Training course in adolescent sexual and reproductive health 2019

Safe abortion care

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Introduction:

Though comprehensive abortion care has improved but still 22 million unsafe abortions are performed every year[1]and 98% occur in developing countries, resulting in high morbidity and mortality amongst women especially adolescents. These death and disabilities could be prevented through sexuality education, provision of family planning and safe abortion and post abortion care. Access to safe abortion care is legally restricted in many countries, which leads to unsafe practices causing high levels of Maternal Mortality. Even if safe abortion is legally allowed it is usually not adolescent friendly as almost 14% of unsafe abortion in developing countries are among women under 20 years of age[2]. The economic burden of treating complications of unsafe abortions is very high especially in developing/poor countries. A large amount of money can be saved if unintended pregnancies are prevented through easy access to contraception and safe abortion services.

In many countries national policies related to availability and access to safe abortion care are restrictive, either they are legally not allowed or require parental/spousal consent. Whereas the policies and laws should include protection for informed and voluntary decision making, autonomy and confidentiality, that means girls and women should have right to decide when to get pregnant and whether to have children or not and they should not be required to have a third party authorization to access safe abortion, contraceptives and health services.

Question 1.1:

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

The difference between the less safe and least safe abortion is:

Less safe abortion is when only one of the criteria for safe abortion is fulfilled i.e. either it is done by trained health worker but using outdated/unsafe method or safe method of abortion is used but the health worker is not trained. Whereas least abortion is when none of the criteria for safe abortion is followed i.e. it is done by untrained health worker using dangerous/outdated method (ingestion of caustic substance/ foreign bodies etc.),

Question 1.2:

Why is this distinction important?

Approximately 8% of maternal mortality among all women was attributed to abortions between 2003 -2012[3]. Adolescents are at much higher risk of undergoing unsafe abortions leading to

[1]WHO publication titled: Safe abortion: technical and policy guidance for health systems (Geneva, 2012).

[2] WHO publication titled: Safe abortion: technical and policy guidance for health systems (Geneva, 2012)

[3] WHO recommendations on adolescent sexual and reproductive health and rights (2018).

major health consequences. Therefore is important to know the distinction between safe and unsafe (less and least safe) abortion, and know your rights concerning abortion and post abortion care and report.

Question 2:

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

Following are the key policy recommendations from the WHO Safe Abortion: policy and technical guidelines[4]:

- Laws and policies on abortion should protect health and human rights of women.
- Regulatory, policy and programmatic barriers that hinders 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 provide 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?

To eliminate unsafe abortion and implementation of policies & programs for improving access and quality of services, accurate and easily accessible information/data on existing laws and policies is required. In many countries it is difficult to get such information on policies and use for various decision making therefore in early 2015 Human Reproduction program, WHO initiated development of new data base: Global abortion policies data base. It is a tool that presents information of abortion laws and policies beyond the legal categories of abortion and includes additional access requirements, information related to service provision and conscientious objection to all WHO states.

This data base presented information on broad range of policy domains – legal grounds and related gestational limits, authorization and service delivery requirements, policies about who can provide abortion services and where, when and how abortion services are permitted and criminal penalties for women, girls, health care providers and others.

[4] A global database of abortion laws, policies, health standards and guidelines (Johnson BR et al, 2017).

Objective of Global abortion policies data base was to provide a comprehensive information resource tool and help users to compare abortion laws & policies to the WHO guidelines as well as countries and geographical regions.

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?

Approximately one- third i.e. 57/158 of countries that permit abortion require parental consent for minors[5]and 16 of these countries do not specify the age below which consent is required. In almost all countries that require parental consent, an alternative individual is permitted to consent in place of a parent, these individuals could be legal guardian, medical commission or other judicial authority. To complicate the matter, in Turkey permission of a justice of the peace is also required if consenting individual is a legal guardian.

Twelve countries require consent from spouse and in some countries spousal authorization is required for special cases and not for others including abortion for social reasons. In Malaysia, spousal consent is required for only Muslim women and for others. In Bahrain, the policy states that the person in charge of the women must provide consent whereas in Finland, the person who impregnated the women must be given opportunity to express his opinion before the final decision of abortion is made.

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 ideal policy and practice related to abortion should be gender transformative and more facilitative rather than restrictive. Parental/spousal or third party consent or authorization should not be mandatory, as this is against women's health and human rights. I feel that requirement of parental/spousal consent acts as barrier to accessing timely and safe abortion care and services. This leads to increased risk of unsafe abortions and risks related to duration of pregnancy are amplified and may cause women to exceed legally allowable gestational limits and force them to have unsafe abortion.

The policy on requirement of third party authorization /consent for abortion according to me does not respect women as autonomous & competent decision maker. I feel decision to have or not to have children should be only with the women and should not be limited by partner, parents

[5] Global abortion policies database: A descriptive analysis of the regulatory and policy environment related to abortion (Best Practice and Research Clinical Obstetrics and Gynecology).

or state[6]. This is more important in case of adolescents, if their access to information on legal termination of pregnancy is prohibited, it will have serious consequences for their health and safety. If they will have to take permission from their parents or spouse they will take services from untrained personnel. I feel minors are individuals and are capable of taking independent of decision related to program.

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?

WHO recommended combination regimen of the medical abortion for an unintended pregnancy of 12 weeks, as it is safer, effective and accessible. Combination regimen is using 200 mg of Mifepristone administered orally followed 1-2 days later by 400µg Misoprostol vaginally/sublingually or buccally every 3hrs[7] up to maximum of five doses to be administered in a health care facility. 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?

To prevent a repeat unintended pregnancy, this young woman should be recommended to start hormonal contraceptive immediately after the first pill of the medical abortion regimen. Immediate initiation of intramuscular depot medroxyprogesterone acetate should be offered as the contraceptive method after medical abortion.

[6] Global abortion policies database: A descriptive analysis of the regulatory and policy environment related to abortion (Best Practice and Research Clinical Obstetrics and Gynecology).

[7] WHO document titled Medical Management of Abortion (WHO, 2018)