Training course in adolescent sexual and reproductive health 2019

Safe abortion care

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Question 1.1:

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

A safe abortion is one that is done with a method that is recommended by the World Health Organization (WHO) which is appropriate to the pregnancy duration and when the person providing or supporting the abortion is trained.

A less safe abortion is one where the abortion meets only one of two criteria. That is, that either the abortion is done by a trained health care provider using outdated methods like sharp curettage, or the abortion is done using a safe method such as misoprostol but without adequate information or support from a trained health care provider if they need help.

A least safe abortion is an abortion provided by untrained personnel or individuals using dangerous methods such as the insertion of foreign bodies or objects, use of traditional and herbal concoctions or ingestion of other caustic substances.

The difference between less safe and least safe abortion is that; less safe methods met at least one of two criteria for safe abortion (either a trained health care provider or a safe method) whereas least safe abortions do not meet any of the two criteria as they are provided or performed using both an untrained individual and using unsafe and dangerous methods. As a result, least safe abortions provide life-threatening complications such as incomplete abortion, severe bleeding, severe infection and injury to the reproductive tract and other organs

Question 1.2:

Why is this distinction important?

When abortions are performed in accordance with WHO guidelines and standards, the risk of severe complications or death is negligible. According to WHO, approximately 55% of all abortions from 2010 to 2014 were conducted safely, which means they were performed by a trained health worker using a WHO-recommended method appropriate to the pregnancy duration. Almost one-third (31%) of abortions were "less safe," and about 14% were "least safe" abortions. Deaths from complications of unsafe abortion were high in regions where most abortions happened in the least safe circumstances. Compared with older women, adolescents are more likely to seek abortions from untrained providers, to have a self-induced abortion, to terminate their pregnancies after the first trimester when the procedure is more dangerous, and to delay seeking medical care for complications following unsafe abortions; they are less likely to know about their rights concerning abortion and post-abortion care and to report having had an abortion. As such this

As such the classification of less safe and least safe abortions and its distinctions is important. The distinction allows for a more nuanced understanding of the different circumstances of abortions among women who are unable to access safe abortions from a trained health care provider. The distinction is crucial for documentation to inform programming to better meet the needs and address barriers for young women's access to safe abortion.

Question 2:

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

WHO's recommendations on regulatory, policy and human rights aspects of abortion are key policy recommendations from the WHO Safe abortion: technical and policy guidance for health systems which was updated in 2012 and includes a compilation of international human rights bodies' observations on abortion laws and policies. The WHO recommendations on regulatory, policy and human rights aspects of abortion state that;

- 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.

Question 3.1:

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

The Global Abortion Policies Database was launched in June 2017 to build on United Nations Department of Economic and Social Affairs (UN DESA) World Population Policies Database, which tracked legal grounds for abortion since the mid-1990s. It is a tool that presents information on abortion laws and policies beyond the legal categories of abortion and includes additional access-related requirements, information related to service provision, and conscientious objection for all WHO and UN Member States. The Global Abortion Policies Database aims to provide a more comprehensive information resource tool which presents information on a broad range of policy domains such as; legal grounds and related gestational limits; authorization and service-delivery requirements; policies about who can provide abortion and where, when and how abortion services are permitted; and criminal penalties for women, girls, health care providers and others. The database includes information on abortion laws, policies, health standards and guidelines for WHO and UN Member States which were extracted onto a policy questionnaire that was rigorously cross-checked by public health and law experts and submitted to countries for their review. Additionally, the database includes individual country profiles with selected sexual and reproductive health indicators, links to state-ratified human rights treaties, and links to UN Treaty Monitoring Body Concluding Observations and Special Procedure Reports that address abortion. The information in the database is linked to source documents that can be accessed and downloaded for further review and presents all abortion laws, policies and health standards as they are stated in their source documents. The

database has extensive notes which provide details on unique policy nuances and in those cases where multiple and sometimes conflicting policy documents exist.

The main objectives of the database are to promote greater transparency of abortion laws and policies and state-accountability for the protection of women and girls' health and human rights. 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 Safe Abortion: technical and policy guidance for health systems. In addition to aiding users to compare abortion laws and policies to the WHO guidelines, as well as among countries and geographical regions, it can also facilitate understanding of the complexities and nuances of laws and policies that were not addressed previously or were obscured behind more simplistic classification schemes.

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?

Globally, approximately one-third (57/158) of countries that permit abortion require parental consent for minors; most of these (24/57) are in the European region. Twenty-eight percent (28%) of these countries (16/57) do not specify the age below which consent is required. 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). The alternative individual may include a legal guardian, medical commission or tribunal, or other judicial authority. In Turkey, however, when the consenting individual is a legal guardian, the permission of a Justice of the Peace is also required. There are twelve countries that require spousal consent, these are Indonesia, Japan, Kuwait, Morocco, Qatar, Republic of South Korea, Saudi Arabia, Syria, Timor-Leste, Turkey, United Arab Emirates, and Yemen. In Timor-Leste, for example, spousal consent can be substituted for the woman's consent. Some countries require spousal authorization for special cases, and not otherwise, including when the abortion is for social reasons (Kyrgyzstan), or where a fetal anomaly or life threat exists (Mongolia). Malaysia requires spousal approval for Muslim women but not for non-Muslims. While the policy in Bahrain states that the person in charge of the woman must provide consent, no additional information is provided as to who that person should be. In Finland, paternal opinion is required as a result of this before the final abortion decision is made, the person who impregnated the woman must be given an opportunity to express his opinion.

The analysis shows that requirements for parental and spousal consent differs across states and regions. In the European region, parental consent requirements are common whereas in some Arabic and select Asian states spousal consent is required. However, there is ambiguity and a lack of harmonization as to the specific age required for parental consent or as to who can provide the consent. In some instances, spousal consent is influenced by religion.

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.

In my opinion, the ideal policy and practice in relation to parental/spousal consent for abortion is not to have it required in law, policy and practice. The requirement of parental and spousal consent acts as a barrier to accessing high quality, private and confidential abortion care and may deter young women from seeking services. It not only violates the right to privacy and access to health care for young women but also undermines their right to bodily integrity and autonomy. Furthermore, parental and spousal consent denies the recognition of the evolving capacities of young women and their role in decision making on issues affecting their lives.

Therefore, ideal policy and practice in relation to parental and spousal consent for abortion is to have laws, policies and practice that eliminates the need for this consent. Abortion laws, policies and practices should respect, protect and fulfill the human rights of young women and enhance their access to safe services to achieve positive health outcomes by leaving out requirements for parental and spousal consent. Policies and practice should protect informed choice, autonomy in decision making, non-discrimination, and confidentiality and privacy. In order to protect the best interest of the young women, and taking into consideration their evolving capacities, policy and practice may encourage but not require parental or spousal engagement though support, information and education without bias, discrimination or coercion.

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?

The WHO recommended medical abortion regimen for a 19-year-old girl who has decided after counselling to have a medical abortion for an unintended pregnancy of 12 weeks is combination regimen of Mifepristone and Misoprostol. The recommended regimen is the use of 200 mg mifepristone administered orally, followed 1 to 2 days later by repeat doses of 400 μg misoprostol administered vaginally, sublingually or buccally every 3 hours. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

Question 4.2:

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

WHO recommends that sexual and reproductive health services, including contraceptive services, be delivered in a way that ensures fully informed decision-making, respects dignity, autonomy, privacy and confidentiality, and is sensitive to individuals' needs and perspectives. Therefore, all women including young women, should be able to choose a method of

contraception according to their needs and preferences. Hormonal contraception, including oral contraception, is safe to use on women who opt for a medical abortion and may be started on the day of the first pill of medical abortion. To prevent a repeat unintended pregnancy, the young woman can initiate uptake of oral contraception immediately after the first pill of the medical abortion.