European Medical Students' Association

Abortion Awareness Booklet

September 28th

Abortion Awareness Booklet

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Opening words

Dear EMSAi,

The SWG of Safe Abortion Awareness Day is thrilled to share this booklet with you. This booklet was designed on the occasion of Safe Abortion Awareness Day, under the supervision of the Medical Ethics and Human Rights Pillar. All the information gathered are as up to date as possible, shedding the light on the situation of Abortion across Europe.

We hope that this booklet will help you to have all the necessary information and to organize successful projects on safe abortion. Please contact the MEHR Director (ethics@emsa-europe.eu) if you need more information on abortion or if you have any questions.

Europeanly yours,

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European Medical Students' Association

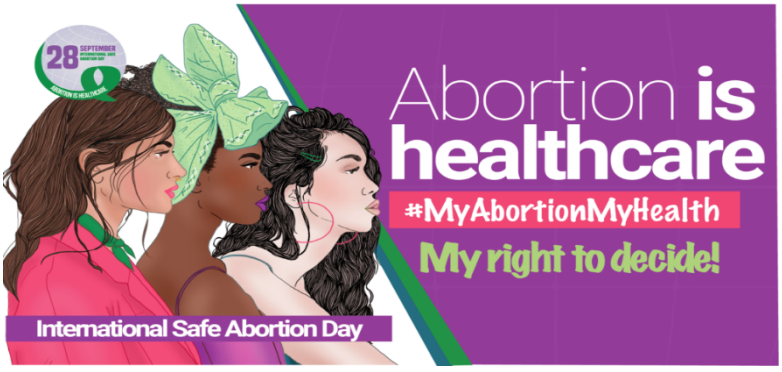
The History of the Safe Abortion Awareness Day

The history of International Safe Abortion Awareness Day originates from slavery in Latin America and the Carribean, and more specifically from the concept of “free womb”. Before the “free womb” laws were created and implemented, slave women had been killing their children right after birth. This was done in order to spare them the life of slavery, as children born from slave women were automatically the property of the slave owner. The “free womb” laws ensured that children that were born to slave women, were going to be free from birth.

The first international day regarding abortion (which initially was International Day of action for Decriminalization of Abortion) was launched and celebrated in 1990 in Latin America and the Caribbean, by the activist group called Campaña 28 Septiembre (or “Campaign of September 28”). Since then, every year they have been organising various activities near this date in this region.

However, it took some years before this date became an international day promoted in other regions. In 2011, the Women’s Global Network for Reproductive Rights declared this day as an international day and began promoting it worldwide.

In 2012, International Campaign for Women’s Right to Safe Abortion adopted 28th of September as one of the most important activities and events of the organisation. It was also agreed that International Campaign for Women’s Right to Safe Abortion should be the umbrella organisation for promoting this day. Since then, the date of 28th September has become a day internationally recognized for activism, supporting safe abortion. In 2013, more than 60 countries celebrated this day, organising various activities on regional, national and international level across the world and only a year later, 100



activities were organised in 65 countries, as this date became more and more recognizable by both government leaders, social media and press.

Source: International Campaign for Women's Right to Safe Abortion, 2019

In 2015, the name of this day was changed into International Safe Abortion Day. Some of the reasons behind this change were the two different names of this day used by two different organisations. Also, advocates decided to apply to the UN in order to establish this date as one of the official UN days of commemoration.

Since 2016, International Safe Abortion Day had an annual theme, chosen as a priority at the time:

2016 - 'Abortion is not a crime'

2017 - '#leavingnoonebehind'

2018 - 'Accessible, legal and safe abortion'

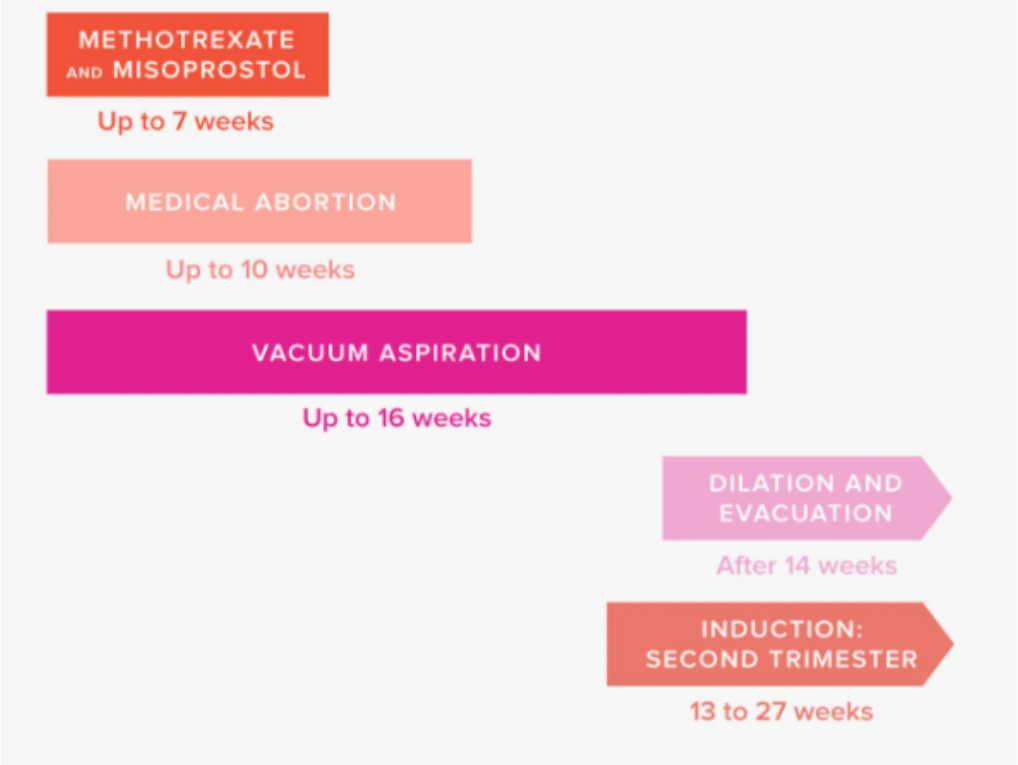
2019 - 'Abortion is healthcare'

2020 - 'Self-managed abortion'

Source: International Campaign for Women's Right to Safe Abortion, 2017&2018

The Different Types of Abortion

The time period during which an abortion can be carried out varies from country to country. In Turkey, abortions (except for those where a mother's life is at risk) are legal until the 10th week of pregnancy. Government hospitals may refuse to carry out abortions and redirect people to private clinics. In case of a fetal disorder such as trisomy 18, or in cases where maternal life is at risk, abortions are legal until the 20th week of pregnancy.



1) Medical Abortion

Misoprostol (Cytotec) can be used by itself until the 8th week of gestation and can be combined with methotrexate until the 10th week of pregnancy. Alternatively, mifepristone can be used instead of methotrexate. This process is called medical abortion because, as the name suggests, this method requires an administration of drugs. Let's talk about the different types of drugs in detail –

a) **Methotrexate**: Methotrexate was originally used as a chemotherapy agent. It is a folate agonist. It inhibits some enzymes responsible for nucleotide synthesis, such as dihydrofolate reductase, thymidylate synthase, aminoimidazole carboxamide ribonucleotide transformylase (AICART), and amido phosphoribosyltransferase. Through this mechanism, it is able to inhibit the growth of rapidly dividing tumor cells, or in our case, fetal cells. It is more commonly used in the USA. Misoprostol is preferred in Europe.

b) **Mifepristone**: It is an antiprogestogen and an antiglucocorticosteroid. Mifepristone's affinity for progesterone receptors is equal to, or even greater than progesterone itself. By inhibiting the binding of progesterone to its receptors, mifepristone increases uterine contractility and the sensitivity of the myometrium to the stimulatory effects of exogenous prostaglandins such as misoprostol, which is a prostaglandin E1 analog.

c) **Misoprostol**: It is a synthetic prostaglandin E1 analog, meaning it has similar functions to PE1. It was originally used as an ulcer medication as prostaglandin E1 lowers gastric acid secretion from parietal cells (and increases mucus + HCO3 secretion). In context, misoprostol binds to the smooth muscle cells in the uterine lining to increase the strength and frequency of contractions as well as degrade collagen and reduce cervical tone.

How is medical abortion carried out?

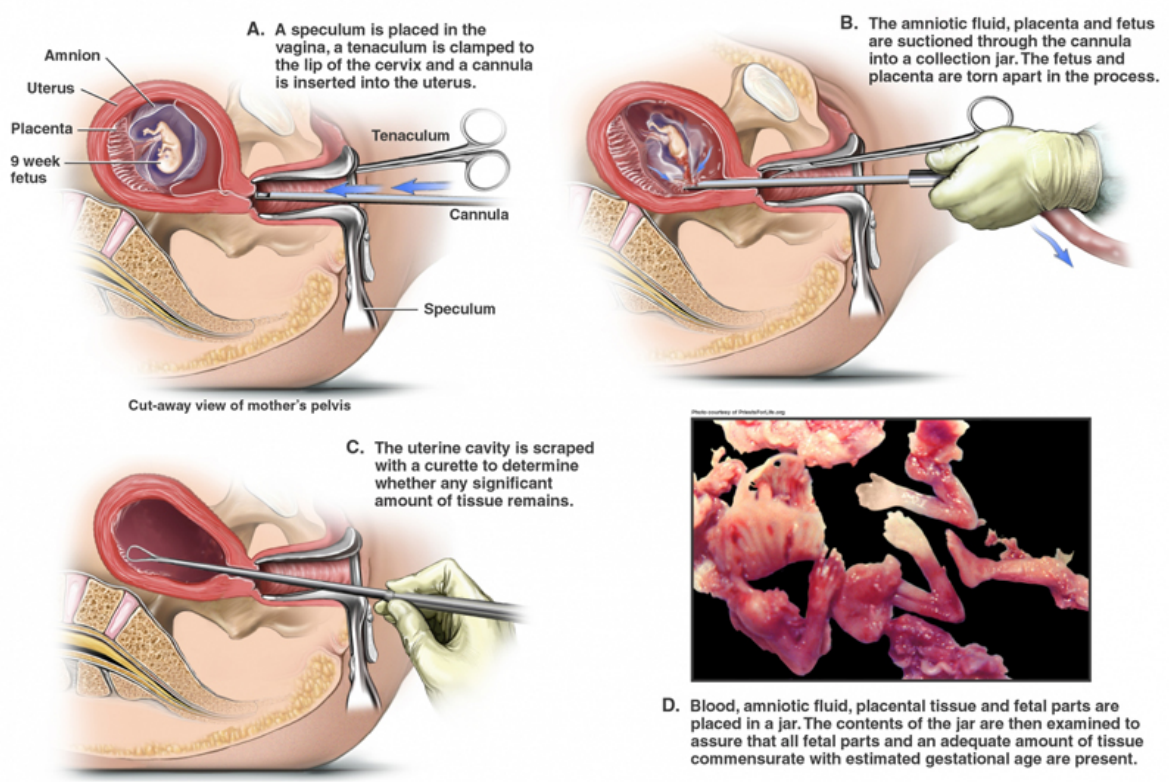
In the FDA approved regimen, 600mg of mifepristone is taken orally, followed by misoprostol or methotrexate 48 hours later. Misoprostol can be administered vaginally, buccally or sublingually as well. Heavy bleeding and cramping can be observed two hours after taking misoprostol. Some women report dizziness, nausea, headaches, diarrhea, and excessive sweating. The bleeding lasts a week and looks like a regular period. Large blood clots and the sac may be flushed down the toilet. If the pregnancy has lasted less than 9 weeks, the patient can go home directly after receiving the medication, but they will have to remain in the hospital for some time if it has lasted more.

In countries where mifepristone is not available, a misoprostol-only regimen can be used for first trimester medical abortion. The regimen includes a loading dose of 800 mcg of misoprostol given vaginally, followed by three further doses of 400 mcg of misoprostol given at three hourly intervals. However, misoprostol-only medical abortion regimens are significantly less effective than those that use a combination of mifepristone and misoprostol.

2) Vacuum Aspiration:

Vacuum aspiration is a surgical method used to terminate first trimester pregnancies. 400 mcgs of intravaginal misoprostol is initially administered for cervical priming and when a minimum of 8mm cervical dilatation is observed, vacuum aspiration is carried out. Vacuum aspiration can be manual or electric, a manual vacuum aspirator is, quite simply, a syringe. A vacuum is produced by retracting the plunger.

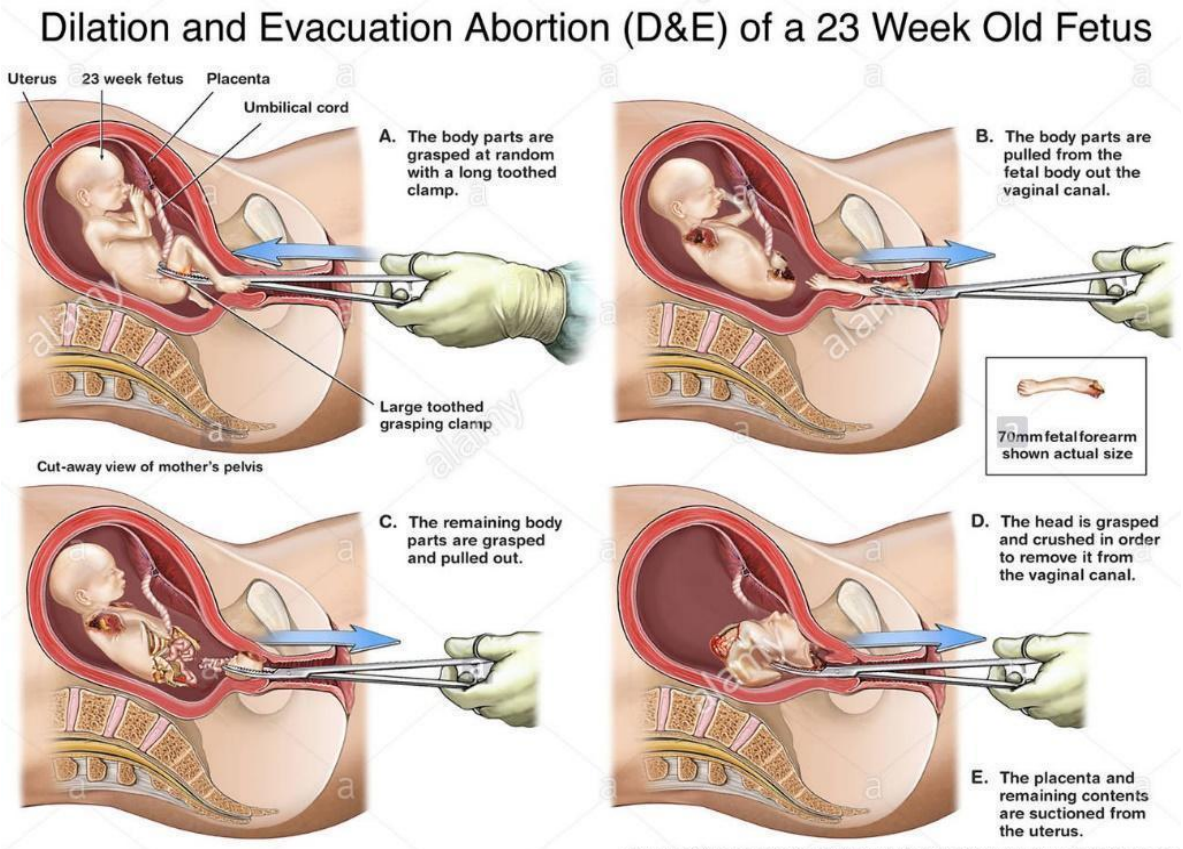
In electric aspiration, a rigid suction curette is inserted into the uterine cavity before suction is applied using an aspiration device. A systematic review reported no significant differences in complete abortion rates or patient satisfaction between both methods for termination of pregnancy at less than 10 weeks gestation. Compared to sharp curettage, vacuum aspiration was associated with a statistically significant decrease in blood loss, pain and duration of procedure.



3) Dilatation and Evacuation – D&E

Dilatation and evacuation have been shown to have half the rate of serious complications compared to installation of abortifacients. Second-trimester extraction requires dilation of the cervix and this technique involves an increased risk of cervical laceration and hemorrhage. It can be carried out using multiple osmotic dilators or intravaginal prostaglandins for cervical ripening.

Vacuum cannula or forceps can then be used to extract the fetal parts depending on the gestational age. Suction curettage is performed to extract any remaining tissue after the evacuation and the surgeon should also examine the specimen to verify that all products of conception have been removed. It is important that dilatation and evacuation can only be undertaken by gynecologists who are trained in the procedure and have the necessary instruments. A majority of second trimester abortions in the United States are carried out by dilatation and evacuation.



4) Induction:

Common methods of inducing abortion are

- Instrumental evacuation of the uterus after cervical dilation
- Medical induction (drugs to stimulate uterine contractions)

The method used depends in part on the length of the pregnancy. Instrumental evacuation can be used for most pregnancies. Drugs can be used for some pregnancies that are < 11 weeks or > 15 weeks.

Uterine surgery (hysterotomy or hysterectomy) is a last resort, which is usually avoided because mortality rates are higher. Hysterotomy also results in a uterine scar, which may rupture in subsequent pregnancies.

a) Instrumental evacuation

At 14 to 24 weeks, dilation and evacuation (D & E) is usually used. Forceps are used to dismember and remove the fetus, and a suction cannula is used to aspirate the amniotic fluid, placenta, and fetal debris. D & E requires more skill and requires more training than do other methods of instrumental evacuation.

Often, progressively increasing sizes of tapered dilators are used to dilate the cervix before the procedure. However, depending on gestational age and parity, clinicians may need to use another type of dilator instead of or in addition to tapered dilators to minimize the cervical damage that tapered dilators can cause. Choices include

- The prostaglandin E1 analog (misoprostol)
- Osmotic dilators such as laminaria (dried seaweed stems)

Misoprostol dilates the cervix by stimulating prostaglandin release. Misoprostol is usually given vaginally or buccally 2 to 4 hours before the procedure.

Osmotic dilators can be inserted into the cervix and left for ≥ 4 hours (often overnight if the pregnancy is >18 weeks). Osmotic dilators are usually used at > 16 to 18 weeks.

b) Medical induction

Medical induction can be used for pregnancies of < 11 weeks or > 15 weeks. If patients have severe anemia, medical induction should be done only in a hospital so that blood transfusion is readily available.

In the US, medical abortion accounts for 25% of abortions done at < 10 weeks.

For pregnancies of < 10 weeks, regimens include the progesterone-receptor blocker mifepristone (RU 486) and the prostaglandin E1 analog misoprostol, as follows:

- Mifepristone 200 mg orally, followed by misoprostol 800 mcg buccally at 24 to 48 hours (for pregnancies of 10 to 11 weeks, an additional dose of misoprostol 800 mcg buccally is taken 4 hours after the initial misoprostol dose)

This regimen is about 95% effective in pregnancies of 8 to 9 weeks and 92% effective in pregnancies of > 9 to 10 weeks. A follow-up visit is required to confirm resolution of the pregnancy and, if necessary, to provide contraception.

After 15 weeks, pretreatment with mifepristone 200 mg 24 to 48 hours before induction reduces induction times. Prostaglandins are used to induce abortion. Options include:

- Vaginal prostaglandin E2 (dinoprostone) suppositories
- Vaginal and buccal misoprostol tablets
- IM injections of prostaglandin F2-alpha (dinoprost tromethamine)

The typical dose of misoprostol is 600 to 800 mcg vaginally, followed by 400 mcg buccally every 3 hours for up to 5 doses. Or, two 200-mcg vaginal tablets of misoprostol every 6 hours can be used; abortion occurs within 48 hours in almost 100% of cases.

Adverse effects of prostaglandins include nausea, vomiting, diarrhea, hyperthermia, facial flushing, vasovagal symptoms, bronchospasms, and decreased seizure thresholds.

Unsafe Abortions

Every year, worldwide, about 50 to 60 million women with unintended pregnancies choose abortion, and nearly half of these procedures, approximately 25 million, are unsafe. Some 23,000 women die of unsafe abortions annually, making it one of the leading causes of maternal mortality.

Methods of unsafe abortion include drinking toxic fluids such as turpentine, bleach, or drinkable concoctions mixed with livestock manure. Other methods involve inflicting direct injury to the vagina or elsewhere—for example, inserting herbal preparations into the vagina or cervix; placing a foreign body such as a twig, coat hanger, or chicken bone into the uterus; or placing inappropriate medication such as chili peppers and chemicals like alum, Lysol, permanganate, or plant poison into the vagina or rectum.

Unskilled providers also improperly perform dilation and curettage in unhygienic settings, causing uterine perforations and infections. Methods of external injury are also used, such as jumping from the top of stairs or a roof or inflicting blunt trauma to the abdomen.

Complications of Unsafe Abortions

An unsafe abortion is an abortion done in unsanitary conditions, by a non-professional, self-managed and without access to post-abortion care. Unsafe abortions are more prevalent in countries that have highly restrictive abortion laws or where abortions are totally illegal.

Several methods of unsafe abortions are used by women without access to reproductive healthcare including:

- Puncturing the amniotic sac with a sharp object. This is very risky and can lead to septicemia from unsterilized objects or injuring organs of the pelvic floor.
- Introducing chemicals into the body. This can increase the risk of chemical damage to the mucosa, allergic reaction, shock.
- Self-administration of abortifacient drugs. This can lead to side effects or worsening of other diseases the person already has, for example, asthma.

Unsafe abortions also have several complications including:

- Incomplete abortion
- Hemorrhage
- Genital tract infection
- Structural damage to pelvic organs due to puncturing
- Retention of post-abortion matter in the uterus
- Disseminated Intravascular Coagulation Syndrome
- Peritonitis
- Hepatitis from unsanitary instruments
- Depression and anxiety: mostly due to lack of a support system and self-administered medication.
- Death

International Law on Abortion in Europe

- Abortions are made available on request in the first trimester (up to 12 weeks) of pregnancy in all European countries except Malta, Poland, Liechtenstein, Monaco, Andorra and The Vatican
- Abortions in the first trimester require authorization in Denmark and Finland
- Abortions can be made available in the 2nd trimester (after 12 weeks) in Sweden and Netherlands on request.
- Abortions can be made available up to 24 weeks on authorization if there's a threat to the patient's life in all European countries except the Vatican.
- Abortions can be made available up 24 weeks if there's fetal impairment in all European countries except Malta, Andorra, Liechtenstein and the Vatican
- Abortions can be made available up to 24 weeks on authorization if the conception was due to rape except in Malta, the Vatican and Andorra.
- Abortions in Poland are allowed if there is a threat to the patient's life, physical or mental health issues, in cases of rape or incest and fetal impairment up to 12 weeks.
- Abortions are not allowed in any situation in the Vatican.

Gestational Limits by Country

- **Austria**: On request up to 16 weeks; after that if there are physical or mental health threats to carrier's health.
- **Belgium**: On request up to 12 weeks; after that if the life of the carrier is in danger or in the case of known incurable disease of the fetus.
- **Bulgaria**: On request up to 12 weeks; between 12-20 weeks if there's a known dangerous disease of the carrier, past 20 weeks if there's a life-threatening for the carrier's life.

- **Croatia**: On request up to 10 weeks; past this only if approved by the commission that it's medically necessary to save the carrier's life or preserve their health, if the child will likely be born with a serious congenital defect or when the conception results from a criminal act.

- **Republic of Cyprus**: On request up to 12 weeks. While there is no specific guideline limiting when an abortion is permitted under Cypriot law, in practice no abortions are performed after the 28th week.

- **Czech Republic**: On request up to 12 weeks; with medical indications up to 24 weeks of pregnancy.

- **Denmark**: On request up to 12 weeks; after that in physical or mental health threats to carrier's health or under certain conditions.

- **Estonia**: On request up to 11 weeks; up to the 21st week if the carrier is younger than 15 years old or older than 45 years old, if the pregnancy endangers the carrier's health, if the child may have a serious physical or mental defect, or if the carrier's illness or other medical problem hinders the child's development.

- **Finland:** Approval needed of one physician for pregnant women under 17 or over 40 years of age or if the applicant has birthed 4 or more children, otherwise two doctors need to approve. If requested between 13-20 weeks, the application is referred to the National Supervisory Authority, between 20-24 weeks abortion is only available on grounds of fetal abnormalities and after 24 weeks only if there is a threat to the physical life of the carrier.

- **France:** On request up to 12 weeks; after that abortions are allowed only if the pregnancy poses a grave danger to the carrier's health or there is a risk the child will suffer from a severe illness recognized as incurable.

- **Germany:** On request up to 12 weeks; after that if the pregnancy is a result of an unjust action (on criminal ground) and there's no limit if the woman's or the newborn's lives are at stake (on medical grounds).

- **Greece**: On request up to 12 weeks without justification; 19 weeks if the pregnancy is a result of an unjust action; 24 weeks if pregnant carrier's or fetus' lives are under stake of death or damage.

- **Hungary**: On request up to 12 weeks (on medical grounds); 18 weeks (on medical grounds and if the carrier was unaware of the pregnancy and this ignorance can be proved); 24 weeks (on medical grounds: more than 50% possibility of teratogenesis in the newborn).

- **Ireland**: On request up to 12 weeks (on medical grounds or early pregnancy); 32 weeks (condition likely to lead to death of fetus), can't terminate in terms of rape or other unfair action or on socioeconomic grounds

- **Italy**: On request up to 12 weeks; until second trimester on medical grounds on carrier and fetus, when the life of the carrier would be at risk, if the pregnancy is carried to term or the fetus carries genetic or other serious malformations which would put the carrier at risk of serious psychological or physical consequences.

- **Latvia**: On request up to 12 weeks + on criminal grounds); after 12 weeks on special non-medical reasons and after 22 weeks on medical grounds.

- **Lithuania**: On request up to 12 weeks upon request; after 12 weeks, special authorisation is required but can be authorized irrespective of time on medical grounds if the carrier or fetus' lives are at stake. Abortion is not legal on criminal grounds.

- **Luxembourg**: On request 12 weeks; after 12 weeks on medical grounds.

- **Malta**: Illegal under any and all circumstances (including life-threatening circumstances, incest and rape).

- **Netherlands**: On request up to 24 weeks, but by law it is required for the woman to be in a state of emergency, open to interpretation of the physician (from not wanting to be pregnant to physical emergency can classify as a sufficient "emergency").

- **Poland**: On request up to 12 weeks in cases of rape and or incest, of immediate threat to the life or health of the pregnant person and on grounds of severe fetal abnormalities

- **Portugal**: On request up to 10 weeks; up to 12 weeks to prevent irreversible damage to the carrier's (mental) health, up to 16 weeks in cases of rape, incest or other sexual crimes and up to 24 weeks for severe, life-threatening and/or incurable fetal abnormalities

- **Romania**: On request until up to 14 weeks. When a carrier's health is threatened, the limit is lifted.

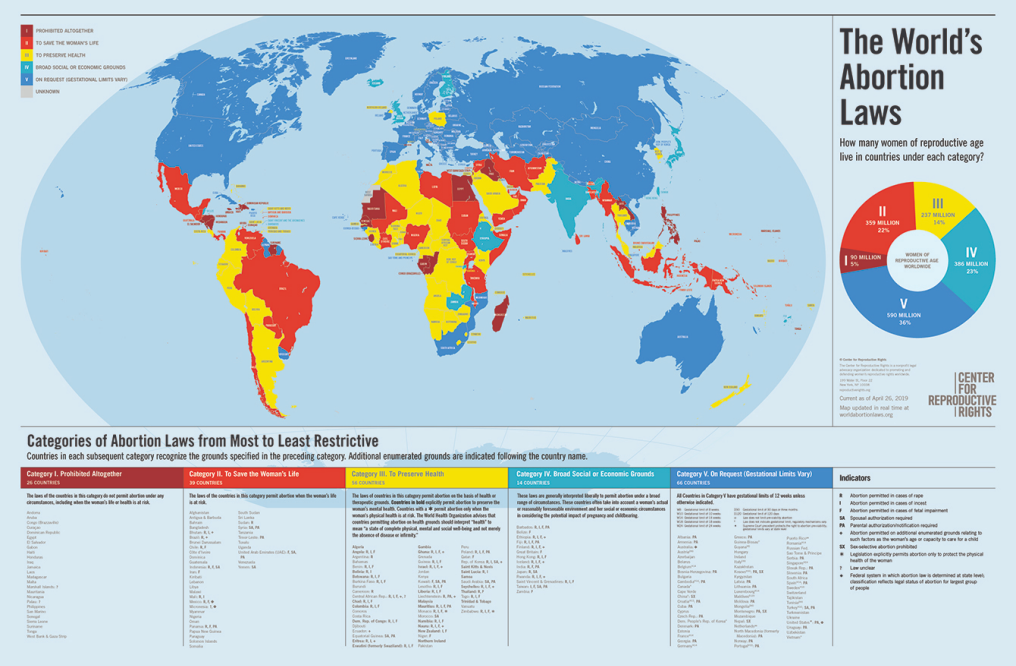
- **Slovakia**: On request up to 12 weeks; after 12 weeks for medical reasons up to a counsel of physicians to choose (carrier's life or health is endangered; the healthy development of the fetus is endangered or fetal development manifests genetic anomalies).

- **Slovenia**: On request 10 weeks. At a later stage, abortion is not possible.

- **Spain**: On request up to 14 weeks; up to 22 weeks for cases of severe fetal abnormalities or if the carrier's health is at risk.

- **Sweden**: On request up to 18 weeks; up to 22 weeks but with permission needed from the National Board of Health and Welfare for any reason or when the fetus will not be viable outside the uterus with no gestational limit.

- **Turkey**: On request up to 10 weeks if the pregnancy threatens the carrier's mental and/or physical health, the fetus would be physically or mentally impaired, if the conception occurred through rape or incest, and economic or social reasons. It can be extended if there is an endangerment to the woman's life or the life of the fetus.



Source: Center for Reproductive Rights, 2019, found at the: http://gabriel-lee.design/wam.html

Conscientious Objection

This is the right of health professionals to refuse to perform a procedure on a moral basis or due to personal values. Despite the less restrictive abortion laws in most European countries, conscientious abortion rights limit the access of individuals to safe abortions and medical practitioners to perform the procedure/administer medication. It is granted in all European countries except Sweden, Finland, Bulgaria and Iceland.

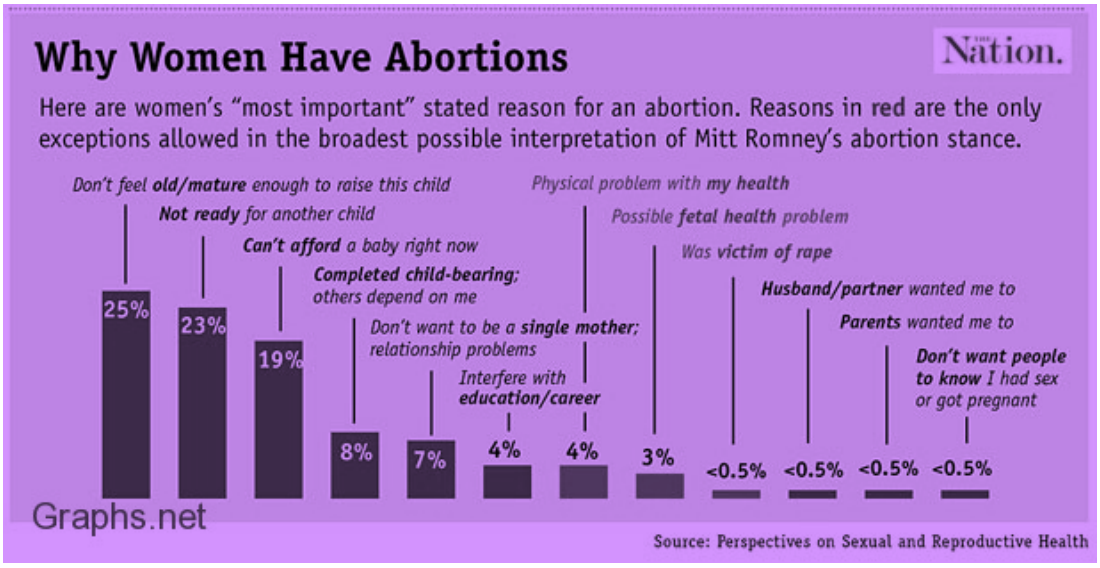
While these laws are put in place to ensure physicians' rights to uphold their beliefs and opinions, they also indirectly lead to the harm of various patients by reducing their access to qualified healthcare workers that can provide abortions in a safe manner. Patients can spend months looking for a doctor who will carry out their procedure and may not find until the first trimester is up, thereby preventing them from getting the procedure at all. In a notable case from Poland, the doctor refused to perform an abortion on a patient because of a "conflict of conscience" and refused to issue a referral before the 24-week period ended, thereby preventing the patient from getting an abortion, and forcing her to deliver an anencephalic child. Access to safe abortions needs to include access to non-objecting medical staff without avoidable delay.

Abortion in Numbers

According to WHO's statistics between 2010-2014, approximately 25% of pregnancies ended in an induced abortion, regardless if legal or not. This indicates that the procedure of abortion is a common event worldwide. It is also estimated that each year (between 2010-2014) worldwide, there were approximately 50-60 million abortions and out of those, around half of them were considered safe, 30% were less safe and around 15% were considered dangerous. This translates into the fact that there are 25 million unsafe abortions happening every year, with most of them (around 97%) occuring in developing countries.

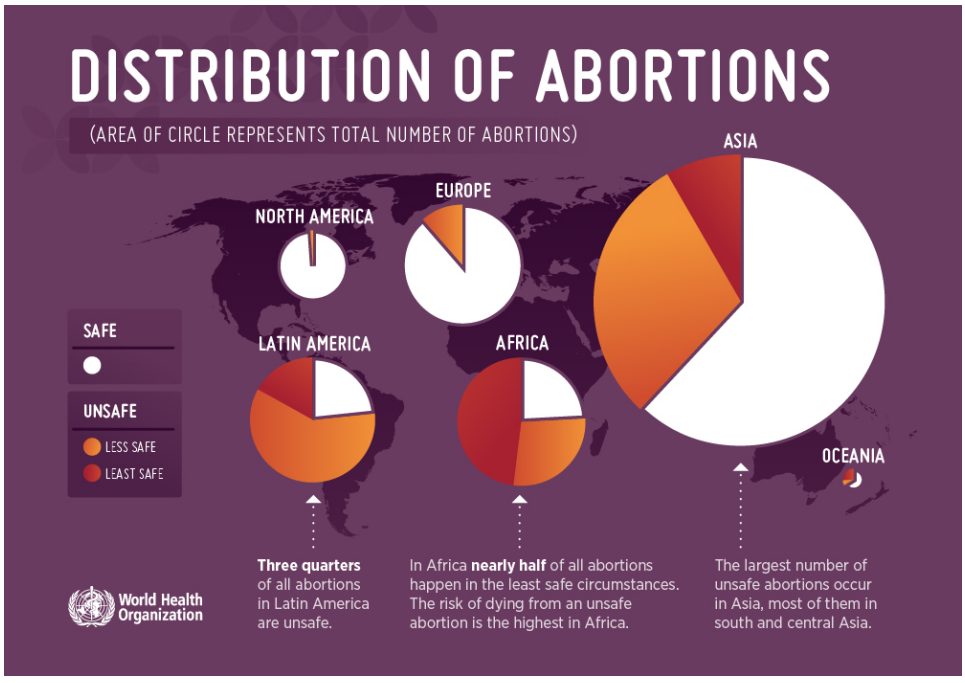
Reasons behind having an abortion

There are various reasons and answers to a simple question: Why patients have an abortion? The chart below indicates they can vary, from economic reasons to life-threatening ones or because of pregnancies that were the result of crimes, such as rape or incest among many more. Multiple abortions happen daily, sometimes to people we know.



Only within a year, 7 million patients have suffered complications due to unsafe abortions, making it the third leading cause of maternal deaths during pregnancy and childbirth. An unsafe abortion accounts for 5% to 13% of deaths in this period. It is estimated by WHO and Guttmacher that annually, around 23.000 patients die due to the complications of unsafe abortions, although the numbers of patients sustaining long-term damage or chronic disease as a result of unsafe abortion is way bigger and somewhere between 2 - 7 million. The costs of treating major complications resulting from unsafe abortion amounts to approximately 553 US$.

Abortion legislation varies from country to country and continent to continent - it is legally restricted in 135 countries and prohibited in any situation in 26 countries. This explains how only one out of three patients have access to a legal and safe abortion. Illegality of abortion contributes to the higher prevalence of unsafe abortion, but it's not the only factor. Another contributor is the lack of access to safe and effective contraception - it is estimated that by implementing modern family planning and improving availability and quality of reproductive health services, we could reduce the number of unsafe abortion by as much as 73%, without any changes to the existing abortion laws.



Source: WHO, Sexual and reproductive health infographics - abortion

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