Training course in adolescent sexual and reproductive health 2021

Safe abortion care

Bouchra Assarag

National School of Public Health, Rabat, Morocco

bassarag1@gmail.com

Question 1

What are WHO's recommendations on safe abortion care for adolescents?

1. **Policy:** Ensure laws and policies enable adolescents to obtain safe abortion services.
2. **Community:** Identify and overcome barriers to the provision of safe abortion services for adolescent girls.
3. **Health facility:**
    - Ensure adolescents have access to post-abortion care as a life-saving medical intervention, regardless of whether the abortion or attempted abortion was legal.
    - Ensure adolescents who have had abortions can obtain post-abortion contraceptive information and services, regardless of whether the abortion was legal.
4. **Individual:** Enable adolescents to obtain safe abortion services by informing them and other stakeholders about the dangers of unsafe methods of interrupting a pregnancy, the safe abortion services that are legally available, and where and under what circumstances abortion services can be legally obtained.

Question 2

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

The WHO recommended medical abortion regimen in case for an unintended pregnancy of 12 weeks is the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.[b,c] The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

We can use the alternate regimen but the combination one is recommended because it is more effective.

b Evidence suggests that vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes, including buccal administration.

c Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. In this guideline we do not provide a maximum number of doses of misoprostol. Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

The young woman can start an oral contraceptive immediately after the first pill of the medical abortion regimen.

Question 3.1

What is the Global Abortion Policies Database?

The Global Abortion Policies Database (GAPD) was launched in 2017, 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 for all WHO member states.

Question 3.2

Review your country's profile in the Global Abortion Policies Database. What strikes you most in relation to access (or lack thereof) to safe abortion care in your country? Why?

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Review your country's profile in the Global Abortion Policies Database. What strikes you most in relation to access (or lack thereof) to safe abortion care in your country? Why?

In Morocco, safe abortion care still facing great challenges and he have not yet been developed adequately to meet the population needs. The national policies, regulations and strategies cover only the post abortion care services. The safe abortion care, as they are not permitted by the laws. Abortion is illegal except to safeguard a woman's life or health.

Legal, religious and social factors hinder women's access to safe abortion services. Illegality also means there are presently no official statistics on the number of illegal abortions performed in Morocco. Therefore, through the efforts made by associative and civil society actors the debate on abortion was placed in public and political space, in 2015 a "national conference" on abortion was organized in Morocco, with a participatory approach by involving the various actors (civil society, learned society, ministerial departments, religious, citizens, media, politicians…), and the bill amending the penal code has been in preparation for almost four years and submitted to parliament. Abortion remains illegal with a few exceptions, despite the amendment to article 453-1 of the Criminal Code. Thus, voluntary termination of pregnancy (abortion) remains legal for four specific cases, namely rape, incest, malformations of the fetus or mental disorders of the mother.

Regarding my position or my response in relation to this health problem, I could say, first of all, that several efforts have been made or are currently being considered to improve the health of women and young girls in general and particularly to improve their sexual and reproductive health. And I can cite the interventions and measures that have been implemented in favor of the protection of the right of women to sexual and reproductive health. Nevertheless, despite the efforts made, it is clear that certain problems remain emerging with the emergence of new sexual and reproductive health needs that will need to be met.

I believe that, where legal services are readily accessible and available, abortions are generally safe. Where access and availability of legal services are highly restricted, abortions tend to be unsafe and can be a significant cause of maternal mortality and morbidity. In

Morocco abortion is one of the main direct causes of maternal mortality. Besides maternal deaths, the abandoned children and single mothers are significant social issues resulting from unwanted pregnancies and restrictive legislation about abortion.

The regulation of abortion is an important enough step in the field of sexual and reproductive health to ensure the right of access to sexual and reproductive health services and to contribute to the achievement of the SDGs.

There is an important need to improve access of adolescent and young to a comprehensive sexual education and essentials services to prevent unwanted pregnancies and promote right to access to safe abortion care.

Question 4

What is self-managed abortion? For whom does WHO recommend self-managed abortion? How safe is self-managed abortion?

- The self-managed abortion is Self-managed abortion is when a person performs their own abortion without clinical supervision [1] as is required by law in most countries.
- The WHO recommends self-managed abortion with medicines as a method of abortion for individuals who are less than 12 weeks pregnant and have “a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.” [2,3].
- Self-managed abortion with medicines is much safer than invasive methods. With the advent of medical abortion, the practice of abortion without formal supervision of a health care professional has become safer and more widespread. The availability of medicines means that pregnant individuals do not have to resort to unsafe methods of abortion, and this therefore reduces the health risks arising from unsafe abortion. Researchers have attributed self-managed abortion with pills to a worldwide decrease in abortion mortality [4]. Researchers continue to generate evidence on the safety of self-managed abortion with medicines, despite the challenges of researching illegal and stigmatized practices [5]. The safety of self-managed abortion depends on an individual’s knowledge, access to quality medicines and ability to seek follow-up care. An individual’s safety can also depend on the degree to which they face risk of arrest when self-managing their abortion.

Question 5.1

Name the two bases that the authors of the article identified as allowing for abortions in the Middle East and North Africa.

The two bases that the authors of the article identified as allowing for abortions in the Middle East and North Africa are save the woman’s life and on fetal development, gestational age.

Question 5.2

What were the three strategies used to advocate for legal reforms in abortion laws?

1. Research on the undesired consequences of unsafe abortion, its link to maternal mortality and a high rate of unwanted pregnancy;

2. Introduction of simpler and safer methods for treating post-abortion complications such as manual vacuum aspiration (MVA); and
3. A cohort of trained providers of MVA (Personal communication, Ayse Akin, September 2001, Obstetrician–Gynaecologist and professor, Hacettepe University). After considerable debate, new legislation was adopted in 1983. Obstetrician–gynaecologists and certain religious leaders were initially opposed to the new law, after a compromise was reached that abortion would be legal on request until ten weeks after conception (12 weeks LMP).

Question 5.3

Did the fact that Saudi Arabia has a fatwa that permits termination of a pregnancy if there is fetal impairment change the respondents' views about abortion?

Yes, the fact that Saudi Arabia has a fatwa that permits termination of a pregnancy if there is fetal impairment helped the change the respondents' views about abortion. In a study among people with hemoglobin disorders in Saudi Arabia of attitudes towards antenatal diagnosis of disorders and abortion in cases of sickle cell anemia and thalassemia, most participants were unaware of increased risk with consanguinity and did not know about the Saudi Arabian fatwa permitting abortion in cases of fetal impairment. Close to half of the participants, who had initially rejected the idea of pregnancy termination, changed their minds when informed of the fatwa [6].

Question 6.1

Who are Lady Health Workers in Pakistan? What has been their role in increasing access to abortion services?

Lady Health Workers is a cadre of female health care workers in Pakistan, who act as a link between the communities and the health facilities. Their work includes disseminating information and educational material on health, family planning and sanitation, administering immunization campaigns.

The led the committee of PRHTAC want to include misoprostol and MVA in the Essential Package of Health Services and essential lists as the reproductive health technology of choice for providing safe UE and post-abortion care (PAC) in February 2013. These policy changes necessitated effective programmatic interventions for capacity building, particularly with mid-level providers (midwives and lady health workers) in use of misoprostol and MVA for UE/PAC.

The role of these ladies health workers in increasing access to abortion services is the using the use of misoprostol and MVA for UE/PAC and the contributed in commodity sustainability and service availability, they Increased availability and accessibility of services for rural women and collaborating to reduce unsafe abortions, and quality of services by developing Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care through the Pakistan Alliance for Post-Abortion Care (PAPAC).

Question 6.2

When dealing with a sensitive and stigmatized issue like abortion, what was identified by Ipas as the key to moving the agenda forward in Pakistan?

The Partnering with the GOVERNMENT – using EVIDENCE-BASED policy INITIATIVES are the identified keys by Ipas to moving the agenda forward in Pakistan to highlight the need for safe abortion care.

During Ipas's experience in Pakistan, they have found that the key to making progress on a politically sensitive and stigmatised issue like abortion is desensitising others to the topic through continuous conversations with a broad range of stakeholders. Ipas and other key partners have played a key role in mobilising professional associations to advance the advocacy work with the Ministry. As an example, they worked with senior officials and members of SOGP through professional conferences to educate members about existing abortion laws, conduct values clarification trainings and build consensus on the importance of access to safe abortion to reduce maternal mortality. Ipas hosted key provincial stakeholders to discuss the impact of unsafe abortion on women and girls, and identify a common solution for mitigating this impact, primarily by advocating for the use of the latest World Health Organization (WHO) endorsed UE technologies. Ipas used local evidence from the national studies conducted by Population Council in 2002 and 2012–13 to discuss induced abortions in Pakistan, focusing on complications and deaths due to unsafe approaches and practices.

Question 6.3

What were the two key approaches used by Ipas to contribute to the improvement of the quality of abortion care in Pakistan?

1. The first was a programmatic intervention by implementing Ipas's global Values Clarification and Attitude Transformation (VCAT) training model [7] with all levels of service providers and health facility officials. These trainings are a powerful tool that help individuals come to the realisation that no matter what their beliefs are about abortion, no woman should suffer the loss of life because of lack of access and that, as providers, their professional responsibility trumps their personal values.
2. The second was a policy initiative where Ipas worked with members of PRHTAC and the Pakistan Alliance for Post-Abortion Care (PAPAC), a cross-regional coalition of stakeholders from government departments, NGOs, UN entities and others collaborating to reduce unsafe abortions, to develop Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care. These guidelines were endorsed by the Department of Health, Punjab in April 2015 and were widely disseminated for implementation at public health facilities. The document served as both a job aid and guide to provide a quality control measure for the facilities where services are being provided [8].

References

1. Moseson H, Herold S, Filippa S, Barr-Walker J, Baum SE, Gerdts C. Self-managed abortion: a systematic scoping review. Best practice & research Clinical obstetrics & gynaecology. 2020 Feb 1;63:87-110.
2. World Health Organization (WHO). Medical management of abortion. WHO; 2018.

3. World health organization (WHO). WHO consolidated guideline and self-care interventions for health, sexual and reproductive health and rights. WHO; 2019. p 54.
4. Ganatra B, Gerdts C, Rossier C, Johnson Jr BR, Tunçalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Bearak J. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet. 2017 Nov 25;390(10110):2372-81.
5. Aghaei F, Shaghaghi A, Sarbakhsh P. A systematic review of the research evidence on cross-country features of illegal abortions. Health promotion perspectives. 2017;7(3):117.
6. Alkuraya FS, Kilani RA. Attitude of Saudi families affected with hemoglobinopathies towards prenatal screening and abortion and the influence of religious ruling (fatwa). Prenatal Diagnosis. 2001; 21:448–51.
7. Turner K, Pearson E, George A, et al. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. Reproduction Health. 2018.
8. Government of Punjab, Pakistan. Service delivery standards and guidelines for high quality safe uterine evacuation and postabortion care. Punjab (Pakistan): Government of Punjab. 2015.