

**GUIDELINE ON TERMINATION OF
PREGNANCY (TOP)
FOR HOSPITALS IN THE
MINISTRY OF HEALTH**

FOREWORD

Maternal mortality in Malaysia has come down significantly over the last 60 years. Further reduction in the maternal mortality ratio will be challenging as Malaysia strives towards meeting the targets set by The Millennium Development Goals. We need to pay attention to causes of maternal deaths that are remediable so as to channel our resources appropriately. We also have to address morbidities that are not documented systematically, and it is unfortunate that unsafe abortions in this country come in this category. While efforts are being made to improve access to family planning, strategies must be comprehensive so as not to leave any stone unturned.

I would like to commend the Obstetrics and Gynaecology Development Committee of The Ministry of Health (JKPPOG) which comprised of gynaecologists and public health specialists for recognizing the need to address unsafe abortion as one of the many strategies to reduce maternal mortality and improve maternal health. After all, abortion has been with us from time immemorial, and it is timely that health systems respond accordingly within the context of the law and other existing provisions.

This guideline is a tool for practice in the government hospitals and is useful for teaching at every level of care. All those who are involved in women's health will welcome this effort to standardise management of termination of pregnancy , especially among the government hospitals.

I would like to congratulate the working committee for the developing a national guideline on termination of pregnancy for use in government hospitals. It is hoped that this guideline will lead to women friendly services and better health outcome of the women population in Malaysia.

Thank you


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PREFACE

Unsafe abortion is one of the main causes of maternal mortality and morbidity. In Malaysia, safe abortion services is legal if the pregnancy is a threat to the woman's life or when the pregnancy poses a threat to the woman's physical or mental health. These provisions are stated in the Penal Code Act 574 (revised 1997) section 312. The fatwa allows it, subject to certain conditions (26th Muzakarah of the National Fatwa Committee, 7-8 Mac 1990) .

Malaysia, a member of United Nations General Assembly Special Session in June 1999, has agreed that ` in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health'

Responding the above situations, and appreciating the differences in viewpoint among health care providers on the subject of abortion, while not denying that abortion does occur in the community, the Obstetrics and Gynaecology Development Committee recognized the need to ensure induced abortion or termination of pregnancy services in government hospitals be carried out professionally and of quality, through development of standards and continuous training . The development of this guideline is an imperative towards this mission.

The Guideline on Termination of Pregnancy in Government Hospitals was developed to create awareness among government health care professionals of the complexity of the issues of induced abortion and to be mindful of existing provisions given by the professional ethics, legislation, religion and reproductive rights during consultation with the woman client. Every case considered for termination of pregnancy should be handled appropriately in a holistic manner. This guideline is to update clinical care of women undergoing abortion including procedures and precautions. Information on the Penal Code, stand of various religions and the Code of Professional Conduct are appended.

This guideline is based on local experiences and references from practices of other countries such as United Kingdom, Singapore, Australia and Canada. It complements the document developed for the primary health care setting which addressed sexual and reproductive health entitled *Garis Panduan Pengendalian Masalah Kesihatan Seksual dan Reproduksi Remaja di Klinik Kesihatan 2011*.

Dr. Soon Ruey and his team must be congratulated for their commitment and successful task in completing this first national guideline on termination of pregnancy for use in government hospitals.



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1. INTRODUCTION

Globally, abortion mortality accounts for approximately 13% of all maternal mortalities. Unsafe abortion procedures, untrained abortion facilitators, restrictive abortion laws and high maternal mortality and morbidity from abortion tends to coexists together.

A range of positive steps have been taken to reduce deaths and morbidity from abortions in many countries over the past 2 decades. Among them include the easy availability of contraception, sex education and last but not the least by making abortions legal as a prerequisite of making it safe.

Women health groups, parliamentarians, health professionals need to work together to support the right of the women not to die from unsafe abortions. While the law, policy and women rights are central to this issue, making abortions safe is above all a public health responsibility of the Governments.

2. DEFINITION OF TERMS

Unwanted Pregnancy is defined as a pregnancy that was not planned for or not desired by the couple or the mother at the time of conception. Sometimes this may be due to an abnormality of the fetus or of an illness in the mother.

Abortion is defined as the expulsion or removal of an embryo or fetus from the uterus at a stage of pregnancy when it is incapable of independent survival (500gms or 22 weeks gestation). It may be spontaneous miscarriage, or induced for medical or social reasons.

Termination of pregnancy for the purpose of this document is confined to procedures to remove an embryo or fetus where the pregnancy is less than 22 weeks of gestation or if the gestation is unknown, where the fetus is estimated to be less than 500 gms.

Unsafe abortion has been defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both.

LEGAL ASPECTS

Legal Status in Malaysia

Although a country's abortion rate is not closely correlated with the legality of abortion, if changes in legislation are not accompanied by corresponding changes in levels of contraceptive use or fertility, it is likely that legal abortions will replace illegal abortions or vice versa. Studies have shown high incidence of

induced abortions mainly due to economic problems, social problems and improper family planning, with serious complications like septicemia (25th International Congress Of The Medical Women's International Association; level 9). Local data from the Malaysian Confidential Enquiry of Maternal Death is indicated in Appendix 1.

In Malaysia, induced abortion is illegal under Act 574 of the Penal Code (Revised – 1997). However, an exception clause has been added to Section 312 (please refer Appendix 2), ***a medical practitioner registered under the Medical Act 1971 who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated.***

In addition, Section 314 indicates that if the process of termination of pregnancy results in the death of the mother, this would constitute a criminal offence (Malaysian Penal Code)

4. TERMINATION OF PREGNANCY – *Standard Operating Procedures*

Pre Requisite :

a. Patients can be seen at any private or public health institution but the procedure should only be done in a setting with Gynaecologist (Specialist) support (this is also in accordance with the Private Health Care Act). This is to ensure that the procedure can be done properly and if complications should occur, these complications can be picked up quickly.

b. While by law, only one medical registered practitioner is required to assess if a termination of pregnancy is, it is suggested that in a Government Hospital setting, two doctors, one of whom is a specialist should concur that the Termination of Pregnancy is necessary and that continuation of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the woman, greater than if the pregnancy was terminated. (For mental health reasons, an opinion from a psychologist or psychiatrist is not needed unless it is deemed necessary by the attending doctor ie because of severe depression or suicidal risk).

c. A full clerking and examination has been done to determine any coexisting health issues and this should include a general mental health assessment. This assessment and examination must be adequately documented.

4.1. Management

4.1.1. Pre-termination management

i. Counselling

Clinicians should provide greater support to the physical and emotional needs of those women who require termination of pregnancy. Care pathways for additional support, including access to social services, should be made available.

a. Clinicians caring for women requesting abortion should try to identify those **who require more support** in decision making than can be provided in the routine clinic setting (such as those with a psychiatric history, poor social support or evidence of coercion)..

b. It has been recommended that an **opt out period of 48 hours** following first counseling should be practiced. This means that the termination should not be carried out until at least 48 hours after first counseling by the health care professional. This will allow the couple or the women to be sure of their/her decision to proceed with the termination and to have further counseling if needed. A delay of 48 hours should not affect the termination of pregnancy procedure but may have a huge impact on the mental status of the woman post abortion.(Appendix 3)

c. In addition, if religious views are needed, the couple/woman should be referred to the necessary authorities for further counseling. A summary the Fatwa and of the religious views from the MCCBCHST are appended with this document (Appendix 7A & 7B).

ii. Blood Tests and other investigations

a. Pre-abortion assessment should include the following:

- measurement of haemoglobin concentration
- determination of ABO and rhesus blood groups screening for red cell antibodies
- If indicated ,testing for other conditions such as haemoglobinopathies, HIV, and hepatitis B and C, in the light of clinical features, individual risk factors, or local prevalence.
- Other investigations as deemed necessary for the safe conduct of anaesthesia and surgery specific for the patient (ECG, CXR, Renal Profile, Liver Function Tests, Echocardiogram etc.)

b. It is not cost effective to routinely cross-match blood for patients undergoing termination of pregnancy, however a Group and Save would be recommended.

c. If the woman has never had a Pap Smear, the clinician should utilize the opportunity for cervical screening as well.

iii. Ultrasound scanning

Ultrasound scanning is not an essential pre-requisite before termination. It is indicated where gestation is in doubt, or where extra-uterine pregnancy or molar pregnancy is suspected. The scanning should be in a setting and manner sensitive to the woman's situation, and should not be undertaken in an antenatal department together with other women undergoing routine antenatal care, if possible .

The image of the fetus on the screen need not be shown to the mother unless she requests to do so.

iv. Prevention of Infective Complications

Antibiotic prophylaxis, where necessary, should be administered to minimise the risk of post-TOP infective morbidity. For example in pregnant women with chronic rheumatic heart disease and valvular involvement, the regimens advised should be followed (refer guidelines Management of Heart Disease in Pregnancy by KKM, Level 9, Antibiotic Guidelines KKM 2008)

A single stat dose of a broad spectrum antibiotic may be given at the time of initiating the Termination of Pregnancy for low risk patients

v. Consent

a. Written consent should be from the women herself. However for Muslim couples, consent from the husband is also necessary as per Fatwa.

b. Married non Muslim women should also be encouraged to discuss the termination of pregnancy with her husband.

c. If the girl is underaged (less than 18 years of age), consent should be sought from her parents or her guardians. If no guardians can be contacted, then consent should sought from a child protector or from the State.

- d. In a women who is of unsound mind or who may be mentally challenged, consent should be from her parents or guardian or in life threatening situations, from the doctors caring for her.

There Informed Consent Form for Termination of Pregnancy should be used (Appendix 8)

4.1.2 Methods of termination

The method of termination should be made after discussion with the couple. The actual technique employed would depend on the period of gestation and the condition of the cervix as seen below.

Condition of cervix

- Nulliparous cervix prostaglandin is recommended for cervical priming
- Multiparous cervix prostaglandin maybe used for cervical priming
- Prostaglandin of choice is Gemeprost 1 mg vaginally, 3 hours prior to procedure
- Misoprostol 400 micrograms administered vaginally 3 hours prior to surgery or 600 mg administered orally 36-48 hours prior to surgery may also be used for cervical ripening **where available**.
- If prostaglandin is contra indicated, priming of the cervix can be done using Laminaria Tent or with a cervical ripening balloon.

Period of Gestation

1) Between 5-9 weeks:

Medical abortion is preferred method when drugs listed below are available

- a) **mifepristone** 600mg orally, **plus** 24-48 hours later vaginal misoprostol 800µg (may be followed by smaller vaginal misoprostol 3-6 hourly if needed)
- b) **mifepristone** 600mg plus gemeprost 1 mg vaginally between 1-3 days later

- c) **In Malaysia where mifepristone is unavailable, gemeprost** (1 mg every 3-6 hours up to 3 doses in 24 hours) or **misoprostol** alone (80-85% effective) (800µg vaginally **daily dose** up to 5 days until abortion occurs, or **total of 2400µg** vaginally every 3-12 hours with 3 application is reached)
- d) Alternatively, **Methotrexate** plus misoprostol (>90% effective): 50mg/m² IM followed by 800µg of misoprostol between day 5 –day 7. Misoprostol dose is usually repeated after 24 hour if abortion has not occurred.

2) Between 7-14 weeks

- Suction evacuation (vacuum aspiration/suction curettage) under local or general anaesthesia, preceded by priming of cervix with PGE1 analogue or hydrophilic/osmotic dilator or mechanical dilators (as per local protocol)
- Manual vacuum aspiration (<10 weeks): using Karman cannula, 50 ml IPAS syringe, paracervical block with 1% lignocaine 10-20mls.

3) Between 14-22 weeks

a) **Medical termination of pregnancy:**

- i) Gemeprost alone 1mg every 3-6 hours up to 3 doses in 24 hours (up to 18 weeks size uterus).
- ii) IM carboprost: 250µg deep IM can be repeated every 2 hours, up to total 1250µg (can be used together with multiple osmotic dilators)

If Misoprostol is available then :

- i) mifepristone 200mg followed after 24-48 hours by misoprostol 800µg vaginally plus misoprostol 400µg 3 hourly up to 4 doses orally
- ii) Misoprostol alone: 400µg vaginally every 3 hours for 5 doses

- b) **Surgical evacuation** is possible in an experience and trained hands up to 18-19 weeks gestation if medical methods fail.

Differences between medical and surgical abortion

Medical abortion	Surgical abortion
High success rate	High success rate
Surgical intervention required in small percentage	Very small percentage may require re- evacuation
Avoids invasive procedure	Typically an invasive procedure
Avoids sedation and anaesthesia	Includes sedation with or without anaesthesia
Severe complications are rare	Complications are rare, infection from surgical instrumentation and injury to genital tract can occur
Time to completion uncertain	Time to completion is predictable
Involves multiple steps	Involves a single step
Woman has greater control	Provider has greater control

The possible complications associated with termination of pregnancy are indicated in Appendix 5.

***Where possible (ie the patient is fit and healthy) a surgical procedure is best done as a day care procedure.*

4.1.3 Post-termination management

i. Rhesus prophylaxis

All non-sensitised RhD negative women should be given Anti-D immunoglobulin G (250 IU before 20 weeks of gestation and 500 IU thereafter), by IM injection into the deltoid muscle, within 72 hours of abortion

ii. Post-abortion information and follow up

- a. Discharge notes providing sufficient information about the abortion procedure should be provided to the patient to allow another practitioner elsewhere to deal with any complications
- b. Written account of possible symptoms, indicating those that require urgent medical attention should be given to the woman.
- c. 24-hour telephone helpline number to use if they feel worried about pain, bleeding or high temperature
- d. Access to urgent clinical assessment and emergency admission when necessary should be readily available.
- e. A 2 week follow-up appointment should be given to assess possible complication post TOP and for counseling where necessary. Counselling for contraception should also be given at this time.
- f. Referral for further counselling to women who are at risk of long-term post-abortion distress. This should include women who are :-
 - ambivalent before the abortion
 - lack of a supportive partner / family
 - psychiatric history
 - religious/cultural belief that abortion is wrong.

iii. Contraception following abortion

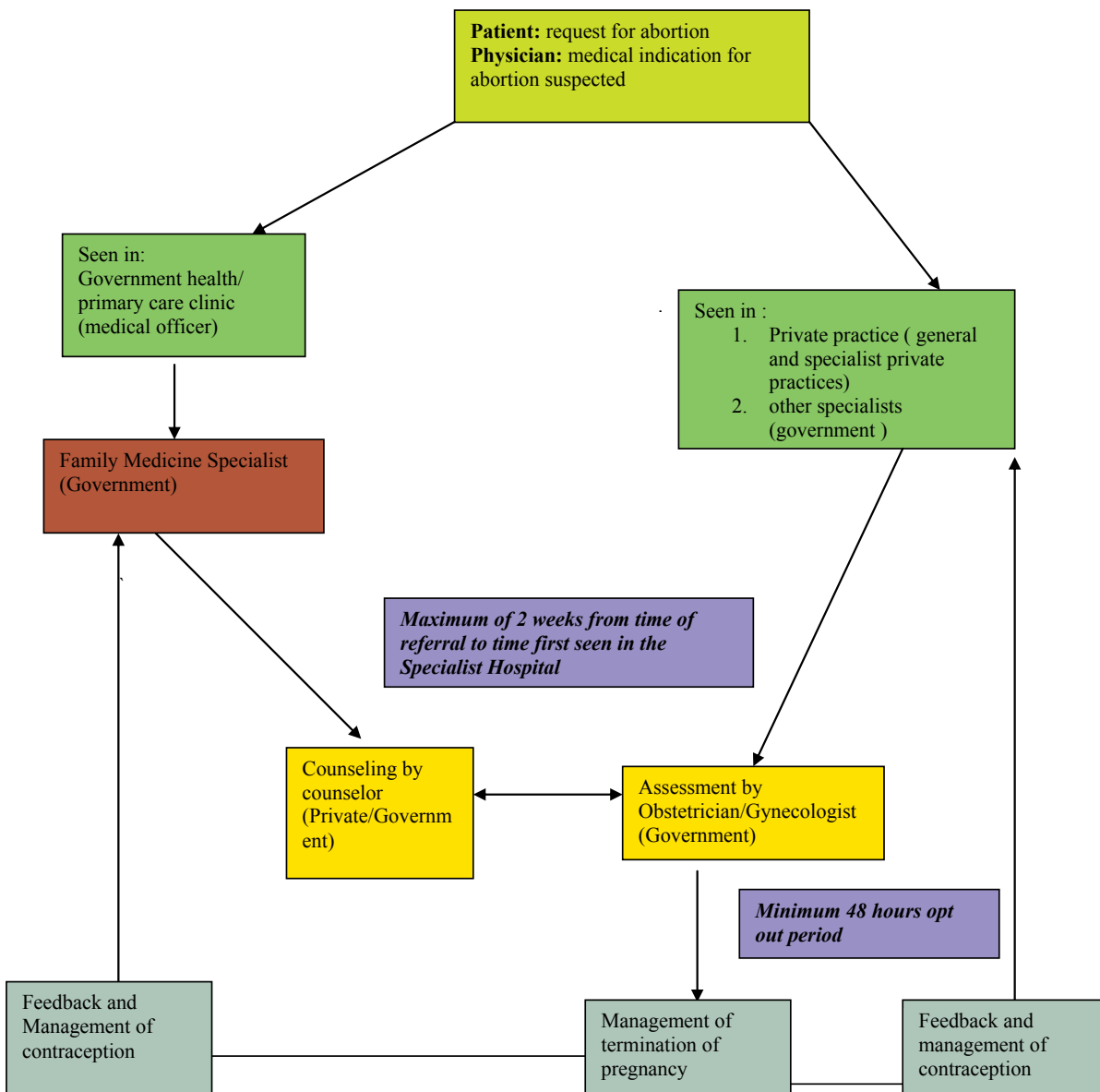
- a. Future contraception should be discussed with each woman and partner and chosen method of contraception should be initiated immediately after abortion where possible.
- b. Intrauterine contraceptive device (IUCD) can be inserted immediately after a first- or second trimester termination of pregnancy.

- c. Sterilisation can be safely performed at the time of induced abortion but combined procedures are associated with higher rates of failure and should be best done as an interval procedure where possible.

4.2 Organisation of Services

- i. Any woman considering undergoing induced abortion should have access to clinical assessment and counselling (refer to Appendix 6)
- ii. Appropriate information and support should be available for those who consider, but do not proceed to abortion
- iii. The earlier in pregnancy an abortion is performed, the lower the risk of complications
- iv. Services should therefore offer arrangements (as in Algorithm), which minimize delay.
 - a. telephone referral system from general practitioners
 - b. direct access from referral sources outside the government healthcare system
- v. Suggested service arrangements are as follows
 - a. women requesting abortion are provided with an assessment appointment as soon as possible or within two weeks of referral
 - b. women can undergo the abortion within 1-2 weeks of the decision to terminate pregnancy but a minimum 48 hours opt out period is recommended.
 - c. In the absence of specific medical, social or geographical contra-indications, termination of pregnancy may be managed on a day-case basis.
 - d. When TOP not performed, **appropriate counseling must be offered throughout the pregnancy and after delivery.** This should include referral to the social welfare department for single mothers or for mothers who may require further support. This is necessary to ensure that the mother does not subsequently abandons the baby or resorts to infanticide.
 - f. The role of a trained counselor is emphasized and the hospital should ensure that counselors are trained with post abortion issues.

Algorithm for organization of services in termination of pregnancy in the Public Hospitals



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Appendix 1

Malaysian Confidential Enquiry of Maternal Death

The report of the Malaysian Confidential Enquiry of Maternal Death from 1997 to 2000, shows a downward trend of maternal deaths related to abortion or miscarriage - from 5 cases in 1997 to 2 cases in 2000. The complications related to abortion were septic abortion, shock and haemorrhage (see tables 1 and 2 below)

Table 1: Causes of maternal deaths in Malaysia, 1980, 1991, 1995, 2000

Causes	1980	1985	1991	1995	2000
Post partum haemorrhage	78		61	60	31
Hypertensive Disorders in pregnancy	25		45	31	13
Associated Medical Complications	42		19	44	22
Abortion	4		2	14	2
Antepartum haemorrhage	3		2	10	5
Obstetric Pulmonary Embolism	19		37	45	23
Puerperal Sepsis	4		22	6	6
Ectopic pregnancy	2		3	4	5
Obstetric trauma	0		10	4	12
Associated Anesthetic complications	-	-	-	2	1
Other unspecified complications	0		18	15	8
Others	21		5	16	18
Unknown	10		0	0	-
MMR	*60	*37	44	46.9	28.1

Source: CEMD, MOH.

Note: *Statistic data

Table 2: Causes of maternal deaths from abortion, 1997 – 2000

Causes	1997	1998	1999	2000
Septicaemia from abortion	2	0	1	1
Excessive haemorrhage from abortion	1	2	0	0
Shock due to abortion	1	2	0	1
Damage to tissue following abortion	1	0	0	0
Total	5 (3.2 %)	4 (2.2%)	1 (0.5%)	2 (1.3%)

Source: CEMD report, MOH.

Appendix 2

Penal Code

Causing miscarriage; Injuries to unborn children; Exposure of Infants; and Concealment of Births

312. Whoever voluntarily causes a woman with child to miscarry shall be punished with imprisonment for a term which may extend to three years, or with fine, or with both; and if the woman is quick with child, shall be punished with imprisonment for a term which may extend to seven years, and shall also be liable to fine.

Causing Miscarriage [Am. Act A727.]

Explanation-A woman who causes herself to miscarry is within the meaning of this section.

Exception-this section does not extend to a medical practitioner registered under the Medical Act 1971 who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated.

Act 50.

313. Whoever commits the offence defined in section 312, without the consent of the woman, whether the woman is quick with child or not, shall be punished with imprisonment for a term which may extend to twenty years, and shall also be liable to fine.

Causing miscarriage without woman's consent.

314. Whoever, with intent to cause the miscarriage of a woman with child, does any act which causes the death of such woman, shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine; and if the act is done without the consent of the woman, shall be punished with imprisonment for a term which may extend to twenty years.

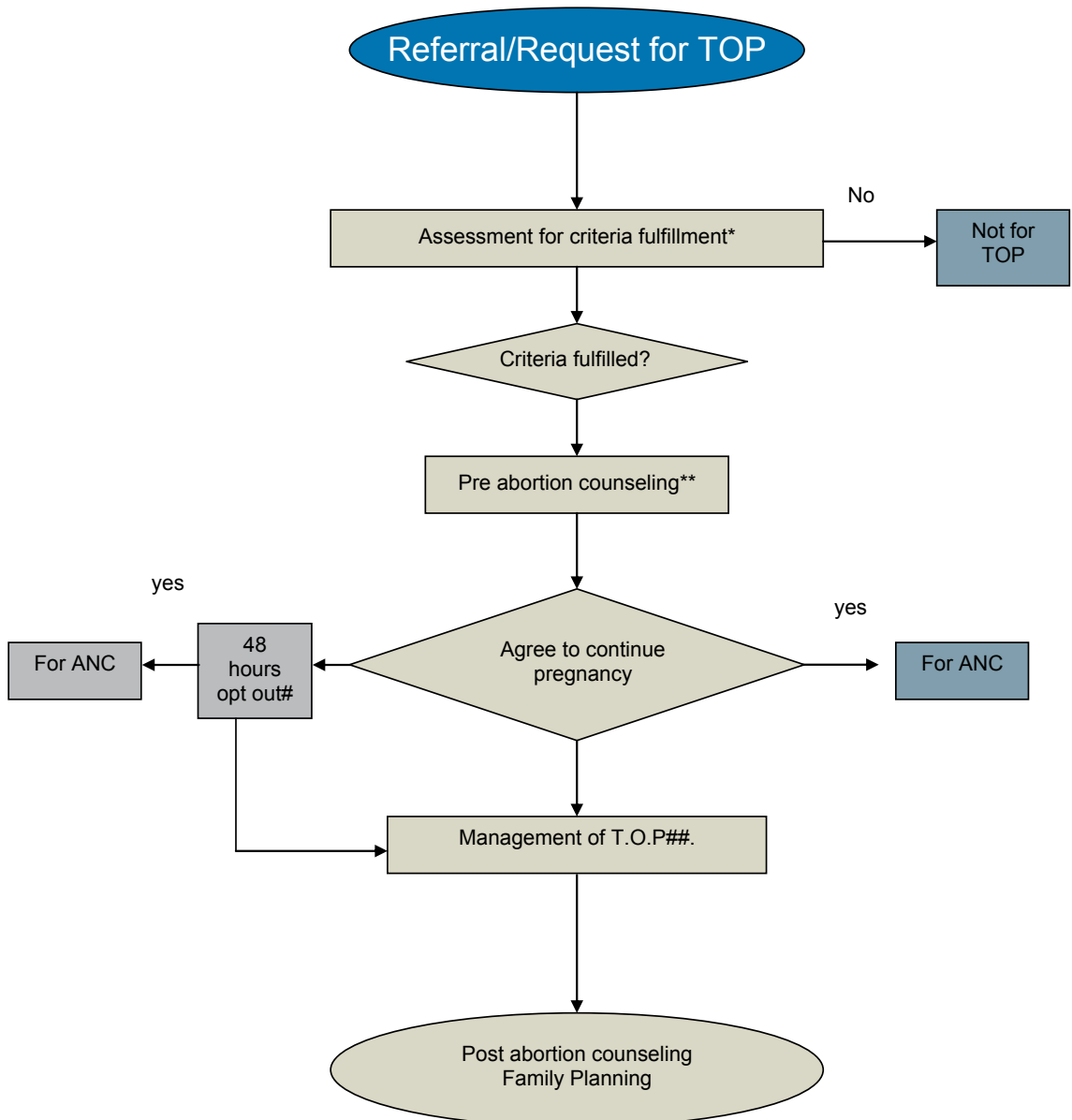
Death caused by act done with intent to cause miscarriage. If act done without woman's consent.

Explanation- It is not essential to this offence that the offender should know that the act is likely to cause death.

315. Whoever before the birth of any child does any act with the intention of thereby preventing that child from being born alive, or causing it to die after its birth, and does by such act prevent that child from being born alive, or causes it to die after its birth, shall, if such act is not caused in good faith for the purpose of saving the life of the mother, be punished with imprisonment for a term which may extend to ten years, or with fine, or with both.

Act done with intent to prevent a child being born alive or to cause it to die after birth.

Flowchart of process for TOP



*need to elaborate on criteria according to law, indication, and religious/moral aspect

**appendix on pre abortion counseling

Appendix on 48 hours opt out (cooling off period/grace period)

Appendix 3 on Management of TOP

METHODS OF TERMINATION OF PREGNANCY

Medical Methods

Currently, the agents used in medical abortion are methotrexate, misoprostol and mifepristone. Misoprostol is not recommended to be used since termination of pregnancy is not a listed indication, so that its use is off-label, and in addition, there is a danger of rupture of the uterus. Mifepristone has not been registered for use in Malaysia.

Medical abortion can be offered at an earlier stage than a suction procedure, being most successful within 49 days of the last menstrual period. Vaginal ultrasonography is recommended for ensuring accurate gestational age.

Surgical evacuation of the uterus is not routinely required following mid-trimester medical abortion, being undertaken where there is clinical evidence that the abortion is incomplete.

Surgical Methods

1. *Menstrual aspiration*

Menstrual aspiration, done within 1 - 3 weeks of missing a period, involves using a syringe to remove the pregnancy from the lining of the uterus. It is effective in emptying the uterine cavity and as effective as standard vacuum aspiration.

2. *Suction and Curettage*

Suction and curettage, can be carried out up to 12 weeks of pregnancy. A suction device inserted into the uterus removes the contents of the uterus.

3. *Dilatation and Evacuation*

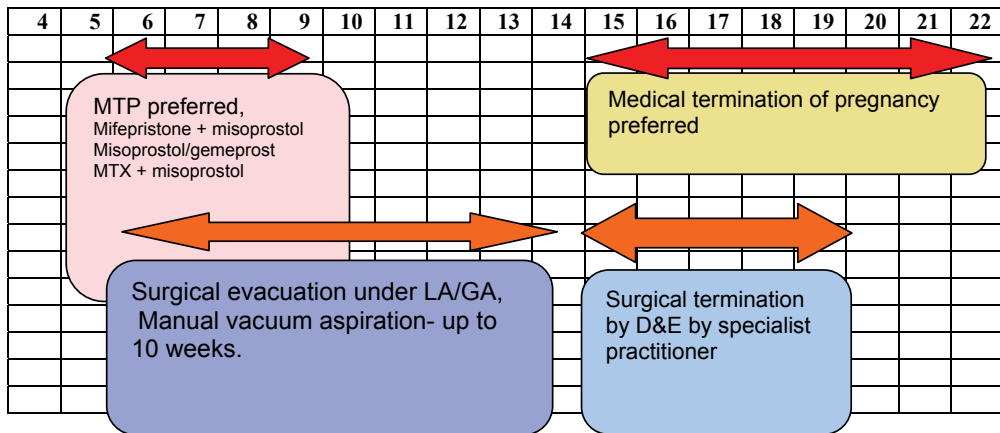
The cervix is dilated with a hegar dilator or use of laminaria tent overnight, or by ripening the cervix with using prostaglandin (cevergam pessary 1 mg 4 hours before the procedure), and the pregnancy removed with sponge/oval forceps, followed by curettage. This is not the method of choice, since it is associated with complications such as bleeding and cervical injury.

4. *Extra amniotic saline infiltration*

Normal saline is infiltrated extra-amniotically using a foley's catheter. Although widely used, there is not much evidence to support its efficacy and safety.

Recommended methods of termination for different gestations
(adapted from UK RCOG⁴)

Gestation (weeks from LMP)



Appendix 5

Definition of Terms (Possible Complications associated with termination of pregnancy)

- 1. Haemorrhage –**
low risk - 1 in 1000 abortions (0.88 in 1000 at < 13 weeks; 4 in 1000 at >20 weeks).
- 2. Uterine perforation-**
moderate risk – 1–4 in 1000 (lower risk early in pregnancy, and in those performed by experienced clinicians).
- 3. Uterine rupture**
very low risk – well under 1 in 1000, associated with mid-trimester medical abortion
- 4. Cervical trauma**
moderate risk of damage to the external cervical os at the time of surgical abortion – not greater than 1 in 100 (lower risk early in pregnancy, and in those performed by experienced clinicians).
- 5. Failed abortion**
small risk of failure to terminate the pregnancy associated with all methods of first-trimester abortion - risk for surgical abortion is around 2.3 in 1000 and for medical abortion 1-14 in 1000 (depending on the regimen used and the experience of the centre).
- 6. Post-abortion infection**
genital tract infection, including pelvic inflammatory disease of varying degrees of severity, occurs in up to 10% of cases. The risk is reduced when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening.
- 7. Future reproductive outcome**
no proven association between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. Abortion may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery.
- 8. Psychological sequelae**
some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to non-pregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions
- 9. Breast cancer**
induced abortion is not associated with increased risk of breast cancer
- 10. Analgesia**
Some women will require analgesia after surgical abortion or during and after medical abortion. Requirements for analgesia vary and there is no benefit in routine administration of prophylactic analgesics.

Appendix 6

Medical Abortion Counseling Model:

- Discuss pregnancy options and ensure that the decision to have an abortion is informed, voluntary and un-coerced.
- Compare the advantages and disadvantages of medical versus surgical abortion. Explain the differences; timing of the visits; known side effects of the medications; what to expect during the process and at home.
- Ask what the patient already knows about medical abortion.
- Ask about any previous abortion experience(s) and fears or anxieties.
- Discuss time off from other responsibilities (work, childcare, etc.)
- Explain the basic clinical procedures.
- Discuss the potential teratogenicity of misoprostol and emphasize that once the drugs have been administered, the abortion should be completed either medically or surgically.
- Clarify the time commitment and the two office visits.
- Discuss issues of confidentiality and social and physical support.
- Discuss the amount of pain and bleeding associated with the abortion process, including possible heavy bleeding with clots and passage of products of conception.
- Instruct the patient on the use of all medications including self-insertion of vaginal misoprostol and use of pain medication.
- Advise the patient regarding substances to avoid (e.g. aspirin and alcohol.) Discuss sexual abstinence until abortion is confirmed.
- Be very sensitive to patients who learn they are not eligible for a medical abortion.
- Offer contraceptive counseling.
- Review aftercare instructions, including emergency contact information and what symptoms warrant a call to the on-call provider.

Sources:

Breitbart, V.(2000) Counseling for medical abortion. *American Journal of Obstetrics and Gynecology* Aug; 183 (2), pp S26-33
Counseling Guide for Clinicians Offering Medical Abortion: Planned Parenthood of New York City, Inc., 1996.

**KEPUTUSAN
MUZAKARAH JAWATANKUASA FATWA
MAJLIS KEBANGSAAN BAGI HAL EHWAL UGAMA ISLAM MALAYSIA
MENGENAI GARIS PANDUAN PENGENDALIAN MASALAH KESIHATAN
SEKSUAL DAN REPRODUKTIF DALAM KALANGAN REMAJA DI KLINIK
KESIHATAN KALI KE-90**

1. **KEPUTUSAN MUZAKARAH**

Muzakarah Jawatankuasa Fatwa Majlis Kebangsaan Bagi Hal Ehwah Ugama Islam Malaysia yang bersidang kali ke-90 pada 1 Mac 2010 telah membincangkan isu pengendalian masalah seksual dalam kalangan remaja dan telah bersetuju memutuskan seperti berikut:

“ Setelah meneliti **keterangan, hujah-hujah dan pandangan** yang dikemukakan, Muzakarah **bersetuju memperakukan ketetapan hukum berkaitan pengguguran kandungan dan pemberian bahan kontraseptif (pencegah kehamilan)** sebagai **panduan dan rujukan** kepada pengamal-pengamal perubatan. Ketetapan hukum berkenaan adalah seperti berikut:

Pengguguran Kandungan:

- i. **Bagi Pasangan Suami Isteri Yang Sah**
(Disebabkan Kecacatan Yang Teruk Dan Penyakit Yang Mengancam Nyawa):
 - a. **Makruh** menggugurkan janin yang berumur **antara satu hingga 40 hari** sekiranya tidak mendatangkan bahaya pada ibu dan mendapat persetujuan kedua-dua suami isteri;
 - b. Pengguguran janin yang berumur **sebelum 120 hari** adalah **harus** sekiranya janin itu **cacat** dan **berpenyakit** yang boleh **membahayakan nyawa ibu**; dan

- c. Pengguguran janin yang telah **berumur 120 hari atau lebih** adalah **haram** kerana pengguguran itu dianggap satu jenayah ke atas janin yang telah ditiupkan roh kecuali pengguguran itu untuk **menyelamatkan nyawa ibu atas sebab kecacatan yang teruk.**

ii. **Bagi Pasangan Luar Nikah (Rogol / Zina)**

Rogol:

- a. **Haram** menggugurkan kandungan janin yang telah **berumur lebih 120 hari** kerana pengguguran itu dianggap satu jenayah bunuh ke atas janin yang telah ditiupkan roh **kecuali** pengguguran itu untuk **menyelamatkan nyawa ibu.**
- b. Pengguguran janin yang berumur **sebelum 120 hari** adalah **harus** sekiranya janin itu **cacat dan berpenyakit teruk** yang boleh **membahayakan nyawa ibu.**

Zina:

Menggugurkan kandungan zina adalah **haram dalam semua keadaan** kecuali mengekalkan kandungan akan memudaratkan nyawa ibu.

iii. **Bagi Golongan Orang Kurang Upaya (OKU)**

- a. OKU (ujian akal di bawah paras 80) **harus menggugurkan** kandungan yang **berusia kurang daripada 120 hari.**
- b. **Haram** menggugurkan kandungan yang **berusia lebih daripada 120 hari** kecuali jika **memudaratkan nyawa ibu.**

Pemberian Bahan Kontraseptif:

i. **Bagi Pasangan Suami Isteri Yang Sah**

- a. Hukum kontraseptif boleh diqiaskan kepada hukum *aza/* dalam Islam. Namun, hukum *aza/* **harus** bagi pasangan dalam **perkahwinan yang sah** sahaja.
- b. Penggunaan pil perancang kehamilan **dibenarkan** selama mana ia **membantu pasangan yang sah untuk merancang keluarga** bersandarkan kepada hadith Rasulullah s.a.w. :

قَالَ عُمَرُ وَأَخْبَرَنِي عَطَاءُ سَمِعَ جَابِرًا رَضِيَ اللَّهُ عَنْهُ قَالَ كُنَّا نَعْرَلُ وَالْقُرْآنَ يَنْزَلُ

(يرأخب ءاور)

Maksudnya: `Amr berkata, "Dan dikhabarkan kepadaku oleh `Ata', beliau mendengar Jabir RA berkata, Kami melepaskan air mani di luar faraj dan waktu itu al-Quran diturunkan (jika ia dilarang sudah pasti Al-Quran menjelaskan larangannya."

(Diriwayatkan oleh Bukhari)

- c. Muzakarah Jawatankuasa Fatwa MKI Kali Ke-28 memutuskan bahawa **Sistem Susuk Norplant** ini adalah **harus digunakan**. Penggunaan sistem ini adalah **tertakluk** kepada keputusan Muzakarah Kali Ke-12 pada 20 Januari 1977 yang **memutuskan hukum Perancang Keluarga** adalah seperti berikut:

- i. Memandul lelaki dan perempuan hukumnya adalah **haram**;
- ii. Mencegah beranak atau menghadkan bilangan anak hukumnya adalah **haram** melainkan dengan sebab yang diharuskan oleh syarak bagi orang perseorangan; dan
- iii. Menyusun keluarga dari kesihatan, pelajaran dan kebahagiaan keluarga dengan cara yang selain daripada (i) dan (ii) di atas adalah **harus**.

ii. **Bagi Pasangan Luar Nikah (Zina/ Rogol)**

Zina:

- a. Pemberian ubat pencegah kehamilan kepada **remaja** yang masih **belum berkahwin** boleh membawa kepada dua keadaan iaitu sama ada remaja tersebut mengambil peluang ini untuk bertaubat atau mereka merasakan bahawa kehamilan bukanlah sesuatu yang sukar untuk ditangani jika terjebak dengan hubungan luar nikah.
- b. Walau bagaimanapun, jika ia mendatangkan **mudharat yang lebih besar** kepada **penzina atau anak** yang mungkin akan lahir, **pakar perubatan Islam yang berkeelayakan** boleh menentukan **tahap mudharat dan keperluan** pemberiannya **dengan syarat**:
 - i. **untuk kes kali pertama sahaja kepada penzina bukan muhsan**;
 - ii. **tiada sokongan ibu bapa, penjaga atau lain-lain**;

- iii. **taraf ekonomi yang meruncing (kemiskinan tegar);**
- iv. **persekitaran tidak sihat;**
- v. **kesihatan mental dan fizikal;**
- vi. **izin keluarga atau penjaga; dan**
- vii. **mempastikan penzina mendapat bimbingan, kaunseling dan pemantauan sempurna.**

Rogol:

Pembekalannya adalah **harus** dengan mengambil kira **maksud mangsa rogol** mengikut **perspektif syariah**.

iii. **Golongan Orang Kurang Upaya (OKU)**

- a. Pembekalannya adalah **diharuskan** untuk **menyekat kitaran haid**, mengelakkan mereka yang berisiko tinggi **dieksploitasi** oleh orang yang tidak bertanggungjawab.
- b. Sekatan kehamilan **secara kekal** boleh dipertimbangkan oleh **pakar perubatan yang berkeelayakan** jika ia mendatangkan **kemudharatan yang lebih besar** kepada golongan terbabit atau keluarga.

iv. **Bagi Golongan Dijangkiti Penyakit**

Pemberian Bahan Kontraseptif **tidak harus** kepada pesakit yang **dijangkiti penyakit seperti HIV atau penyakit kelamin atas perbuatan sendiri**. Tetapi **harus** jika penyakit itu disebabkan oleh **jangkitan melalui suami** (melalui perkahwinan yang sah) atau **pemindahan darah**.

2. **PENJELASAN ISU**

- 2.1. Masalah kesihatan seksual dan reproduktif yang dikemukakan oleh Kementerian Kesihatan Malaysia merangkumi empat isu yang menjadi empat subtopik utama dalam garis panduan ini, iaitu:
 - i. Kehamilan dalam kalangan remaja dan pengguguran;
 - ii. Jangkitan Kelamin – HIV/AIDS;

- iii. Pengurusan Keganasan Seksual (Rogol, Cabul, Liwat dan Sumbang Mahram); dan
 - iv. Perkhidmatan Kontraseptif.
- 2.2. Terdapat beberapa isu syariah yang timbul dalam keempat-empat topik tersebut seperti berikut:
- i. Pengguguran anak kepada remaja yang normal dan remaja OKU. Ia bertujuan untuk menyekat kes-kes pembuangan bayi dan membantu mengurangkan rasa trauma dan takut seseorang remaja perempuan akibat kehamilan luar nikah.
 - ii. Pemakaian kondom oleh remaja yang belum berkahwin agar tidak dijangkiti penyakit kelamin HIV/AIDS. Kaedah ini hanya membuka ruang amalan seks bebas berlaku kerana ia hanya bertujuan untuk menyekat penyakit berjangkit tetapi tidak menolak perbuatan zina itu sendiri.
 - iii. Pemberian pencegahan kehamilan iaitu '*emergency pil*' yang berupaya mencegah kehamilan dalam masa 72 jam dari tempoh hubungan seks berlaku. Dalam perkara ini pemberian pil ini merupakan salah satu daripada *sadd al-zari`ah* untuk menghalang berlakunya kehamilan yang tidak diinginkan yang bukan dengan kerelaan sendiri. Justeru, penafsiran mangsa rogol perlu diperjelaskan kerana sekiranya pil ini diberikan kepada pasangan yang melakukannya dengan kerelaan ia hanya akan membuka ruang perzinaan.
 - iv. Kontraseptif adalah bahan atau kaedah sama ada kondom, pil atau apa-apa kaedah yang berkaitan yang digunakan sebelum atau semasa berlakunya hubungan seks untuk mengelakkan kehamilan. Hukum kontraseptif boleh dikiasakan kepada hukum *azal* dalam Islam. Namun, hukum *azal* harus bagi pasangan yang berkahwin sahaja. Manakala bagi pasangan yang belum berkahwin, kaedah ini hanya akan membuka lagi ruang perzinaan.
- 2.3. Berdasarkan isu-isu syariah dalam keempat-empat subtopik utama dalam garis panduan tersebut, Muzakarah Jawatankuasa Fatwa MKI telah membuat rumusan bahawa isu utama yang memerlukan penentuan hukum

ialah **Hukum pengguguran anak** dan **Pemberian bahan kontraseptif** untuk tujuan pencegahan kehamilan seperti kondom, pil dan sebagainya.

2.4. Isu 1: Hukum Pengguguran Anak

- i. Isu ini telah dibincangkan beberapa kali dan telah mendapat keputusan Muzakarah Jawatankuasa Fatwa Kebangsaan:

Keputusan Muzakarah Jawatankuasa Fatwa Kebangsaan Bagi Hal Ehwal Ugama Islam Malaysia Kali Ke-26 dalam membincangkan isu **Pengguguran Kandungan Kerana Kecacatan** ialah:

- a. Menurut ijmak fuqha, haram menggugurkan janin yang telah berumur lebih 120 hari kerana pengguguran itu dianggap satu jenayah bunuh ke atas janin yang telah ditiupkan roh kecuali pengguguran itu untuk menyelamatkan nyawa ibu atas sebab-sebab keccatan yang teruk.
 - b. Makruh menggugurkan janin yang berumur antara satu hingga 40 hari sekiranya tidak mendatangkan bahaya pada ibu dan mendapat persetujuan kedua-dua suami isteri; dan
 - c. Ijmak fuqaha berpendapat pengguguran janin yang berumur sebelum 120 hari harus sekiranya janin itu cacat dan berpenyakit yang boleh membahayakan nyawa ibu.
- ii. Keputusan Muzakarah Jawatankuasa Fatwa Kebangsaan Bagi Hal Ehwal Ugama Islam Malaysia Kali Ke-52 dalam membincangkan isu **Menggugurkan Janin Pembawa atau Pengidap Penyakit Thalassemia** ialah:
 - a. Makruh menggugurkan janin yang berumur antara satu hingga 40 hari sekiranya tidak mendatangkan bahaya pada ibu dan mendapat persetujuan kedua-dua suami isteri;

- b. Pengguguran janin yang berumur sebelum 120 hari adalah harus sekiranya janin itu cacat dan berpenyakit yang boleh membahayakan nyawa ibu; dan
 - c. Pengguguran janin yang telah berumur 120 hari atau lebih adalah haram kerana pengguguran itu dianggap satu jenayah ke atas janin yang telah ditiupkan roh kecuali pengguguran itu untuk menyelamatkan nyawa ibu atas sebab kecacatan yang teruk.
- iii. Keputusan Muzakarah Jawatankuasa Fatwa Kebangsaan Bagi Hal Ehwal Ugama Islam Malaysia Kali Ke-52 dalam membincangkan isu **Menggugurkan Kandungan Mangsa Yang Dirogol** ialah:
- a. Haram menggugurkan kandungan janin yang telah berumur lebih 120 hari kerana pengguguran itu dianggap satu jenayah bunuh ke atas janin yang telah ditiupkan roh kecuali pengguguran itu untuk menyelamatkan nyawa ibu.
 - b. Pengguguran janin yang berumur sebelum 120 hari adalah harus sekiranya janin itu cacat dan berpenyakit teruk yang boleh membahayakan nyawa ibu.

2.5. **Isu 2: Hukum Pemberian Bahan Kontraseptif**

- i. Pemberian pil pencegah kehamilan dan kondom mungkin merupakan bantuan yang boleh diberi oleh sesetengah pihak kepada golongan ini. Tetapi hukum pemberiannya perlu jelas supaya ia membawa kepada perkara makruf dan tidak sekali-sekali mendatangkan perkara mungkar.
- ii. Penggunaan pil perancang kehamilan dibenarkan selama mana ia membantu pasangan yang sah untuk merancang keluarga bersandarkan kepada hadith Rasulullah SAW:

ي عطاء سمع جابراً رضي الله عنه قال كنا نغزل القرآن ينزلنا عمراً وأخبرنا

(يرأخب داور)

Maksudnya: `Amr berkata, “Dan dikhabarkan kepadaku oleh `Atta, beliau mendengar Jabir RA berkata, Kami melepaskan air mani di luar faraj dan waktu itu Al-Quran diturunkan (jika ia dilarang sudah pasti Al-Quran menjelaskan larangannya.”

(Diriwayatkan oleh Bukhari)¹

Oleh itu, apa-apa penemuan terbaru atau melalui teknologi terkini untuk tujuan ini ia adalah diharuskan sama ada kaedah ini dibuat oleh lelaki atau perempuan atau melalui ubat-ubatan yang diberikan oleh pengamal perubatan. Yang pasti kaedah ini hanya mencegah kehamilan secara sementara dan bukan untuk selama-lamanya.²

iii. Jabatan Mufti Negara Brunei juga memutuskan bahawa **pil perancang keluarga menyalahi syarak** jika ia digunakan untuk menghadkan jumlah bagi setiap pasangan suami isteri. Tetapi ia diharuskan dalam keadaan-keadaan khusus seperti:

- a. Isteri-isteri yang terlalu cepat mengandung;
- b. Isteri yang menghidap penyakit berjangkit;
- c. Kumpulan kecil yang lemah urat sarafnya menghadapi tanggungjawab atau tugas berat dan banyak, di mana mereka tidak memperolehi kerajaan atau orang-orang kaya yang dapat membantu menanggung beban mereka; dan
- d. Lain-lain seperti yang telah diterangkan terdahulu khususnya dengan merujuk pendapat dan ulasan Imam al-Ghazali.³

iv. Di Malaysia Muzakarah Jawatankuasa Fatwa Majlis Kebangsaan (MJKF) Kali Ke-28 memutuskan bahawa Sistem Susuk Norplant ini adalah harus digunakan. Penggunaan sistem ini hendaklah tertakluk kepada keputusan Muzakarah Kali Ke-12 pada 20 Januari 1977 bersamaan 9 Muharram 1392 yang memutuskan hukum Perancang Keluarga adalah seperti berikut:

- i. Memandul lelaki dan perempuan hukumnya adalah haram;

¹ Al-Asqalani, Ahmad bin Ali, *Fath al-Bari Syarh Sahih al-Bukhari*, Jilid 9, (Riadh: Dar al-Salam, 2000), m/s: 378. Sahih Bukhari: 5208, Kitab Nikah, Bab al-'Azl. Lampiran 1.

² Muhammad Abduh et al., *al-Fatawa al-Islamiyyah min Dar al-Ifta' al-Misriyyah*, Jilid 9, Cetakan ke-2, (Kaherah: Jumhuriyah Misr Al-'Arabiah, 1997), m/s: 3088-3089.

³ Awang Abdul Aziz, *Fatwa Mufti Kerajaan*, Cetakan Kedua, (Brunei: Jabatan Mufti Kerajaan, Jabatan Perdana Menteri, Negara Brunei Darussalam, 2003), m/s: 353-354.

- ii. Mencegah beranak atau menghadkan bilangan anak hukumnya adalah haram melainkan dengan sebab yang diharuskan oleh syarak bagi orang perseorangan; dan
- iii. Menyusun keluarga dari kesihatan, pelajaran dan kebahagiaan keluarga dengan cara yang selain daripada (I) dan (II) di atas adalah harus.

2.6. Kesemua keputusan fatwa ini menunjukkan keharusan menggunakannya adalah bagi pasangan yang sah di sisi syarak sahaja tanpa memasukkan pasangan di luar nikah kerana ia boleh membuka jalan untuk melakukan penzinaan yang berterusan. Larangan ini bersesuaian dengan kaedah fiqh . . مآرح وهف مآرح لآ ءلآ! ءدؤي ام

Pandangan Agama Lain Mengenai Pengguguran oleh Majlis Perundangan Agama Buddha, Hindu, Kristian, Sikh dan Tao (MCCBCHST)

A. AGAMA BUDDHA

The Buddhist Perspective

“The early Christians were marked out by their opposition to abortion and to infanticide, which was also common in the ancient world. In large part because of the influence of Christian opposition, the Western world historically tended to place severe limits on abortion,” says Andrew Goddard in his book, *A Pocket Guide to Ethical Issues*. Goddard is an Anglican priest, and member of the Faculty of Theology, Oxford University.

The famous Hippocratic Oath historically taken by doctors, written in the fourth century BC, contained the statement: “I will not give a woman a pessary to cause abortion.”

This attitude has changed, however, since the 1960s due to legislative changes. In the United Kingdom the abortion act of 1967 made a decisive shift, while in the United States it was the decision of the Supreme Court 1973. This has resulted in a very significant frequency of abortion in the West. In the mid-1960s, there had been about 15,000 to 20,000 legal abortions a year in the United Kingdom. There may have even been a similar number or more of illegal abortions. Now there are ten times more of such legal abortions each year in the UK, and about 1.3 million each year in the US. Judging from these facts, we may even question the necessity for any ethical considerations regarding abortion.

The Debate about abortion mainly focuses on human rights and on the status of the embryo. Often the attention is focused on a woman’s rights over her own body. If the pregnancy occurs as a result of rape, the woman’s rights become important.

Pregnancy is fundamentally a parasitic relationship. The embryo is dependent on the mother, and lives off her body to grow. Is not the womb being misused when a fertilized egg begins to grow inside a mother’s womb? On the other hand, some may ask, how can the relationship between mother and embryo be reduced merely to a biological one; does it not involve emotion and a love relationship between mother and child?

Some view pregnancy as an illness for which abortion is a medical cure. There is an element of truth in this, as pregnancy risks some damage to the mother’s health. The ground for almost all abortions under the British law is the continuity of a pregnancy that involves a risk. By maintaining a pregnancy a woman goes beyond what she is obliged to do, because she meets someone else’s needs. Abortion, in this sense, is not a violation of someone’s rights, although it would be a failure to love one’s neighbour. The risk of damage does not, however, mean that pregnancy should be considered an illness.

From another point of view pregnancy is fundamentally positive and good. It is a divinely ordained means of receiving the gift of a human life; one even learns to love a totally new neighbour.

The important question, however, is whether the meaning and significance of any pregnancy should be determined by the decision of the pregnant woman, or whether we should take into account the reality of the embryo that is removed or destroyed as part of the process.

Most people like to make a distinction here, between killing a baby, or “infanticide,” and killing an embryo, or “abortion.” This requires drawing a line between “conception” and “birth.” The embryo is perhaps a “potential person” rather than a real “person,” similar to the difference between the “potential energy” of a body being at rest, and the “kinetic energy” of a body being in motion.

It is between 24 and 26 weeks of pregnancy (around six months) that the foetus reaches viability, according to modern scientific research. It is at this stage that a functional cerebral cortex emerges, and organized and measurable electrical activity appears in the brain. Therefore we may conjecture that a consciousness can arise in the embryo only at this stage. This fact is important for the Buddhist, because this is the time a rebirth can take place, and the embryo becomes a living human individual. This also draws the line between the embryo and the baby, from the Buddhist standpoint; and it provides an answer to the question: “Is it an abortion, or an infanticide?”

This means we need not assume that every abortion represents an intentional ending of the development of a life that has the potential to become a human being. Abortion is not necessarily something close to the killing of a human being. No justification would be necessary for every abortion, to explain why the abortion was needed. There are only two main reasons for abortion.

- 1) Related to the position of the mother
- 2) Related to the importance of the embryo

In most cases the reason for abortion is “unwanted pregnancy.” Pregnancy in this case is seen as an unnecessary assault on a woman’s body. The woman therefore does not have to respond in case of rape, as she would respond to consensual sexual intercourse. Further if the woman had no intention of becoming pregnant she may have reason to consider abortion. This would not, however, convince those who think abortion is equivalent to killing. Prochoice does not give adequate reason for abortion, for those who are in favour of anti-choice.

The decision to abort is a serious, difficult, and often painful moral decision. The effect of the pregnancy on a woman, however, is the strongest argument for abortion. The most substantive reasons relate to the medical situation of the mother.

When the focus is not the health of the mother but on the embryo, the argument is sometimes made that the future life of the embryo is likely to be so poor that it would be better if it is not born. This decision can give rise to a number of ethical issues. Decision to abort on grounds of handicap raises questions about the “eugenic mentality” this represents. Some passionate critics point out that those who are themselves disabled would feel demeaned when embryos that would become people like

themselves are being considered legitimate objects of abortion. Some, however, argue that parents have a responsibility or even a duty to abort if the future life of the embryo is likely to be handicapped, and that failure to do so should be seen as immoral, and even worthy of being sued for “wrongful life.” Under UK law, abortions can be carried out with no time limit if “there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.”

The Buddhist Perspective

All these arguments above deal with the rights of the mother, the rights of the embryo, or even the rights of the father, or other relatives, or even the public in general. It must be pointed out that in Buddhism the attention is focused not on the rights but on the duties. If the duties are performed adequately, the rights will look after themselves automatically.

The next point is that the attention is given to the motive rather than the action. If the motive is good, the action or its consequences cannot be blamed. Therefore before we make any judgements about an action we must examine the motive behind the action.

The other important consideration is whether the motive is a rational motive or emotional motive. Because emotions are blind and only reason is aware of the realities of life, when making a decision we must not be carried away by emotions. Due to the tendency to rationalize emotions, blind emotions can take a rational form and begin to compete with logical reasoning. This condition is called cognitive dissonance, where two opposed views can come in conflict in the same mind, leading to indecision or incorrect decision. This is what has led to the problems mentioned above concerning prochoice and anti-choice.

For the Buddhist who does not worship a Creator, or believe in a Creator, but believes and worships an anthropomorphic God, who is omniscient, omnipotent, and omnibenevolent, he does have a sense of right and wrong. His sense of right and wrong is based on *Metta* or universal benevolence, which comes from a broad mind. He would consider the importance of the mother as well as the baby, foetus, or embryo. Yet it is the motive that determines the goodness of the act; not whether the mother is affected or the baby, foetus, or embryo.

Case study

1. Case of rape
We do not focus on woman’s rights or rights of embryo. We think of our duty and find a solution where we harm no one. E.g., if we do not want to bear the child, give over the child to someone who needs a child, or give to an orphanage. Yet even though the father was not wanted, the child still has a part of the mother. Therefore the mother might want to bring up the child.
2. Case of risk for the mother for medical reason. In this case save the mother through abortion.
3. Case of Unwanted child due to poverty, family problem, or mere freedom. The child can be given to others who need, or even to an orphanage.

4. Case of handicapped embryo. Better to save both mother and child by an abortion. Ignore the criticism comparing to eugenics, or suffering in sympathy for the handicapped.
5. Use of contraceptives could easily be a way of avoiding pregnancy. It does not harm any living being.

It is important to mention as a final statement that because the Buddhist does not believe in a Creator who wants the creatures to keep reproducing, no guilt is felt in avoiding pregnancy. Abortion, however, being a destructive process should be avoided if possible.

B. AGAMA HINDU

Hinduism and Abortion

Hinduism teaches that “Abortion” is a great crime and one of the worst sins. It is one of the six kinds of murder described in Hindu Culture. Moreover, abortion thwarts in soul in its progress towards God, like any other act of Violence. It teaches that “fetus” is a living, conscious person deserving of protection.

Hinduism has traditionally taught that a soul is reincarnated and enters the embryo at the time the embryo is conceived. In fact, one of the seven legendary immortals or ‘Chiranjeevin’ in Hinduism, Ashwattama, was cursed by Lord Krishna, avatar of Vishnu to immortality and eternal suffering partly for killing the fetus, later born as Parikshat, grandson of Arjuna, when he was in mother’s womb. Parikshat was born stillborn but was raised from the dead by Shri Krishna.

Hindu Medical Ethics

Hindu medical ethics stem from the principle of ‘ahimsa’ or non-violence. When considering abortion, the Hindu way is to choose the action that will do least harm to all involved: The mother and father, the fetus and the society. Hinduism is therefore generally opposed to abortion except where it is necessary to save the mother’s life.

Classic Hindu texts are strongly opposed to abortion:-

- a) One text compares abortion to the killing of a priest;
- b) Another text considers abortion a worse sin than killing one’s parents.

Traditional Hinduism and many modern Hindus also see abortion as a breach of the duty to produce children in order to continue the family and produce new members of society. Many Hindus regard the production of offspring as a 'public duty', not simply an 'individual expression of personal choice' [see Lipner's, the "Classical Hindu View" on abortion and the moral status of the unborn, 1989].

The status of the fetus in Hinduism

The soul and the matter which form the fetus are considered by many Hindus to be joined together from conception. According to the doctrine of reincarnation a fetus is not developing into a person, but it is a person from a very early stage. It contains a reborn soul and should be treated appropriately.

By the ninth month fetus has achieved very substantial awareness. According to the Garbha Upanishad, the soul remembers its past lives during the last month the fetus spends in the womb and these memories are destroyed during the trauma of birth.

The Mahabaratha refers to a child learning from its father while in the womb.

Reincarnation

The doctrine of reincarnation, which sees life as a repeating cycle of birth, death and rebirth, is basic to Hindu thinking.

The doctrine of reincarnation can be used to make a strong case against abortion.

If a fetus is aborted, the soul within it suffers a major karmic setback. It is deprived of the opportunities its potential human existence would have given it to earn good karma, and is returned immediately to the cycle of birth, death and rebirth. Thus abortion hinders a soul's spiritual progress.

Reincarnation can also be used to make a case that abortion should not be permitted. Under the doctrine of reincarnation, abortion only deprives the soul of one of the many births that it will have.

Abortion and non-violence

“Ahimsa” (non-violence) teaches that it is wrong not only to kill living beings, but to also kill embryos. Hindus believe that all life is sacred, to be loved and revered, and therefore practice ahimsa or non-violence. All life is sacred because all creatures are manifestations of the Supreme Being.

Hindu Scriptures Forbid Abortion

From time immemorial, Hindus consider children as gifts from God. In the code of ‘Manu’, Manu forbids abortion. One of the worst acts described in the scriptures is ‘Sis-Hatya’ meaning destruction of the unborn fetus. There are prayers in the Rig Veda to guard a growing embryo. Only time abortion is allowed is when the fetus is known to be defective as per “Suswruta Samnita”, the Hindu Ayurvedic Book.

‘Arbha-hatya, or the "killing of a fetus," is listed in Hindu law books as one of the "Five Great Sins," Pañca-maha-pataka. Clearly, the intent of the “Smriti” is to discourage the practice.

Therefore in conclusion, abortion is allowed if it is to preserve the life of the mother, for instance. Ahimsa, "non-injury," however, has been extolled as the supreme duty, and therefore care should always be exercised to avoid unnecessarily harming the unborn and others.

Compilation assisted and coordinated by: Khrisna RajaMohan/Mrs Secretary, Welfare Division, Malaysia Hindu Sangam

C. AGAMA KRISTIAN

The Christian perspective on Abortion – with contributions from the Catholic Church, the CCM and the NECF, constituent bodies of the Christian Federation of Malaysia.

Human Life and Killing

The Christian moral teaching on the issue of abortion is rooted in our understanding of human life. God is the creator of all things – spiritual realm and the material world, all living creatures, all of human life, male and female (Book of Genesis chapters 1 and 2, The Holy Bible).

All life is sacred because God created out of nothing (*creatio ex nihilo*) all living creatures and gave them life. This is the very first principle for a Christian understanding of life and abortion.

According to the Catechism of the Catholic Church (CCC), “human life is sacred because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can under any circumstances claim for himself the right directly to destroy and innocent human being.” (CCC 2258).

The Psalmist in Psalm 139 verses 13-16 tells us :

V 13 “For You [God] created my inmost being;

You [God] knit me together in my mother’s womb.

V 14 I praise you because I am fearfully and wonderfully made;

Your works are wonderful, I know that full well.

V 15 My frame was not hidden from you

when I was made in the secret place.

when I was woven together in the depths of the earth,

V 16 Your eyes saw my unformed body.

all the days ordained for me were written in your book

before one of them came to be.

At the moment of conception God was already in a special relationship with the foetus at the moment of conception – watching over it and forming it in the “secret place” i.e. in the womb of the woman. (Read also the Book of Jeremiah chapter 1 and verse 4-5).

Furthermore, in the Old Testament, the fifth commandment provides the general injunction against killing, “You shall not kill” (or ‘murder’; Ex 20:13; Dt 5:17). Thus, the fifth commandment forbids direct and intentional killing and condemns it as gravely sinful. The commandment also forbids anything with the intention of indirectly bringing about a person’s death. The moral law prohibits exposing someone to mortal danger without grave reasons, as well as refusing assistance to a person in danger.

What constitutes Human Life?

Having established the general principle which prohibits killing, the obvious question would be, “when does something become a human being?” Does a single cell organism that has arisen from the fertilization of a human ovum (i.e. a zygote) constitute a human being?

Although life is a difficult concept to define we can certainly recognise when a biological system is alive. A living system has an organisation by which it can transform energy,

grow, reproduce, and interact with its environment. In this sense, the zygote is certainly alive. The embryonic or fetal being carries out all the basic functions of life, e.g. assimilation, excretion, and growth. The zygote has itself all the necessary information, the whole 'code' necessary for the complete process of its development. The genetic code remains unchanged and marks the individual for his whole life. The embryo is not 'part' of the mother.

Christians therefore view life as the continuum from conception to its natural death. The embryo is not a potential human life but **a human life with potential**. Therefore, it enjoys the same rights accorded to all members of the species. Christians would reject a physical model of life that does not do justice to the deeper underlying reality of biological life. The deeper reality is inherent in the life-principle itself. The life principle is not inherent in the brain; it is not inherent in the differentiation of the cells; it is the DNA, the human genome, the genetic code which not only exists prior to all these stages but is the active and activating principle which is responsible for the continuity, the coordination, the gradually increasing complexity, the unity and the individuality of the organism.

Therefore three points must be noted:

1. From the moment of conception – we must attribute to the human embryo the unconditional respect due to each human being.
2. We must treat the human being (and the embryo) as a person.
3. We must recognise the embryo's rights as a person, the foremost of which is the inviolable right of every human being to life.

Christian Teaching on Human Life and Abortion

The Christian Church has taught consistently that from the first moment of its existence, as the product of human generation, the embryo must be guaranteed the unconditional respect which is morally due to a human being in his spiritual and bodily totality. "Since it must be treated from conception as a person, the embryo must be defended in its integrity, cared for, and healed, as far as possible, like any other human being." (CCC. 2274)

The Christian Church defends the right to life not only out of respect for the majesty of God, the creator and giver of life, but also out of respect for the essential good of man. The Catholic Church for instance in its canonical provision for baptism of an aborted foetus, implies that the Catholic Church accepts the infusion of the soul at the moment of conception.

Since the Christian Church teaches that human life begins at the moment of conception, then abortion is thus seen as a killing. According to the Catholic Church's *Evangelium Vitae* n. 62, "abortion is the deliberate and direct killing by whatever means it is carried out of a human being in the initial phase of his/her existence extending from conception to birth." The late Pope John Paul II in *Veritatis Splendor*, n 80 described abortion as an intrinsic evil – whatever is hostile to life, whatever violates the integrity of the human nature are considered a negation due to the creator.

So strongly does the Catholic Church feel about abortion, that she imposes the penalty of excommunication (Canon 1398) on all those involved in the deliberate and successful effort to bring about a completed abortion.

The Principle of Double Effect

Abortion, as a direct and deliberate killing, is always regarded as an intrinsic evil and a sin by the Christian Church. The Catholic Church views it as a grave sin. However, there may be instances that may be ***morally permissible*** that does not involve direct or deliberate killing. The moral permissibility of an act which has both good and bad effects and has for centuries been determined by **the principle of double effect**.

The principle of double effect is designed to protect and preserve the integrity of the good human act, arising from the fundamental structures of human nature and action and is not intended as a loophole nor as an excuse for abortion.

The Principle itself has 5 (or sometimes 4) conditions:

- 1) The act is in itself good or at least morally indifferent;
- 2) The good effect is directly intended and the bad effect is foreseen but unintended.
- 3) The good effect is not achieved by means of the bad effect;
- 4) The good effect is proportionate to the bad effect; and
- 5) The good effect can only be achieved concomitant with, but not by means, of the bad effect.

Thus it may be *morally permissible* to save the life of an expectant mother and her child through a medical procedure, **where the lives of both are immediately threatened, although such procedure may result in the death of the child (which is not primarily intended)**.

Summary of the Christian teaching on abortion:

1. God alone is the Lord of life and death.
2. Human beings do not have the right to take the lives of other human beings.
3. Human life begins at the moment of conception.
4. Abortion at whatever stage of development of the conceptus, is the taking of innocent human life.

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D. AGAMA SIKH

SIKH RELIGIOUS PERSPECTIVE REGARDING ABORTION

It is very brief and needs further research and development. It's prepared with the help of some friends and I am thankful to them especially Sardar Manjeet Singh.

Gurbani emphasises that God is the Doer. He is "karan karavanhaar suami". He is "Karta Purakh".

Jajji Sahib Ji tell us He operates through His Hukum it is emphasised that we have to abide by His Hukum.

Guru Nanak Dev Ji in pauri no 1 that-

"Hukum razayee chalna Nanak likhya naal"

"O Nanak it is written that you shall walk in the Way of His Command".

There is no exception to His Hukam. Of course in His Kirpa (Grace) He can do anything He wishes including over-riding His Hukam, but Gurbani tells us again and again that you need to take Naam and get the Guru's Grace before any kirpa takes place. And that is not easy.

In pauri no 2 Guruji tells us.

"Hukami hovan akaar hukam na kaheya jai"

"By His Command all creation takes place; His Hukam is beyond words"

The next line says.

"Hukami hovan jee hukam millai vadiayiee"

“By His Command souls come into being; by His Command one gets glory and greatness”

Thus, Gurbani tells us that His Hukam operates for all and we have to live in accordance with His Hukam. It is according to His Hukam that a woman gets pregnant with child. [hovan akaar]. Gurbani also tells us that you need seed from a man and eggs from a woman to beget a foetus.

Bhagat Ravidass ji says at page 659 that the body is actually a....

“Rakat boondh ka garaa”

“The egg and the sperm are the mortar” [for forming the base of the body].

Thus, it is in accordance with His Hukam by which creation takes place in the mother’s womb.

In the Pahire at page 74, Guru Nanak Dev Ji again tells us.....

“Pehle pahire rain ke vanjareaya mitra hukam bhaeyaa garbhaas”

“In the first watch of the night O my merchant friend you were cast into the womb by the Lord’s Command”

Thus when conception takes place, it is in accordance with His Hukam, His Divine Order.

Gurbani tells us at many places that you have to abide by His Hukam. If you breach His Hukam, there will be consequences and you will be liable to punishment.

At pauri 20 Guru Nanak Dev Ji also says

“Sanjog vijogh doey kaar chalavai...”

“Union and separation come as He operates His Will...”

At page 700 Guru Arjun Dev Ji says.

“Maat pita banita sut bandap isst meet aur bhai

Purab janam ke millai sanjogi antah koiy na sahaieey”

“Mother, father, spouse, children, relatives, lovers, friends, siblings, they meet, having been associated in previous lives; none however will be of support in the end”

Thus Bani tells us that a pregnancy occurs in accordance with His Hukam. It further tells us that children [including children to be born] have a sanjog with that set of parents from past lives [purab janam ke millai sanjogi].

To do an abortion would be to act in defiance of His Hukam and there would naturally be consequences.

Gurbani does not tell us when life actually begins. By life I mean when the soul is infused into the foetus. At page 1007 in Maru Mehla 5 Guru arjun Dev Ji says

“Sanjogh vijjogh dhuro hi huaa”

“Union and separation are Divinely Ordained”

The foetus is made of 5 elements.

“Panch dhaat kar putla keeya”

“The puppet [foetus] is made of five elements”

The soul however is infused into this foetus when He so wishes – in His Mauj.

“Saahai ke furhmairhai jee dehi vich jeeo aaey peaaya”

“By the Command of the Lord, the soul is made to come and occupy the body”

So, the pregnancy is a play of His hukam. Any interference with His hukam, will invite Divine Displeasure.

From the viewpoint of Gurbani abortions are treated as an interference with His divine Hukam and are wrong.

Baba Fareed Ji states in Raag Suhi that the foetus takes 6 months to fully form. Page 488 tells us.

“Gandediya sheh mah...”

“It takes six months to form the body...”

Nevertheless, as His Hukam is in operation from the time of conception itself, as Pahire tell us, abortion of any foetus is wrong from the standpoint of Gurbani and the SIKH faith.

1) GURBANI - It is the DIVINE WORD AS recorded in the SRI GURU GRANTH SAHIB, the Sikh Holy Book. It is now treated as the LIVING GURU and all the guidance for spiritual and worldly living is given in its.

2) KARAN KARAVANHAR SUAMI - ALL POWERFUL LORD

3) KARTA PURAKH - CREATOR

4) KIRPA - GRACE

5) NAAM - MYSTIQUE MANTAR from the Sri GURU

All pages given here are from the SIKH HOLY Book i.e. SRI GURU GRANTH SAHIB JI.

Sardar V. Harcharan Singh

Consent Form OG8 - Patient agreement to investigation or treatment

Patients name: _____	IC Number: _____
Hospital RN : _____	

Name of proposed procedure:**TERMINATION OF PREGNANCY****A. Statement of health professional:**

I have explained the procedure to the patient. In particular, I have explained:

1. The intended benefits: (tick where applicable)

To evacuate the uterine cavity of products of conception with the sole intention of preventing a continuing pregnancy

2. Primary reason for termination of pregnancy (please state): _____3. Possible serious risks:

- Uterine perforation
- Cervical trauma or bleeding
- Intra-abdominal trauma
- Intrauterine adhesions
- Bleeding
- Failure of termination (i.e a continuing pregnancy) in up to 1% of cases

4. Possible frequently occurring risks:

- Infection - approximately in 3 to 5% of cases
- Incomplete evacuation

5. Any extra emergency procedure which may become necessary during the procedure

- Blood transfusion
- Repair bladder, bowel, major blood vessel or uterus
- Laparoscopy or laparotomy to identify / confirm and / or repair any damage to bladder, bowel, major blood vessel or uterus
- Return to theatre for repeat evacuation
- Other procedures (please specify) _____

Serious complication such as these occur (in general) in approximately 2% of cases.

women who have pre-existing medical conditions must understand that the quoted risks for both serious and frequent complication may be increased.

All operations carry risk of death. The risk in an operation such as this is estimated as 1 in 200000 procedures.

I have also discussed the following issues with the patient:

- That should the initial treatment for termination be unsuccessful and the patient then decide to continue with the pregnancy, fetal anomalies may result from the medication used. The exact risk of these anomalies occurring is difficult to quantify,
- That option of medical termination versus surgical termination, including the advantages and disadvantages of each option and the possibility of reverting to surgical evacuation should medical management fail (in approximately 5% of cases),
- That the patient may choose to refuse any treatment and the possible detrimental effects to her wellbeing as well as that of her fetus have been discussed.

Signed: _____ Date: _____ Time: _____

Name (print): _____ Designation: _____

COG 4/2009

B. Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in the a way which I believe she can understand.

Signed: _____ Name: _____ Time: _____ Date: _____

C. Statement of patient

Please read this form carefully. You must also read the front page carefully which describes the benefits and risks of the proposed treatment. If you have any questions, please ask as we are here tu help you. You have the right to change your mind at any time, including after yu have signed this form

- 1. I have read the previous sheet and understood the benefits and risk of the proposed treatment YES NO
- 2. I agree to the procedure described YES NO
- 3. I understand that you cannot give me a guarantee that a particular person will perform the procedure. Then person will, however, have appropriate experience YES NO
- 4. I understand that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure, unless the urgency of my situation prevents this YES NO
- 5. I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my live or prevent serious harm to my health YES NO
- 6. I have been told about additional procedures which may become necessary during my treatment. YES NO
- 7. I have received a patient information leaflet describing the procedure YES NO
- 8. I have listed below procedures which I do not wish to be carried out without further discussion YES NO

Signed: _____ Name: _____ Time: _____ Date: _____

D. Witness

A witness should sign below if he/she has witnessed the patient’s signature above. Parents or guardians should sign below on behalf of patients under the age of legal consent (18 years and above).

Signed: _____ Name: _____ Time: _____ Date: _____
 Relationship to patient: _____ Designation: _____

E. Confirmation of consent

This section to be completed when the patient admitted for a procedure has signed the form in advance. On behalf of the team treating this patient, I have confirmed with the patient that she has no further questions and wishes the procedure to go ahead.

Signed: _____ Name: _____ Time: _____ Date: _____

Suggested Training Programme

Day 1

8.00am	: Registration / Welcome remarks
8.30am	: Definition and Legality of Top
9.00am	: Referral procedures from Health / OPD ? Private
9.45am	: Pre TOP assessment and examination and criteria
10.30am	: Tea break
11.00am	: TOP methods and procedure
12.00pm	: Post TOP care
1.00pm	: Lunch
2.00pm	: Counselling for TOP
3.30pm	: Identifying & Assisting high risk groups
5.00pm	: End

Day 2

8.00am	: Bereavement Counselling
9.30am	: Contraceptive Advice and Assistance
10.30am	: Tea Break
11.00am	: Question and Answers
12.30pm	: Lunch Break
2.00pm	: religious Perspective - small group discussion
5.00pm	: End

ACKNOWLEDGEMENT

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