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?

Less safe abortion is done by either by a trained health care provider who uses outdated method like sharp curettage or done by an untrained person or pregnant woman herself using WHO recommended method like misoprostol to induce abortion without support from a trained individual. On the other hand, least safe abortion is performed by untrained person who use dangerous methods such as ingestion of caustic substances, ingestion of foreign bodies and use of traditional concoctions.[1]

Question 1.2:

Why is this distinction important?

This distinction is important since it allows broader picture of different situations of abortions women and girls find themselves in when they are not able to access safe abortion from a trained health care provider. This exposes them to high health risks. An estimated 3.9 million girls aged 15–19 years undergo unsafe abortions every year in the developing world. [1] It is therefore important that women and girls seek services from trained health care providers who uses WHO recommended method that is appropriate to pregnancy duration.

Question 2:

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

The recommendations on regulatory policy and human rights aspects of abortion are:

1. Laws and policies on abortion should protect women's health and their human rights
2. Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.
3. An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care.
4. 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[2].

Question 3.1:

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

Global Abortion Policies Database (GAPD) is an open access online policy tool that contains comprehensive information on abortion laws, policies, health standards and guidelines for WHO and UN member states.[3] I addition, it contains country profiles showing a list of

identified policies and legal sources related to abortion together with a list of ratified human rights treaties.

The objective of the global policy database is to promote greater transparency of abortion laws and policies and state accountability for the protection of women and girls' health and human rights. [3] With this information system in place, women, service providers, policy makers and adolescents will be able to access information of country specific existing abortion policies and laws, point out laws that had not been addressed and advocate for their enactment and provide correct interpretation to unclear laws. This will lead to realization of their legal entitlements and eventually eliminate unsafe abortion

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, parental and spousal consent has continued to create barrier for girls and women as they seek safe abortion services and care. Even though 71% of countries in European region have broader liberalized clear laws on age of parental consent, this has been seen to delay abortion process. In 28% of the countries, laws concerning age of consent for minors or who should give spousal consent are not clear.[4] This makes it difficult for parents, spouses, women, minors and health care providers to understand their legal entitlements. In 12 other countries women do not have autonomy of making decisions since abortion will take place only after spouses have given consent. Nearly all countries that require parental consent have increased obstacles for minors to access safe abortion care by introducing parental substitutes such as legal guardian who can only consent after getting permission from the justice of peace, judicial authority and medical commission or tribunal. Minors may not be in a position to navigate these systems and may also lack finance needed to facilitate the processes involved. Only women from one country have autonomy to decide on when, how, where and from whom to get the abortion services. This analysis shows that women and girls still lack knowledge and access to existing abortion laws that govern their countries and do not also know their countries ratified human rights bodies through which they can advocate for enactment of laws that have not been implemented.

These barriers will continue to violate privacy of women and girls and place them at risk of violence, prosecution, complications including death as they seek unsafe abortion options

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.

Use of parental and spousal consent has been seen to deter women and girls from seeking safe abortion. In my opinion, the ideal policy is to encourage parents/spouses engagement through support in education and information. This will protect the best interest of minors since parental consent usually denies the evolving capacities of girls as while spousal consent usually as deny women to access health care. [4]

Unmarried girls may not wish to talk to their parents before carrying out abortion out of fear of being stigmatized discriminated, rejected, and judged or being forced to leave home and may therefore opt for self-induced abortion without support of a trained health care worker or seek unsafe abortion from untrained providers who offer cheap services. On the other hand, married women who are under pressure to have children while at the same time facing the dilemma of abortion due to gender biased sex selection may not have autonomy in making decisions.

Parental and spousal support through information and education will improve quality of relationship between parents/unmarried girls /spouses and create an environment through which discussions on comprehensive sexuality education including legal policies on safe abortion care will take place.

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?

With gestation period of 12 weeks, she is not likely to experience complications since the decision is taken medically by a trained health worker. From the guidelines, the patient will be provided with 200 mg mifepristone administered vaginally, followed 24 hours later by repeat doses of 400 µg misoprostol administered vaginally every 3 hours until the abortion process is completed successfully.[5]

For the misoprostol-only regimen, the guidelines suggest the use of repeat doses of 400 µg misoprostol administered vaginally every 3 hours until abortion is completed successfully. [5]

Question 4.2:

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

In order to prevent a repeat unintended pregnancy, the guideline recommends that girl be given combined oral contraceptives or progesterone – only pills immediately after the first pill of 200mg mifepristone.[5]

References

1. World Health Organization. WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018).
2. Safe abortion: Technical and policy guidance for health systems. Geneva: World Health Organization; 2012.
3. Lavelanet AF et al., Global Abortion Policies Database: A descriptive analysis of
4. the regulatory and policy environment related to abortion, Best Practice & Research Clinical Obstetrics and Gynaecology, https://doi.org/10.1016/j.bpobgyn.2019.06.002

5. Johnson BR Jr, Mishra V, Lavelanet AF, Khosla R, Ganatra B. A global

6. database of abortion laws, policies, health standards and guidelines. Geneva: Bull World Health Organ. 2017;95:542–4.

7. Kapp NE, Eckersberger E, Lavelanet A, Rodriguez MI. Medical abortion in the late first trimester: a systematic review. Contraception. 2018 (in press) doi:10.1016/j.contraception.2018.11.002.