Training course in adolescent sexual and reproductive health 2019

Safe abortion care

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Introduction

Despite the consequences associated with unsafe abortion practices, about 3.9 million girls aged 15-19 years undergo unsafe abortions every year in the developing world (Woog et al., 2016). This is primarily because safe abortion services are frequently not available due to high restrictive laws and policies; leading to high maternal mortality and morbidity among adolescents (Ahman and Shah, 2011; WHO, 2008). This short report explores the distinction between less and least safe abortion and the regulation and human right aspect of abortion. It further examines the global abortion policies database and its main objectives and the WHO recommended medical abortion regimen for adolescents with 12 weeks of pregnancy.

Question 1.1:

What is the difference between less safe abortion and least safe abortion?

Generally, unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. Abortion is less safe when meets only one of two criteria: either the abortion is done by a trained health-care provider but with an outdated method (e.g. sharp curettage), or a safe method of abortion (e.g. misoprostol) is used but without adequate information or support from a trained individual (Ganatra, et al., 2017). On the other hand, abortion is least safe when it is provided by untrained individuals using dangerous methods e.g. ingestion of caustic substances, insertion of foreign bodies (Ganatra, et al., 2017).

Question 1.2:

Why is this distinction important?

Unsafe abortion is sub-classified into two categories: less and least abortion. This distinction is important as it allows for a more nuanced understanding of the different circumstances of abortions among women who are unable to access safe abortions from a trained provider. For e.g. based on data from 2010–2014, there were approximately 25 million unsafe abortions annually (Singh and Maddow-Zimet, 2015). Of these, one third or approximately 8 million were performed under the least safe conditions by untrained persons using dangerous and invasive methods (Singh and Maddow-Zimet, 2015). This distinction helps to identify the percentage of women who still go through the crude and dangerous (Least safe) abortion practices and the relative complications associated with it and could perhaps, trigger actions to promote safe abortion services.

Question 2:

What are WHO's recommendations on the regulatory, policy and human rights aspects of abortion?

In 2012, the WHO Safe abortion, technical and policy guidance for health systems was updated and included a compilation of international human rights bodies' observations on abortion laws and policies: The policy recommendations from these guidelines are:

- Laws and policies on abortion should protect women's health and their human rights.
- Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.
- An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care.
- Policies should be geared to respecting, protecting and fulfilling the human rights of women, to achieving positive health outcomes for women, to providing good-quality contraceptive information and services, and to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV (WHO, 2012; Johnson et al., 2017).

Question 3.1:

What is the global abortion policies database? What is its objective?

The Global Abortion Policies Database (GAPD) is an online database launched in 2017 through a collaborative effort of UNDP, UNFPA, WHO, World Bank and the Population Division of the United Nations Department of Economic and Social Affairs (UNDESA). The online database contains comprehensive information on abortion laws, policies, health standards and guidelines for WHO and UN Member States. It is envisioned for use by policy-makers, human rights bodies, nongovernmental organizations, public health researchers and civil society. The database is designed to further strengthen global and national efforts to eliminate unsafe abortion by facilitating comparative and country-specific analyses of abortion laws and policies, placing them in the context of information and recommendations from WHO technical and policy guidance on safe abortion (Johnson et al., 2017). The objectives of the GAPD are to promote greater transparency of abortion laws and policies and State accountability for the protection of women and girls' health and human rights (Lavelanet *et al.,* 2018; Johnston *et al.,* 2017). The database expands on existing knowledge related to the legal categories of abortion by capturing unique or complex policy nuances, a starting point by which to better consider legal entitlements to abortion (Lavelanet *et al.,* 2018).

Question 3.2:

Drawing from an analysis of the Global database of abortion laws, policies, health standards and guidelines, what is the situation in terms of parental/spousal globally?

Analyses of the Global Abortion Policies Database show that globally, parental and spousal consent is still a requirement in many countries where abortion is permitted. Evidence from the database shows that approximately one-third (57/158) of countries that permit abortion require parental consent for minors and surprisingly most of these (24/57) are in the European region (Lavelanet *et al.,* 2018). Although twenty-eight percent of these countries (16/57) does not specify the age below which consent is required but of the 41 countries that do specify an age, the range is from 14 to 18 years with a median of 16 years. In almost all countries that require parental consent, an alternative individual is permitted to consent in place of a parent; 2 countries do not specify whether this is permitted. These individuals may include a legal guardian, medical commission or tribunal, or other judicial authority. Interestingly, in Turkey, when the consenting individual is a legal guardian, the permission of a Justice of the

Peace is also required. Furthermore, twelve countries require spousal consent (Indonesia, Japan, Kuwait, Morocco, Qatar, Republic of South Korea, Saudi Arabia, Syria, Timor-Leste, Turkey, United Arab Emirates, and Yemen). Some countries require spousal authorization for special cases, and not otherwise, including when the abortion is for social reasons or where a fetal anomaly or life threat exists. Malaysia requires spousal approval for Muslim women but not for non-Muslims. It is clear from the GAPD analysis that spousal/parental consent is still a requirement in most countries but spousal consent and approval seems to be a strong requirement among the Arab nations than the non-Arab countries.

Question 3.3:

What – in your opinion – is the ideal policy and practice in relation to parental/spousal consent for abortion? Please explain your answer.

Without doubt, parental notification will negatively impact the health of adolescents. Studies have shown that adolescents are more likely to discontinue using most reproductive health services (Reddy, et al., 2002), and are less likely to disclose all pertinent medical history to their medical provider (Ford, 2002) if confidentiality is not guaranteed. Therefore, I'm of the opinion that parental notification should not be mandated for minors. This is premised on the fact that parental involvement laws increase the likelihood of delay even further leading to complications (Henshaw, 1995) and mandated parental notification does not increase parental involvement in adolescents' abortion decisions (Blum et al., 1987). Having said that, there is a need for adolescents to be encouraged by service providers to involve their parents in abortion decisions especially among minors without mental capacity (Gillick-competent) to manage the situation but this should not be mandated through any policy or laws. With reference to spousal consent, I'm of the view that decision to terminate a pregnancy should rest with the woman and guided by her doctor. The woman's spouse or partner should not be mandated by law to be notified and get their approval before a woman demand pregnancy termination. However, I feel is a good practice to encourage women to discuss such important decisions with their partners and should be encouraged for mutual benefits and support. However, where a woman refuses to share information with her partner, confidentiality must be maintained by the service provider unless there are exceptional reasons to justify a breach of confidentiality (Paton, 1994) that's my take.

Question 4.1:

An 19 year-old girl has decided after counselling to have a medical abortion for an unintended pregnancy of 12 weeks. What is the WHO recommended medical abortion regimen in this situation?

As shown in Table 1, WHO recommended medical abortion regimen at 12 weeks is that 200 mg mifepristone should be administered orally, followed 1–2 days later by repeat doses of 400 μg misoprostol administered vaginally, sublingually or buccally every 3 hours. The minimum recommended interval between the use of mifepristone and misoprostol is 24 hours. The combined regimen is recommended because use of misoprostol alone is less effective than when combined with mifepristone (WHO, 2018; Hamoda et al., 2005) and the vaginal route is the most effective. Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process but the guideline did not provide a

maximum number of doses of misoprostol and could be based on health professional's judgement. However, combined regimen is more effective (Hamoda et al., 2005). Although about 104 countries still include misoprostol alone on an official list of medications despite being less effective (Lavelanet *et al.*, 2018).

Table 1: Medical management of induced abortion at ≥ 12 weeks of gestation

Induced abortion at 12 weeks	**Combination regimen recommended**	
	mifepristone	misoprostol
	≥ 12 WEEKS 200 mg PO once	400 µg B, PV or SL every 3 hours
	Key: B: buccal; PO: oral; PV: vaginal; SL: sublingual	

Question 4.2:

To prevent a repeat unintended pregnancy, when could this young woman be recommended an oral contraceptive?

Averting repeated unintended pregnancy for the 19-year-old girl would require oral contraceptive to be introduced immediately after the first pill of medical abortion. WHO recommended that for individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or the misoprostol-only regimen who desire hormonal contraception (oral contraceptive pills, contraceptive patch, contraceptive ring, contraceptive implant or contraceptive injections), that they be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. Although, evidence from a Randomized Control Trial (RCT) has shown that immediate initiation of intramuscular (IM) depot medroxyprogesterone acetate (DMPA) is associated with a slight decrease in the effectiveness of medical abortion regimens (Raymond et al., 2016). However, immediate initiation of DMPA should still be offered as an available contraceptive method after an abortion (WHO, 2018) as evidence has shown that women who initiated DMPA immediately medical abortion reported high satisfaction with DMPA administration (Raymond et al., 2016) and showed high continuation rates at six months (Krashin et al., 2018).

Conclusion

In conclusion, this short report shows that adolescent still undergo least safe abortion services due to restrictive laws and policies and where abortion is permitted parental and spousal consent is still a requirement. This shows the need to ensure laws and policies promote the respect and protection of women and girls. This includes ensuring timely access to safe abortion and addressing stigma and discrimination against those who seek abortion services or post-abortion care.

References

Ahman E, Shah (2011) New estimates and trends regarding unsafe abortion mortality. International Journal of Gynecology and Obstetrics, 115:121–126.

Blum R, Resnick M, Stark T (1987) The impact of a parental notification law on adolescent abortion decision making. Am J Public Health; 77: 619-620.

Ford C, English A (2002) Limiting confidentiality of adolescent health services: What are the risks? JAMA; 288(6):752-3

Ganatra B, Gerdts C, Rossier C, Johnson BR Jr, Tunçalp Ö, Assifi A, (2017) Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. Lancet. 390(10 110):2372–2381.

Hamoda H, Ashok PW, Flett GM, Templeton A. A randomized trial of mifepristone in combination with misoprostol administered sublingually or vaginally for medical abortion at 13–20 weeks gestation. Hum Reprod. 2005;20(8):2348-54.

Henshaw S. (1995) The impact of requirements for parental consent on minors' abortion in Mississippi. Family Planning Perspectives; 27: 120-122

Human Rights Committee: General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life [Online] available at https://www.ohchr.org/Documents/HRBodies/CCPR/CCPR_C_GC_36.pdf (Accessed 6/10/2019).

Krashin J, Kim CR, Morgan IA, Tepper NK, Jatlaoui T, Curtis K. (2018) Immediate compared with delayed provision of contraception after abortion and long-term outcomes: a systematic review with meta-analysis.

Lavelanet, A., Schlitt, S., Johnson, B. and Ganatra, B. (2018). Global Abortion Policies Database: a descriptive analysis of the legal categories of lawful abortion. *BMC International Health and Human Rights*, 18(1).

Paton (1994) British Pregnancy Advisory Service Trustees discussed in - Mason & McCall Smith. Law and Medical Ethics (Fourth Edition). London: Butterworths;118.

Raymond EG, Weaver MA, Louie KS, Tan YL, Bousieguez M, Arangure-Peraza AG, (2016) Effects of depot medroxyprogesterone acetate injection timing on medical abortion efficacy and repeat pregnancy: a randomized controlled trial. Obstet Gynecol;128(4):739-45.

Reddy D, Fleming R, Swain C. (2002) Effect of mandatory parental notification on adolescent girls' use of sexual health care services. JAMA; 288: 710-714

Singh S, Maddow-Zimet (2015) Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world: a review of evidence from 26 countries. BJOG; published online Aug 19. DOI:10.1111/1471-0528.13552.

Tang OS, Miao BY, Lee SW, Ho PC (2002) Pilot study on the use of repeated doses of sublingual misoprostol in termination of pregnancy up to 12 weeks gestation: efficacy and acceptability. Hum Reprod. 2002;17(3):654-8.

World Health Organization, (2008) Global burden of disease 2004 update. Geneva:

WHO (2012) Safe abortion: technical and policy guidance for health systems. Geneva: World Health Organization [Online] Available at http://who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/. (access, 04/10/2019).

WHO (2018) Medical management of abortion [Online] Available at https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1 (Accessed 5/10/2019).