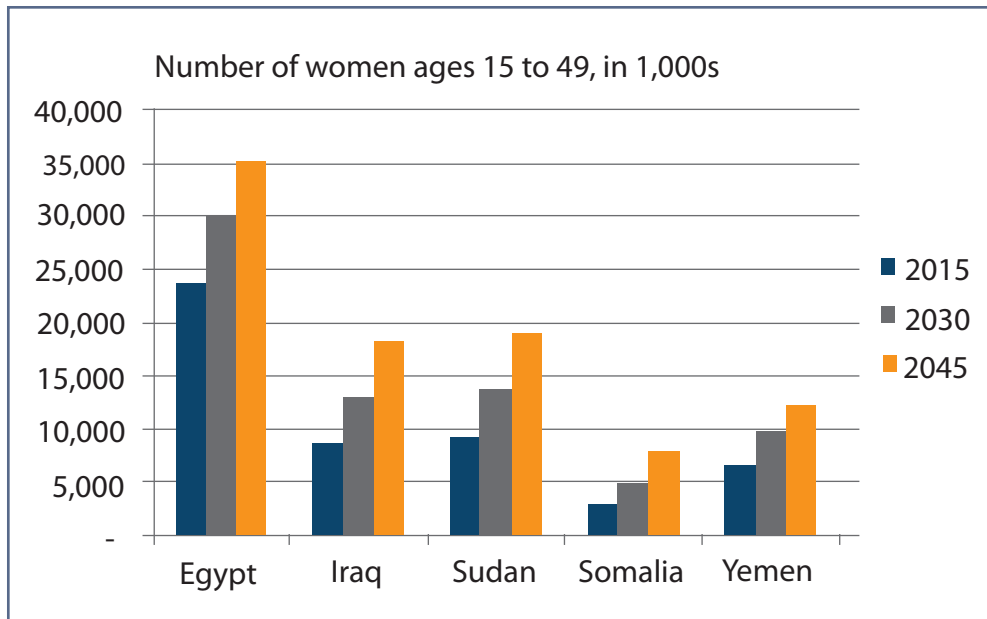


Source: UN Population Division, World Population Prospect 2017.

The four most populous countries—Egypt, Algeria, Morocco, and Sudan—are home to more than one-half of the region's population. The largest increase in the number of women of reproductive age will be seen in Egypt (in part because of its large population to begin with), Iraq, Somalia, Sudan, and Yemen (Figure 6). These five countries account for 70 percent of the increase in the number of women of reproductive age in the region between 2015 and 2030, and nearly 80 percent of the increase between 2015 and 2045. Between 2015 and 2045, Egypt will add 11 million to its female population aged 15–49, reaching 35 million; Sudan nearly 10 million, reaching 29 million; Iraq over 9 million, reaching 18 million; Yemen almost 6 million, reaching over 12 million; and Somalia nearly 5 million, reaching 8 million. The fastest rate of increase, however, will be seen in Somalia, followed by Sudan, Mauritania, Iraq, and Palestine, where the number of women will double or more by 2045.



Figure 6: Arab countries with the largest increase in their female population of reproductive age, 2015–2045



Source: UN Population Division, World Population Prospect 2017.

Inequality in accessing reproductive health services is a major challenge across and within countries. Even in countries that did achieve their MDG5a of “reducing maternal mortality ratio by three-quarters, between 1990 and 2015,” disparities in women’s reproductive health are unacceptably high and the achievement of MDG5b of “Universal access to SRH services” is far away. Morocco, for example, is one of the few Arab countries to achieve its MDG5a, reducing its maternal mortality ratio from 332 deaths per 100,000 live births around 1990 to 112 deaths per 100,000 live births in 2010—a 66 percent decline.<sup>28</sup> However, women living in rural Morocco are still twice as likely to die due to pregnancy-related causes as women in urban areas. Sudan’s maternal mortality ratio fell from 744 deaths per 100,000 live births in 1990 to 311 deaths per 100,000 live births in 2015.<sup>18</sup> However, women and girls in conflict-affected areas do not have access to the key government health services that have contributed to this decline.

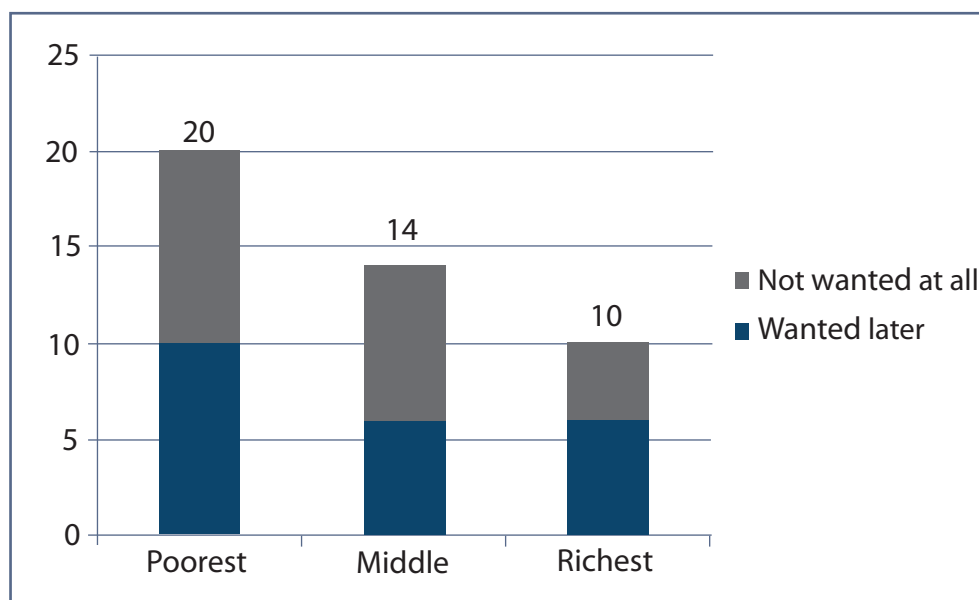
Arab countries’ populations are young. They mostly have an unprecedented number of people in their late teens and early twenties—the age at which most people initiate sexual activity. Yet the region is still characterized by inadequate youth-friendly health services. Only nine countries have developed national youth policies or strategies. For these countries, progress also remains hindered by ineffective implementation of those policies that do exist.<sup>29</sup>

Early marriage is still common in parts of the region, namely in the least developed countries, where one-third of girls are married off before age 18. In Sudan and Yemen, one in three girls are married off before their 18th birthday, one in four in Iraq, one in six in Egypt, and one in seven in Palestine.<sup>18</sup> Girls who marry at a young age are at higher lifetime risk of unintended pregnancies. For these girls, early marriage means early childbearing. They generally are not empowered at that young age to make

decisions about their health and do not have the means and mobility to seek family planning services. In general, they reach their desired number of children earlier in age than those who marry later in their mid or late 20s. Therefore, they are in need of modern contraception to avoid unintended pregnancies for a longer period of their reproductive life. Young women who marry in their teens, especially those

in rural areas, require special attention from health providers and policy makers who want to reduce unintended pregnancies in the region. In Egypt, pregnant women belonging to the poorest fifth of the population—who mainly reside in rural areas—are twice as likely to report their pregnancy as unintended as pregnant women belonging to the richest fifth (Figure 7).

Figure 7: Percent of pregnant women whose pregnancies were unintended, by wealth quintile, Egypt, 2008



**Source:** Farzaneh Roudi and Ahmed Abdul Monem, *Unintended Pregnancies in the Middle East and North Africa*. Population Reference Bureau, July 2010. Figure 4.

**Note:** Wealth quintiles (five population groups of equal size) were created using an index of household assets. Data are shown for the first (poorest), third (middle), and fifth (richest) quintiles.

Another trend that makes some young women vulnerable to unintended pregnancy is the increasing likelihood that they will enter into an unconventional marriage. Throughout the Arab region, conventional marriage is the standard and culturally acceptable prerequisite for a couple to engage in sexual relations. Public ceremonies mark the union and both families are involved in the marriage. However, many young men and women, particularly in urban areas, enter into unconventional

marriages—such as urfi marriages in Egypt and temporary marriages in Lebanon—to give religious legitimacy to a sexual relationship. Although many young women may see these secret unions as a step toward a conventional marriage, most are short-lived. This leaves the former wives in legal limbo, socially stigmatized, and possibly pregnant or with a child. Urfi marriages are associated with many contested paternity cases in Egypt.



Throughout the Arab region, women in unconventional relationships are at a disadvantage in preventing pregnancy because almost all reproductive health services are tailored to the needs of women in conventional marriages. Social and legal constraints, inability to pay for the service, and

shyness can deter them from seeking family planning services. Because of their secrecy and lack of social acceptance, pregnancies that occur within unconventional marriages are most likely to be unintended and often voluntarily aborted, putting young women's health and life in danger.

## 7 Avoiding unsafe abortion

Despite the magnitude of the problem of unsafe abortion, it is one of the most easily preventable causes of maternal death and ill health. Unfortunately, this cannot be said for most parts of the Arab region, where women run the risk of experiencing complications due to unsafe practices. If complications arise, women may avoid or delay medical care if they are unaware of the necessity or unsure where to receive care. They may also fear abuse, ill treatment, or legal reprisal. However, abortion-related mortality and morbidity can largely be reduced by ensuring that PAC is available and affordable to all women in need of such care, regardless of their marital status.

The only conference on unsafe abortion and sexual health ever held in the region was in Syria in 1992. Organized by the Syrian Family Planning Association and the International Planned Parenthood Federation (IPPF) Arab World Regional Office, the conference brought together health professionals, religious leaders, and women's health advocates in an attempt to raise awareness about the dangers of unsafe abortion and the need to promote preventive

measures. The participants concluded that unsafe abortion was a major public health problem in almost all countries in the region. It called on their governments and family planning associations to review existing laws and provide better contraceptive services and treatment for women seeking PAC.<sup>7</sup> After nearly three decades, this same conclusion could still be reached today.

In the Arab region, research on abortion is rare and generally done on a small scale. A study conducted in six villages to determine the morbidity and determinants of abortion in rural Upper Egypt revealed that 21 percent of pregnancies were ended in abortion, 41 percent of women had at least one abortion, and 25 percent of these women had more than one. The incidence of abortion was estimated to be 265 per 1,000 live births. The vast majority of the women who had an abortion (92 percent) did not seek medical care; they were assisted by traditional and domestic sources: a midwife (60 percent), relative or neighbor (30 percent), or traditional practitioner (10 percent). The study showed that the incidence

of abortion is significantly associated with gravidity (the number of times a woman has ever been pregnant), consanguinity, and the woman's occupation, while recurrent abortion is associated with gravidity, consanguinity and the woman's age at marriage. It concludes that the risk of morbidity due to unsafe abortion is high in Egypt and its maternal mortality due to abortion is underestimated.<sup>30</sup>

In 2015, the Palestinian Family Planning and Protection Association (PFPPA), conducted a study in four of its sites located in both rural and urban areas of Hebron Governorate. The study included quantitative and qualitative components. In the quantitative part, women visiting PFPPA clinics and service delivery points were targeted with a questionnaire. The qualitative portion comprised interviews and group discussions with key informants.<sup>31</sup>

The quantitative part of the study revealed that 40 percent of the women had their first pregnancy before their 19th birthday and that more than 70 percent had at least one abortion. Of those abortions reported, 11 percent were induced and 66 percent were spontaneous. One-half (50 percent) of the women who had spontaneous abortion received treatment for incomplete abortion, which ranked first in participants' use of PAC services. Two-thirds (68 percent) of those who had an induced abortion did so secretly without anyone's knowledge. In all, two-thirds (66 percent) of women who ever had an abortion had more than one. Severe vaginal bleeding was the complication endured by most. The fact that one-half of the participants in the study said a female relative or friend confided to them

about a personal experience of abortion—81 percent had an induced abortion – presents further evidence that abortion is widespread in Palestine, despite its prohibitive laws and traditions. The majority of participants (93 percent) believed that abortion is prohibited religiously except when a woman's life is at risk. Such paradoxically opposing beliefs and practices are not unique to Palestinian women or Arab women at large. This can be seen in other parts of the world as well.

In the qualitative part of the study, interviews and focus group discussions conducted with service providers, health care planners, social workers, policy makers, and human rights lawyers unfolded ample evidence on the lack of recognition of women's right to health. The key informants expressed that women largely end up engaging in unsafe practices by going to female family members or dayas, or using traditional healers' remedies and advice. Women generally have no clue about incomplete spontaneous abortion, emergency contraception and its role in preventing a pregnancy, and the psychosocial counseling they are entitled to as part of post-abortion services. Therefore, women do not take signs of incomplete abortion seriously until they become too grave. Serious complications, such as severe bleeding, compel a long hospital stay until recovery, resulting in higher cost to families and overburdening the health system.

The key informants noted that abortion is not on the Ministry of Health's agenda except for the conventional D&C/E&C that is therapeutically performed in hospitals for incomplete abortions. They also noted that abortion is not



included in any policy document, strategic or operational plan, technical protocol, awareness campaign, training activity, service program, or any recognized health care/outcome report.

The findings and conclusions of the Egyptian and Palestinian studies are relevant to the wider region. While amending laws and establishing regulatory guidelines takes time, countries need to make sure that PAC services are universally available in accordance with the WHO guidelines. PAC includes:<sup>7</sup>

- Emergency treatment for complications of induced abortion or miscarriage.
- Counseling to identify and respond to a woman's emotional and physical health needs and other concerns.
- Family planning services to help prevent another unintended pregnancy.
- Reproductive or other health services provided on site or through referral to other facilities.

In the 1990s, Egypt was a pioneer in the region in research, training, and advocacy on PAC and made some progress. A pilot study conducted in two hospitals in Egypt in 1994 concluded that upgrading PAC services and training physicians in MVA, infection control, and counseling led to significant improvements in the care of PAC patients. Three years later, a larger study was designed with the goal of improving PAC services in university and Ministry of Health hospitals by institutionalizing MVA with local anesthesia as a safer and simpler method in treating post-abortion complications than

sharp curettage with general anesthesia. However, such improvements did not come to fruition, and only 12 percent of hospitals providing PAC services now have the MVA equipment.<sup>32</sup> A study published in 1998 revealed that almost one in five obstetrical and gynecological hospital admissions in Egypt were for PAC.<sup>33</sup>

To help alleviate the burden of unsafe abortion on women's health and lives, current family planning programs and PAC need to be enhanced and expanded to the broadest extent possible by health systems. The outcome of unsafe abortion also depends on women's willingness to use medical services and the readiness of medical staff to deal promptly with any complications. The situation is particularly problematic for young and vulnerable women. Too often, they lack information, power, and means to unauthorized information sources that offer family planning information and services. Access to correct information is critical and life-saving to women seeking to prevent a pregnancy.

Finally, it is imperative to remove barriers to conducting research and collecting reliable data, which are needed to inform policies and programs on family planning services. Without adequate data, it is impossible to track any change in abortion rate. Restrictive laws make it difficult for researchers to collect data and study the incidence, circumstances, and impact of abortion on women and societies.

## 8 International agreements and development goals

Sexual and Reproductive health and reproductive rights are not only a critical component of individuals' health but also a critical dimension of sustainable development. The burden of unsafe abortion goes beyond women's health, affecting both families and societies. Arab governments and civil societies have the opportunity to improve women's sexual and reproductive health by giving priority to provision of quality family planning services and improving women's reproductive health, adhering to international agreements and human rights documents, and taking advantage of instruments to monitor their progress, including the SDGs. ICPD's Programme of Action clearly states the right of women to "have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions."<sup>34</sup>

Having the information and means to decide the number, timing, and spacing of their children is fundamental to protecting individuals' and couples' reproductive health and rights. Reproductive rights are derived from the basic rights of all individuals and couples to make decisions in their reproductive lives, free of discrimination, coercion, or violence. They include rights regarding marriage, family planning, healthy childbearing, and protection from HIV and other sexually transmitted infections. In international agreements,

individuals' freedom to decide the number and timing of their children is acknowledged as a basic human and reproductive right.<sup>35</sup>

UNFPA leads global efforts toward the achievement of universal health coverage for sexual and reproductive health. It was one of the agencies that adopted the UN Statement of Common Understanding on a Human-Rights-Based Approach (HRBA) to Development Cooperation and Programming (the Common Understanding) in 2013. The Common Understanding clarifies how human rights standards and principles should be put into practice in development programs.<sup>36</sup> The purpose behind developing a common understanding was to ensure that UN agencies apply a consistent HRBA to their programming processes at global, regional, and especially country level.

Most Arab countries' constitutions make a direct reference to health, which can be used as the basis for making the case for women's right to accessing reproductive health information and services, including family planning.<sup>37</sup>

The SDGs were adopted by world leaders in 2015 as a universal call to action to end poverty, tackle inequality, and protect the planet. They consist of 17 goals and 169 targets. Goals 3 and 5 of the SDGs directly relate to sexual and reproductive health and reproductive rights. Targets of Goals 3 and 5 that are linked to preventing unsafe abortion are:<sup>38</sup>

- **Goal 3 – Ensure healthy lives and promote well-being for all at all ages**

- **3.1** – By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- **3.7** – By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information, and education, and the integration of reproductive health into national strategies and programs.
- **3.8** – Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

- **Goal 5 – Achieve gender equality and empower all women and girls**

- **5.1** – End all forms of discrimination against all women and girls everywhere.
- **5.2** – Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

- **5.3** – Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation.
- **5.6** – Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the program of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.
- **5.9** – Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

Progress in reaching these targets helps reduce unintended pregnancies and therefore abortions. Unsafe abortion is a hidden public health problem in the Arab region that has largely been ignored. It is imperative for Arab countries to create a supportive legislative and regulatory framework conducive to addressing women's unmet need for reproductive health information and services free from discrimination by ensuring that any national and community reproductive health discourse, strategy, and plan adheres to up-to-date clinical guidelines for provision of quality family planning information and services and PAC.<sup>39</sup>

## 9 Conclusions

Meeting women's family planning needs is central to any efforts aimed at reducing unintended pregnancies and therefore preventing the recourse to unsafe abortion. It requires both political and financial commitments to address the underlying factors contributing to women's unmet need by expanding and improving quality family planning information and services to make them accessible and affordable to everyone, including unmarried women. It also requires investing in research to identify health system-related and social barriers, including stigmas surrounding reproductive health issues. Achieving equity in reproductive health demands multisectoral efforts that go beyond the health system. It requires efforts such as encouraging girls' education, discouraging families from marrying off their daughters at a young age, and raising the status of girls and women in family and society.

Moreover, family planning programs should be designed and implemented based on evidence so that program planners understand the size and major causes of unmet need for family planning among different population groups, including marginalized girls and women and the poor. Evidence gathered on the family planning needs of couples and available services to identify gaps should include research on discontinuation, correct use of methods, and method failure.

Finally, public and private health sector collaboration helps ensure that family planning information, commodities, and services are universally available and accessible to those who need them—regardless of their marital, legal and social status. In all, such actions will help Arab countries address the ICPD PoA unfinished agenda and achieve the SDGs' main objective of "leaving no one behind."

## References

- 1 Guttmacher Institute, 2017, *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017—Estimation Methodology*, Tables 6 and 7. Accessed online on May 11, 2018 at <https://www.guttmacher.org/report/adding-it-up-investing-incontraception-maternal-newborn-health-2017-methodology>.
- 2 Ganatra B., et al., 2014, From Concept to Measurement: Operationalizing WHO's Definition of Unsafe Abortion. *Bulletin of World Health Organization*, 92, 155.
- 3 Guttmacher Institute, 2017, *Abortion Worldwide 2017: Uneven Progress, Unequal Access*.4-
- 4 Guttmacher Institute, March 2018, *Induced Abortion Worldwide. Fact Sheet*.
- 5 Guttmacher Institute, 2017, *Adding It Up: Investing in Contraception and Maternal Newborn Health, 2017—Estimation Methodology*, Table 10.
- 6 World Health Organization (WHO), 2015, *Trends in Maternal Mortality: 1990 to 2015*, Estimates by WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Annex 13.
- 7 Rasha Dabash and Farzaneh Roudi. September 2008, *Abortion in the Middle East and North Africa* Population Reference Bureau.
- 8 United Nations, 1994, *Programme of Action of the International Conference on Population and Development*, para. 8.25.
- 9 "A Global Database of Abortion Law, Policies, Health Standards and Guidelines, 2017, *Bulletin of the World Health Organization*, 95, 542-544.
- 10 Guttmacher Institute, March 2018, *Induced Abortion Worldwide. Fact Sheet*.
- 11 Ibid.
- 12 Jocelyn DeJong and Hyam Bashur, July 2016, *Sexual and Reproductive Health Laws and Policies in Selected Arab Countries*. The Middle East and North Africa Health Policy Forum.
- 13 Hessini, Leila, May 2007, Abortion and Islam: Policies and Practice in the Middle East and North Africa, *Reproductive Health Matters*, 15 (29), 75–84.
- 14 Morocco World News, June 10, 2016, Morocco Liberalizes Abortion Laws, Amends Penal Code, Egypt DHS report, 2014, Table 5.7.
- 15 UNFPA, State of the World Population 2017.
- 16 Guttmacher Institute, 2017, *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017 — Estimation Methodology*, Table 15. Accessed online on September 17, 2018 at <https://www.guttmacher.org/report/adding-it-up-investing-incontraception-maternal-newborn-health-2017-methodology>.
- 17 Guttmacher Institute, 2017, *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017 — Estimation Methodology*, Table 7.



- 18 J.D. Gipson, M.A. Koenig, and M.J. Hindin, 2008, the Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature. *Studies in Family Planning*, 39, 18–38. And Amber J. Hromi-Fiedler and Rafael Perez-Escamilla, 2006, Unintended Pregnancies Are Associated With Less Likelihood of Prolonged Breastfeeding: An Analysis of 18 Demographic and Health Surveys, *Public Health Nutrition* 9, no. 3.
- 19 United Nations Office for Coordination of Humanitarian Affairs (OCHA), 2018 *Humanitarian Needs Overview*.
- 20 M. Murat Erdogan, Den Hubbard, Maha Yahya, and Jihad Yazigi, 2018, *Triggers of Return of Syrian Refugees*. *Carnegie Middle East, Beirut*.
- 21 Cindy Huang, Nazanin Ash, Katelyn Gough, and Lauren Post, 20xx, Designing Refugee Compact: Lessons from Jordan. *Forced Migration Review Online*.
- 22 UNFPA Arab States Regional Office, 2014, *The State of Midwifery in Arab States Region, 2014*, Box 6, p. 23.
- 23 UNFPA, *Regional Interventions Action Plans for Arab States, 2018–2021*, p. 4.
- 24 Shible Sahbani, Maysa Al-Khateeb & Ruba Hikmat (2016) Early marriage and pregnancy among Syrian adolescent girls in Jordan; do they have a choice?, *Pathogens and Global Health*, 110:6, 217-218, DOI: 10.1080/20477724.2016.1231834)
- 25 WHO, *Yemen Humanitarian Response Plan 2016*, accessed online on April 18, 2018 at <http://www.who.int/hac/crises/yem/ap-peals/en/>.
- 26 UNFPA, *Regional Interventions Action Plans for Arab States, 2018–2021*, p. 3.
- 27 Moroccan Ministry of Health and UNFPA, 2015, *Reducing Maternal Mortality in Morocco: Sharing the Lessons*.
- 28 UNFPA, *Regional Interventions Action Plans for Arab States, 2018–2021*.
- 29 K.M. Yassin, July 2000, *Incidence and Socioeconomic Determinants of Abortion in Rural Upper Egypt*. *Public Health*, 114(4), 269-72
- 30 Ayesha Al Rifai, January 2015, *Assessment of Safe and Unsafe Abortion among Palestinian Women in Hebron Governorate in Southern West Bank -Palestine*. Palestinian Family Planning and Protection Association (PFPPA), Jerusalem.
- 31 Guttmacher Institute, 2018, Dr. Stanley Henshaw: Reflections on Four Decades of Abortion Research, *Perspectives on Sexual and Reproductive*, Special Report, 5 February. <https://onlinelibrary.wiley.com/doi/full/10.1363/psrh.12049>
- 32 Egyptian Initiative for Personal Right, September 2013, *Reclaiming and Redefining Rights, ICPD+20: Status of Sexual and Reproductive Rights in the Middle East and North Africa*, 43.
- 33 Dale Huntington et al., 1998, The Postabortion Caseload in Egyptian Hospitals: A Descriptive Study. *International Family Planning Perspectives* 24, no. 1, 25-31.
- 34 United Nations, 1994, para. 8.25.
- 35 United Nations, 1994, para 7.3; and African Union, 20xx, *Plan of Action on Reproductive Health Rights (Maputo Plan of Action)*.
- 36 UNFPA, *the Human Rights-Based Approach*. Accessed online on May 7, 2018, at <https://www.unfpa.org/human-rights-based-approach>.
- 37 UNFPA, *Regional Interventions Action Plans for Arab States, 2018–2021*
- 38 United Nations, Sustainable Development Goals: 17 Goals to Transform Our World.
- 39 Sneha Barot, 2018, The Roadmap to Safe Abortion Worldwide: Lessons from New Global Trends on Incidence, Legality and Safety. *Guttmacher Policy Review*, Volume 21, March 20.



