Promoting Access to Safe Abortion Care for Women of All Ages:
A Review of National Guidance on Abortion Care for Young Women in Sub-Saharan Africa

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Abstract

This review examines medical guidelines from seven Sub-Saharan African countries, looking specifically at documents pertaining to abortion care and adolescent sexual and reproductive health. Documents were reviewed to determine how such guidelines address abortion care for young women, and how closely they match the guidelines recommended by the World Health Organization (WHO) in their recent publication, Safe abortion: technical and policy guidance for health systems. Topics such as age of consent for abortion, third party consent, pain management, and contraception are explored in depth. Based on the review and the evidence based guidelines provided by the WHO, recommendations are given for creation and revision of future abortion care guidelines.
PROMOTING ACCESS TO SAFE ABORTION CARE FOR WOMEN OF ALL AGES

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Introduction

In 2008 an estimated 43.8 million induced abortions were performed worldwide, of which 21.6 million were estimated to be unsafe. (1) Nearly all unsafe abortions occur in the developing world, and 2008 estimates suggest 47,000 maternal deaths resulted from unsafe abortion, with 29,000 in Africa. (2) An additional 5 million women were estimated to suffer disability as a result of unsafe abortion. (3) In developing regions, women ages 15-24 make up 41% of those seeking an abortion under unsafe conditions. (1)

As defined by the World Health Organization (WHO), unsafe abortion is “a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both.” (3) Recognizing that “Access to safe abortion depends not only on the availability of services, but also on the manner in which they are delivered and the treatment of women within the clinical context,” (3) the WHO, in consult with other global health and human rights entities, has created the Safe abortion: technical and policy guidance for health systems to aid in the development of national standards and guidelines for abortion care in countries where abortion is legal, and post abortion care in places where it is not. (3) The second edition of this tool was released in 2012.

Acknowledging the importance of standards of care, many countries have created their own national standards and guidelines, often modeled on the first or second addition of
the WHO guidance.

The WHO recognizes that standards and guidelines of care can ensure the best possible care for all women, but can also create unnecessary barriers to access. As stated in the second edition of the WHO guidance, “Services should be delivered in a way that respects a woman’s dignity, guarantees her right to privacy and is sensitive to her needs and perspectives. Attention should be given to the special needs of the poor, adolescents, and other vulnerable and marginalized women.” (3) With that in mind, the WHO document gives a number of recommendations of particular interest to young women. By creating standards and guidelines that address the unique needs of young women, without creating new barriers or restrictions to receiving abortion care, national health systems can help reduce the likelihood that young women resort to unsafe abortion, especially in contexts where safe and legal abortion is available.

This review explores how African national guidance documents address young women and how closely such standards and guidelines match those proposed by the WHO with regards to young women. An understanding of this content is helpful in illuminating how faithfully the recommendations provided by the WHO are being applied in national guidance, as well as what efforts should be made to create a more enabling environment for safe abortion care for women of all ages. In this paper the need for safe abortion care will be established, with further explanation given as to why young women are disproportionately burdened by unsafe abortion. The methods of this review will be explained and findings from national guidance documents in seven countries will be presented. Finally recommendations will be given for the creation and revision of national guidance on abortion care.
Background

In Africa, the majority (51%) of people who experience an unsafe abortion are young women aged 15-24. (1) To compare, in 2006 29% of the population in the developing world were between the ages of 10 – 24, while 33% of the population in Africa were between the ages of 10-24. (4) The fact that young women, ages 15 -24, make up less than a third of the total population in Africa, but more than half the women receiving an unsafe abortion, is illustrative of the need to advocate for better abortion care for young women in Africa.

The high proportion of young women seeking abortion stems in part from an unmet need for sexual and reproductive health information and services, including receipt of contraceptives, resulting in a high number of unintended pregnancies. In sub-Saharan Africa for instance, 83% of all unmarried, sexually active women between the ages of 15-19 wished to avoid pregnancy for at least two years, yet only 38% were using some form of contraception. (5) Research has shown repeatedly that a number of barriers consistently prevent young women from accessing sexual health care. Chief among them are a lack of sexual and reproductive health knowledge, cost, geographic barriers such as lack of transportation and accessible facilities, partner influence, and social-psychological issues including fear, stigma, lack of confidentiality, and provider bias. (6) The issues that prevent young women from accessing other sexual health services also prevent young women from accessing abortion care.

These barriers make young women more likely to delay seeking abortion services, including post abortion care, or to seek care from an unskilled provider. The later the gestational age of a pregnancy, the greater the likelihood of complications associated
with an abortion. A review of hospital records from developing countries found that the proportions of women under the age of 20 treated for complications of abortion, ranged from 38% and 68% of all those treated at each facility. (7) The result is an increase in morbidity and mortality among young women related to unsafe abortion. The WHO estimates that in sub-Saharan Africa up to 70% of women hospitalized for abortion complications are under 20. (8, 9) In a Ugandan study, almost 60% of abortion-related deaths were among adolescents. (8) These high numbers make clear the grave effects resulting from barriers for young women seeking abortion and other reproductive health services.

Recognizing the importance of safe abortion care to the health and well-being of all women, regardless of age, many in the international community have identified access to abortion care as a basic human right. (10) In the second edition Safe Abortion: Technical and Policy Guidance for Health Systems, the rights based argument is clearly articulated. As explained in the document, most governments have already ratified legally binding international treaties and conventions that protect human rights, including “the right to the highest attainable standard of health, the right to non-discrimination, the right to life, the right to liberty and the right to security of the person, the right to be free from inhuman and degrading treatment, and the right to education and information.” In consideration of these rights, and as acknowledged at the International Conference on Population and Development +5 in 1999, government health systems in countries where abortion is not against the law should train and equip health service providers and take other measures to ensure safe and accessible abortion care. The document goes further, stating:
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 groups such as poor women, adolescents, rape survivors and women living with HIV. The respect, protection, and fulfilment of human rights require that comprehensive regulations and policies be in place...to ensure that abortion is safe and accessible. (3)

Additionally, the United Nations has recognized the potential infringements posed by abortion restrictions to rights such as right to health, right to non-discrimination, and right to life. The United Nations treaty monitoring bodies have called on all governments that criminalize medical procedures that are needed only by women, such as abortion, and that punish women who undergo these procedures, to reform their laws and ensure abortion is legal at least when continuation of the pregnancy endangers the life and health of the woman and in cases of rape and incest. (11) A 2013 report by the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, states that denial of life-saving abortion or post-abortion care is tantamount to torture, and calls upon states to better ensure access to abortion where legal, and post-abortion care everywhere. (12)

Beyond the human rights argument, increased access to safe and legal abortion is also known to improve maternal health outcomes. Evidence shows that restricting abortion does not reduce the number of induced abortions, but rather increases the number of unsafe abortions. (13) The abortion rate is 29 per 1,000 women of childbearing age in Africa and 32 per 1,000 women in Latin America. In both regions, abortion is illegal under most circumstances in the majority of countries. Meanwhile in Europe, where abortion is broadly permitted in most countries, the rate is 12 per 1,000,
showing no decrease in the rate of abortion as a result of prohibition. Additionally the maternal mortality ratio due to unsafe abortion is generally higher in countries with major restrictions and lower in countries where abortion is available upon request or under broad conditions, as the clandestine nature of illegal abortion forces women to seek abortion from unskilled providers or under unhygienic conditions. Legalizing abortion, even if only to save a woman’s life, allows ministries of health to establish criteria and guidelines for providing care, and better ensure all providers are trained and skilled.

Examining the maternal mortality rate (MMR) in countries where abortion has been legalized, before and after the law changed, illustrates how the expansion of access to safe abortion care can have a huge impact on the health of a population. Countries such as Nepal, Romania, and South Africa all provide examples to consider.

In 1996, when Nepal had a highly restrictive abortion law, they also had one of the highest maternal mortality rates (MMR) in the world, with 539 deaths per 100,000 live births. In 2002, Nepal drastically liberalized its law, allowing the termination of a pregnancy up to 12 weeks for any reason. By 2009 comprehensive abortion care was available in all 75 districts throughout the country, and the MMR had dropped to 229 per 100,000 live births.

Similarly, Romania saw a drop from the highest recorded MMR in Europe of 170 maternal deaths per 100,000 in 1989, to an overall MMR of 15 per 100,000 in 2006. Prior to the abolition of the pro-natalist law restricting abortion in 1989, 87% of all MMR was attributed to abortion complications, while in 2006 the abortion-related mortality was
at 5 per 100,00 live births. (16) This contrast shows clearly the associations between legal restrictions, unsafe abortion, and maternal mortality.

The case of South Africa illustrates how expanding access to safe abortion is particularly vital to the health of young women, as research shows a positive impact on abortion-related morbidity for all women, but especially for young women. In 1994, prior to the adoption of the Choice of Termination of Pregnancy Act (CTOP), complications from unsafe abortion led to 32.69 deaths per 1,000 abortions. In 1998, just two years after CTOP was ratified, only 0.80 deaths per 1,000 were reported, a number which remained steady in subsequent years. (16) A separate study, looking at the severity of abortion complications (low, medium, and high) for women admitted with an incomplete abortion, found that in 1994, women under the age of 21 were most at risk for the high severity complications associated with unsafe abortion, with 20.5% in the high severity category. High severity was defined as a temperature of 38.0°C or above, a pulse of 120 or above, or any sign of organ failure, peritonitis, or death. By 2000 only 8.6% of teenage abortion complications were high severity. (17)

In light of the compelling human rights arguments and the significant burden of unsafe abortion amongst young women, countries should strive to make abortion safe and accessible for all women, regardless of age. National public policies should support this priority, and once in place, governments must work to ensure such policies can be implemented effectively throughout the health system. National guidance documents developed by the Ministry of Health, such as standards and guidelines, translate existing law into practice, spelling out underlying principles and essential requirements for providing equitable access to and adequate quality of health services. Guidelines are
expected to be evidence-based, as they are in the WHO document. Guidelines generally
determine standards of care and outline how, where and by whom services are delivered.
Health system administrators, providers and other staff are expected to follow these
guidelines, which are used for service delivery planning, training, supervision,
monitoring and evaluation. Ideally, standards and guidelines will address organizational
and individual barriers to their implementation. There is a considerable need for future
research, which will be discussed later in this paper, to better understand the effect of
guidelines on care provided and patient outcomes. In the available research, some
evidence supports significant improvements in both the process of care and the outcomes
associated with that care after the introduction of new clinical guidelines, when those
guidelines are monitored and frequently evaluated. (18, 19)

For young women to feel comfortable seeking out safe abortion care, abortion
should not only be legal, but service must also reflect youth-friendly standards, such as
those recommended by the WHO, in their toolkit “Making health services adolescent
friendly.”(20) National guidance documents on abortion, as well as any guidance
pertaining to medical care received by young people, should reflect these standards.

This review considers national guidance documents in seven African countries,
with a range of policies regarding the legal status of abortion. At the time of this review
no published literature could be found examining the existence of youth content in
national guidance documents regarding abortion. Several articles have explored the
creation and dissemination of the World Health Organization’s Safe abortion: technical
and policy guidance for health systems but as they focus broadly on how this work
affects all women, no information is presented specific to how this tool has affected
young women. (21, 22) One review was found that explored multiple aspects of accessibility of abortion care in six countries where the legality of abortion was liberalized. In some countries improving accessibility included the creation and dissemination of guidance documents; however the review did not explore the existence of youth content within the guidance documents. (23)

Methods

For purposes of this review documents were selected only from the countries where Ipas is currently working. Ipas is a global nongovernmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, Ipas works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counseling and choice of post-abortion contraception to prevent future unintended pregnancies. The countries where Ipas works are diverse in legal restrictions on abortion, health system strength, stigma and cultural beliefs related to abortion. Ipas works in Africa, Asia, and the Americas, in countries where the greatest potential exists to improve access and abortion care, through policy change, health systems improvements, and/or the shifting of cultural norms and community access. For those countries where Ipas works guidance documents were reviewed that fell into one of two categories: national guidance on abortion care that might contain youth content, and adolescent sexual and reproductive health (ASRH) documents that might contain content related to abortion care. While documents were
reviewed for all three regions, this paper explores only the findings from African countries.

All documents were selected from The Ipas Abortion Guidance Documents Archive. The archive was developed in late 2011, as a reference tool for all Ipas staff and colleagues from outside agencies that request to see specific documents. Though the archive is not exhaustive, efforts have been made to make the archive as up to date and complete as possible. At the time of this review’s completion the archive contained 161 documents, from 54 countries, including all but one of Ipas’ current program countries, Pakistan, which has yet to develop standards and guidelines. Documents are dated from 1992 until present. The archive is primarily made up of complete, published documents, but also includes current drafts of documents for which Ipas is providing technical assistance in their creation and/or revision. Though this review focused on standards and guidelines and adolescent sexual and reproductive health (ASRH) documents, the archive includes five types of documents.

- National standards and guidelines
- Clinical protocols
- Training curricula
- Service delivery documents
- Strategy documents

For each country only select documents were reviewed. Preference was given to the most recent National Standards and Guidelines documents, both those pertaining to abortion care and those pertaining to ASRH. When National Standards and Guidelines for abortion care did not exist for a country, the most recent and comprehensive clinical protocols or service delivery guidelines were used. Training curricula were only used if
they were more current, more comprehensive in their discussion of abortion care, and were endorsed by the Ministry of Health. Strategy and policy documents were generally only reviewed when no National Standards and Guidelines, clinical protocols, or service guidelines were available. Strategy documents were not reviewed if the implementation was to be completed and targets achieved prior to 2010.

The review was conducted by a single individual. Each document was searched for the following keywords: youth, young, adolescen*, minor, child, girl, age, consent, parent, guardian, spouse, husband. Any content specific to women under the age of 24 was recorded and categorized. Definitions of age categories, such as minor or adolescence were also recorded. Regional staff members were consulted at the beginning of the process to confirm the documents being reviewed were the most current and appropriate. Staff from the Ipas youth program assisted in editing the internal report based on the review.

For each country with guidance documents regarding abortion, the following topics were explored to better understand how issues related to and affecting young women are addressed. The themes were selected on the basis that they were areas in which unique barriers are known to exist for young women accessing abortion care or they are areas in which great potential to improve the care received by young women exists:

a) Age of consent for abortion
b) Marital status
c) Third party consent
d) Clinical considerations

1 Age of consent for abortion is defined as the age at which a young woman can consent to having an abortion, without further consent from a parent, guardian, or spouse. This age may differ from the age of majority or the age to give consent to other medical procedures, or other acts such as marriage, owning property, etc.
e) Contraceptive services
f) Additional topics as indicated (i.e., post-abortion care, youth specific guidance)

ARSH documents were reviewed for any content pertaining to abortion care or post abortion care. This review found that only Ethiopia had National Standards and Guidelines documents specific to ASRH. Other countries addressed adolescent and sexual reproductive health through strategies, policies, plans, and frameworks. Again, documents were only reviewed if their specified target dates had not already passed.

In total 24 documents were reviewed for seven program countries. The countries reviewed and types of documents reviewed for each are detailed in Table 1. A complete list of the documents reviewed is provided in appendix A.

**Table 1: Document types reviewed by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>National standards and guidelines</th>
<th>Clinical protocols</th>
<th>Training curricula</th>
<th>Service delivery documents</th>
<th>Strategy documents</th>
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<td>South Africa</td>
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<td>2</td>
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**Findings**

Throughout the review process, a number of topics related to care for young women came up repeatedly. The most mentioned topics included age restrictions, marital status, third party consent, pain management, cervical preparation, counseling, postabortion care, contraception, and referrals for additional health services. For
purposes of this paper four key themes are discussed in depth, highlighting key examples from guidance documents as they relate to young women. The themes were selected from the six topics listed above, as they clearly illustrate the ways in which standards and guidelines both create barriers and facilitate access to safe abortion care for young women. Additionally all four themes are commonly addressed in the documents reviewed, allowing for cross-country comparison. The four themes are as follows:

i. Age of consent for abortion  
ii. Third party consent  
iii. Clinical Considerations  
iv. Contraception

Each theme will be presented in conjunction with the corresponding statement provided by the Safe abortion: technical and policy guidance for health systems. As the WHO document provides the most current evidence and research on abortion, it is a fitting standard by which to compare national guidance. The key findings are summarized in Table 2, found at the end of this paper.

Age of consent for abortion

For this review the age of consent for abortion is defined as the age at which a young woman can consent to having an abortion, without third party involvement in the consent process. It is important to note that in some countries the age of consent for medical procedures other than abortion may differ. Additionally the age at which young women can marry, own property, consent to have sex, etc. may also differ. For instance in South Africa, any “woman” can consent to have an abortion. According to the “Choice of Termination of Pregnancy Act,” a woman is defined as “any female person of any age.” The same act, however, also discusses the concept of a minor, meaning “any
female person under the age of 18 years.” It is assumed there are other areas in which a woman under the age of 18 may not be considered able to give consent. The age discussed in this paper is simply relative to abortion, and should not be presumed to be relevant to other areas of consent.

For the countries reviewed, the only ages specified for young women to be able to independently consent to abortion were either 16 or 18, generally in line with a given country’s definition of a minor. Several countries such as South Africa have no age restrictions for abortion. Nigeria and Malawi also provide no additional age restrictions, but as the laws are already so restrictive it is likely young women encounter many difficulties obtaining a safe abortion. Evidence for this is the disproportionately high rate of unsafe abortion among young women in Malawi. (24)

*Safe abortion: technical and policy guidance for health systems* does not recommend an arbitrary age cut off at which a young woman is able to give consent. It states definitively that, “Abortion laws and services should protect the health and human rights of all women, including adolescents.” (3) It is concerning then that only Ethiopia and South Africa allow for abortion at any age without third party consent.

**Third Party Consent**

For those countries that give a legal age of consent, all address the topic of how a minor can obtain an abortion. For some countries such as Ghana and Kenya the age restriction is effectively a formality, as young women can be encouraged, but not required to consult their parents or guardian. In both cases the best interest of the minor is considered to be of greatest importance.
According to Kenya’s Standards and Guidelines:

*In case of pregnancies in an under-18 year old or in women with no capacity to consent, the parent’s or guardian’s approval to terminate pregnancy must be sought and documented. However, the best interest of the child shall be of paramount importance in every matter concerning them. (See Article 53 (2) of the Constitution and Section 4 of the Children’s Act 2001).* (25)

In Ghana a similar statement is made:

*The service provider should encourage minors to consult a parent or a trusted adult if they have not done so already, provided that doing so will not put the minor in danger of physical or emotional harm. However, abortion services shall not be denied because such minor chooses not to consult them.* (26)

Of particular interest is the concept of *In Loco Parentis*, which allows service providers or any other adult to give consent on behalf of the minor. This provision is given in Ghana, and Zambia. In the Ghana Standards and Guidelines, it is described as such:

*A parent, next of kin, another adult or trained service provider acting in loco parentis (in place of the parent) can give consent on behalf of the minor.* (26)

Arguably, the question of when third party consent is required and who can give consent is one of the most ambiguous topics within the standards and guidelines reviewed. Several of the documents present inherent contradictions in the way they speak about consent. Zambia for instance states that:

*Standard 6: If the patient's age is below that of legal consent (<16 years of age) the parent's or legal guardian approval to terminate pregnancy must be documented*

However within that standard is a guideline, which states:
The best interest of the minor will take precedence over that of parent or guardian and must be made on the principle of the evolving capacities of the minor to participate in decision making affecting her life. (27)

This lack of clarity in the guidance has the potential for causing confusion among providers and health management personnel and could potentially result in non-provision of services to minors or other young women.

The fear of violating a law produces a chilling effect. Women are deterred from seeking services within the formal health sector. Health-care professionals tend to be overly cautious when deciding whether the legal grounds for abortion are met, thereby denying women services to which they are lawfully entitled. (3)

Efforts should be made to promote consistency and clarity within policies to minimize the potential for non-provision of abortion care services for young women.

An additional finding related to consent is that the documents reviewed reflected no legal requirement or recommendation to be married. While evidence suggests that young unmarried women may face greater stigma and difficulty when seeking an abortion, marital status was not mentioned as a factor in determining a women’s eligibility to receive care. (28) A more explicit statement that women should be guaranteed care regardless of marital status, might improve access for young women, but those standards and guidelines cannot be said to create additional barriers in regards to this topic.

According to the WHO:

The requirement for partner or parental authorization may deter women from seeking safe, legal services. The requirement for authorization by spouse, parent or hospital authorities may violate the right to privacy and women’s access to health care on the basis of equality of men and women. Negotiating authorization
procedures disproportionately burdens poor women, adolescents, those with little education, and those subjected to, or at risk of, domestic conflict and violence, creating inequality in access. Parental authorization – often based on an arbitrary age limit – denies the recognition of evolving capacities of young women. (3)

Clinical considerations

In addition to stating who can provide an abortion, who can receive an abortion, and under what circumstances an abortion can take place, most guidance documents provide guidance on some of the clinical issues to be addressed when an abortion is to be performed. While most clinical aspects of the procedure are consistent across ages, there are some portions of a procedure that indicate special instructions for young women. Most commonly seen in the guidance documents were instructions pertaining to cervical preparation and pain management, such as the following examples from Ethiopia and Malawi:

_Cervical preparation (From Ethiopia)_

_The following groups of women need cervical preparation regimens:_
  - _Nulliparous women and those aged 18 or below with gestational duration of more than nine weeks_
  - _All pregnant women at gestations more than 12 weeks (29)_

_Pain Management (From Malawi)_

_Most women report some degree of pain with abortion. The factors associated with pain during surgical abortion with local anesthesia have been evaluated in several observational studies. The degree of the pain varies with the age of the woman, length of pregnancy, amount of cervical dilatation and the fearfulness of the woman (Smith et al. 1979).(30)_

As stated in _Safe abortion: technical and policy guidance for health systems_, “Most women report some degree of pain with abortion….The degree of the pain varies with the
age of the woman, parity, history of dysmenorrhoea and the anxiety level or fearfulness of the woman.” (3) It is positive then that guidance documents acknowledge the need for pain management. The WHO also states in regards to cervical preparation:

*Cervical preparation before surgical abortion is especially beneficial for women with cervical anomalies or previous surgery, adolescents and those with advanced pregnancies, all of whom have a higher risk of cervical injury or uterine perforation that may cause haemorrhage...However, cervical preparation has disadvantages, including additional discomfort for the woman, and the extra cost and time required to administer it effectively.* (3)

Because risks and benefits of cervical preparation need to be weighed for young women, the WHO does not recommend requiring cervical preparation for all women, but including age as a potential indication for it.

Other issues pertaining to clinical care mentioned in the documents include the need for additional counseling, youth friendly referrals, the necessity to not refuse care to a minor even in cases of conscientious objection, and postabortion care.

**Contraception**

Contraception was another topic frequently discussed in the national guidance documents. Most commonly referred to as Family Planning, most documents address the need for all women to receive contraceptive counseling, regardless of age, as part of comprehensive abortion care services. On a positive note, no guidance documents specify any restrictions regarding the contraceptive methods or services that can be provided for young women versus their older counterparts. Zambia is the only country identified in this review that has unique guidelines regarding contraceptive services to be provided to young women. The national guidance document specifically highlighted the
need for increased access to sexual and reproductive health information among adolescents in schools and communities. The following policy statement is made, along with two standards given here. Omitted here, each standard has additional guidelines that can be found in the original document.

*Policy Statement:* providing adolescents with quality [family planning] services reduces unwanted pregnancies, teenage fertility and risk of unsafe abortion thereby reducing morbidity and mortality

*Standard 1:* Youth friendly services should be available in all facilities providing Reproductive Health services including those at community level.

*Standard 2:* All adolescents and youths, both in-school and out of school, should have access to comprehensive sexual and RH information and services. (27)

The WHO document does not state the need for special contraceptive service for young women, but rather states the need for contraceptive services for all women.

*All women should receive contraceptive information and be offered counselling for and methods of post-abortion contraception, including emergency contraception, before leaving the health-care facility...Abortion-service-delivery sites should be able to provide a woman’s contraceptive method of choice in the facility. If the contraceptive method chosen by the woman cannot be provided on-site (e.g. sterilization is rarely offered at primary-care level), the woman should be given information about where and how she can obtain it, and be offered an interim method. For those methods not available on-site, the abortion facility should develop a direct referral system to ensure women are able to obtain their chosen contraceptive method. (3)*

Though, as the document repeatedly states the need to pay special attention to the unique needs of adolescence, some adaptations may be warranted for young women.
Discussion

Safe and accessible abortion is vital to the wellbeing of all women, regardless of age. The examples above illustrate the ways in which standards and guidelines can potentially influence the care provided to young women, for instance by promoting the best interest and evolving capacity of the patient versus necessitating the involvement of a third party. While standards and guidelines are intended to protect against mistakes or abuses, they have the potential to create barriers to service. Stipulations regarding age requirements, third-party notification, or consent that do not exist in the law are of particular concern to young women, as they may unnecessarily delay or prevent a young women from receiving vital care.

Governments and health systems should act to ensure both policy and medical guidance support a woman’s right to safe abortion care. Given the fact that young women experience a disproportionate amount of the burden created by unsafe abortion, special care must be taken to ensure equitable access to safe abortion care among young women. Policies which reduce restrictions to accessing safe abortion are critical to laying the groundwork for young women to access care. However as medical standards and guidance are crucial to the implementation of such policy, guidance documents must also address the needs of young women. At the least guidance documents must avoid creating additional and unnecessary barriers or restrictions not present in national laws. Ideally, guidance documents should ensure services are responsive to young women’s sexual and reproductive health needs. Such documents should reduce barriers and promote sensitive and appropriate safe abortion care services for young women.
Based on this review and recommendations provided in *Safe abortion: technical and policy guidance for health systems* the following recommendations are given for health systems revising old or drafting new guidance documents.

- Only consent of the woman seeking the abortion should be required. Third party consent should not be required, evolving capacity for decision making should be considered, and the best interest of the minor should be paramount. Young women should be given the opportunity to voice and explain what they feel is in their best interest. In cases where third party consent is required, consent by someone acting in place of a parent, *In Loco Parentis* (including consent from providers) should be permitted.

- Marital status should not be a factor in determining a women’s eligibility for abortion care services.

- Confidentiality and privacy must be ensured, even when third parties are involved in the consent process. Notification of parents or other adults should not be required.

- Providers should take into consideration the fact that a young woman’s visit to receive an abortion might be her first gynecologic event (e.g. first pelvic exam). Additional efforts must be made to explain the procedure and reduce fears. Extra time should be afforded for counseling regarding their abortion care as well as other sexual and reproductive health issues they might wish to discuss.

- Young and nulliparous women report increased pain during abortion. Efforts to manage pain should also consider how a woman’s fear and anxiety might contribute to her pain and be prepared to provide additional medical and psychological methods of pain management as indicated.

- Contraception should be offered to all women regardless of age. Providers should offer young women a full range of options that meet their needs and work with their lifestyle, such as long acting reversible contraception, when young women are not able to visit the clinic frequently.

- For all guidance pertaining to young women, efforts should be made to ensure consistency across documents so as to avoid unnecessary confusion, barriers, or restrictions.
Limitations and Future Research

The primary limitation of this review is the limited number of countries reviewed and the lack of documentation regarding practitioner’s adherence to these guidelines. While diverse in the legal status of abortion and strength of health systems implementing the guidelines, all countries are from the same region, where abortion is restricted or liberalization is relatively recent. Future research should consider guidance from other regions, in particular countries where abortion is minimally stigmatized, has been legal for a longer period, and safe abortion care may be more established.

Additionally research is needed to better understand adherence to guidelines and how guidelines affect care and the resulting health outcomes. Currently the WHO is only monitoring the number of requests from countries for assistance to implement the abortion guidelines and the number of countries that modify their monitoring plan for abortion according to the WHO guidance document. The number of hard copies requested and distributed and the number of downloads of the WHO guidance are also being tracked. The resources invested by the WHO and their partners to develop the original Safe abortion: technical and policy guidance for health systems and the subsequent revision indicate a strong belief in the value of medical guidelines. The fact that so many countries have created their own guidelines often based on the WHO recommendations, suggests that these countries also believe in the potential for the guidelines to improve their health systems.

Currently no research has evaluated whether the adoption of abortion guidelines based on the first edition of the WHO document has resulted in a change in the provision
of care or the resulting medical outcomes. The broader literature explores successes and barriers to adherence of a variety of medical guidelines, often finding adherence is strongest when guidelines are monitored. Given strong adherence, medical guidelines can result in improved patient outcomes. (18, 31, 32) Such research is limited to western developed countries. Given the increasing emphasis placed on health systems improvement to address global health issues, similar research should be conducted to understand the impact of medical guidelines in the developing world.

Conclusion

At 1.8 billion, young people aged 10-24 years comprise more than a quarter of the world’s population. With the consistent emphasis placed on reducing maternal mortality and child mortality over the years, young and adolescent women in the developing world have received little attention and have not experienced the improvement in health that other groups have shown. (33) Special care should be taken to ensure young and adolescent women can access the health care vital to their current and future wellbeing. This review highlights the critical issue of abortion care, but health systems can use a similar approach to review other medical guidelines. Adolescents need comprehensive, confidential, affordable, and accessible care for a wide variety of sexual and reproductive health issues, including safe abortion as a key component. Ministries of Health are responsible for ensuring the training and guidance they give to medical providers improves the quality of care adolescents receive and does not further restrict their ability to realize their rights, including those related to sexual and reproductive health.
Notes

All texts obtained for this review can be found in the Ipas Abortion Guidance Documents Archive, which is available to the public for future research. A list of documents currently found in the archive can be found on Ipas’ website at the following address: http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Standards-and-Guidelines.aspx. To receive a copy of a document’s full text, or for more information on the archive and its contents please contact the library (library@ipas.org).
References


Table 2: Guidelines of abortion care as they relate to young women

<table>
<thead>
<tr>
<th>Country</th>
<th>Abortion permitted to…</th>
<th>Age of consent for abortion</th>
<th>Third party consent</th>
<th>Discusses contraception for young women</th>
<th>Relevant clinical or service delivery topics addressed</th>
<th>National standards &amp; guidelines on abortion care</th>
<th>National ASRH documents with guidance on abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>F I R +</td>
<td>Available at any age</td>
<td>I</td>
<td></td>
<td>Cervical preparation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ghana</td>
<td>F I MH R</td>
<td>18</td>
<td>II</td>
<td></td>
<td>Right to refuse</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
<td>18</td>
<td>I</td>
<td>✓</td>
<td>Psychosocial/economic support</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Malawi</td>
<td>L</td>
<td>Restricted at all ages</td>
<td>III</td>
<td></td>
<td>Cervical preparation, pain management</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>L</td>
<td>Restricted at all ages</td>
<td>III</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>Available at any age</td>
<td>I</td>
<td></td>
<td></td>
<td>Referrals, pain management</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Zambia</td>
<td>F</td>
<td>16</td>
<td>I</td>
<td>✓</td>
<td>Counseling, cervical ripening</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Abortion permitted to…
- ■ – To save the woman’s life or prohibited altogether
- □ – To preserve health
- ▼ – Socioeconomic grounds
- ▶ – Without restriction as to reason

F – Abortion permitted in cases of fetal impairment
I – Abortion permitted in cases of incest
L – Abortion explicitly permitted to save a woman’s life
MH – Recognizes an exception to preserve a woman’s mental health
R – Abortion permitted in cases of rape
+ - Abortion permitted on additional grounds, relation to such factors as the woman’s age or capacity to care for a child

Third party consent: I – Third party consent not required
II – When third party consent is required, loco parentis is permitted
III – Information not available

2 Source: http://www.worldabortionlaws.com/map/
Appendix A: Types of documents reviewed

National Standards and Guidelines: Official government guidelines on abortion or reproductive health care. Almost always include information about which services can be provided by which cadres of providers at which level of the health system tiers of services and the legal indications for abortion within the country. Content is generally outlined first by standards of care, followed by specific guidelines relating to those standards. May include elements of each of the other four document types.

Clinical protocols: Describe in detail the clinical aspects of providing abortion care, such as MA dosages or MVA procedures.

Training curricula: Provide instructions and materials for trainers to train providers and other health care workers on how to perform certain tasks (in this case, to deliver abortion care).

Service delivery documents: Designed for use by managers, providers and other staff. Usually include reproducible checklists and/or forms for proper service provision and facility management.

Strategy documents: Outline government commitments to and plans for reproductive health services within the health system. This category includes national policies on reproductive health, which are designed to guide the actions and decisions of those responsible for implementing government policies.
Appendix B: Documents reviewed by country

Ethiopia

3. **National comprehensive reproductive health services for adolescents and youth** (2008) – Ministry of Health, Ethiopia, *Training curriculum*

Ghana


Kenya

Malawi


Nigeria


South Africa

Zambia
