Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module I

Unsafe abortion in adolescents

This handout presents background information to complement the material in module I entitled *Unsafe abortion in adolescents*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. The nature and scope of unsafe abortion

WHO estimates that about 25% of all pregnancies worldwide end in an induced abortion. Table 1 that follows presents global estimates relating to abortions for women of all ages (*1*). The vast majority of unsafe abortions take place in developing countries, and as can be expected, in countries in which abortion is restricted by law.

Unsafe abortion accounts for up to 13% of all maternal deaths (*1*). Some 80,000 women are estimated to die every year as a result of unsafe abortion. Many more women survive the experience only to suffer throughout the rest of their lives from chronic health problems, and in many cases infertility.

TABLE 1

Global estimates relating to abortions for women of all ages

	Estimated annual figure
Abortions performed globally	50 million
Abortions performed in developing countries	30 million
Unsafe abortions	20 million
Death from unsafe abortions	80,000

Source: Reference (1).

In many parts of the world, more adolescent girls than adult women will resort to abortion as a way of solving an unwanted pregnancy. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2 million to 4.4 million annually. In many developing countries, hospital records of women treated for complications of abortion suggest that between 38% and 68% are less than 20 years old. A recent review of unmarried women aged 15-19 years who gave birth in the preceding five years showed that 32-93% of the births were unwanted or mistimed. Even among the married adolescents, up to 61% of the last births were unwanted or mistimed (*2,3*).

The choice to have an abortion is not an easy one. Adolescents often state a number of reasons for resorting to abortion (*4*):

- **Education:** Pregnant girls who fear expulsion from school or the interruption of their studies may believe that they have no choice but to terminate their pregnancy.
- **Economic factors:** Since adolescents have fewer economic resources to care for a child, it is not surprising to find economic pressures influencing their decision to seek an abortion.
- **Social condemnation:** In societies where a pregnancy before marriage is considered immoral, adolescent girls choose termination of pregnancy to avoid bringing shame and condemnation on themselves and their families.
- **Having no stable relationship:** This reason is encountered more commonly among adolescents than in adults.
- **Failed contraception:** Contraceptive use among adolescents is often low. Where they are used, this is often done so inconsistently and incorrectly. Also, less effective methods tend to be used.
- **Coerced sex (including rape and incest):** Cross-cultural data point to the fact that a larger percentage of rape and sex abuse incidents are perpetrated against adolescents than among adults.

Early studies on unsafe abortion, especially in developing countries, reported a higher prevalence in the urban and educated than in the rural areas. This may be as a consequence of greater access to information and wider availability of services in urban areas. In countries where abortion laws are restrictive, the rich are often able to obtain safe abortion from competent, well-trained providers at exorbitant fees. The rich are therefore less likely to suffer the consequences of unsafe abortion. On the other hand, the poor are forced to seek the services of clandestine, unqualified providers with all the attendant implications.

2. Factors contributing to unsafe abortion in adolescents

There are several factors which determine the magnitude and severity of unsafe abortion:

- Delays in seeking care
- Resorting to unskilled providers
- Use of dangerous methods
- Legal obstacles
- Service-delivery factors.

Delay in seeking abortion is the largest single factor in determining the risk of complications and death due to unsafe abortion among adolescents (*5*). Adolescents, like some adults, may delay seeking help even after complications develop. Adolescent women may delay seeking care because they may not know that they are pregnant, or may not want to admit it even if they are aware of their pregnancy. They may not know where to obtain help. Even if they do so, they may not be able to obtain help because factors such as cost may prevent them from doing so. Finally, even if they can obtain help, they may be unwilling to do so because of the attitudes and behaviours of health-care workers.

Adolescent girls are more likely than adult women to seek abortion from unskilled providers. The younger the adolescent, the more likely that her abortion will be self-induced or carried out by a non-medical person.

Adolescents are more likely than adults to use dangerous methods for abortion, such as inserting objects into the cervix, placing herbal preparations into the vagina, or taking various preparations from modern and traditional systems of medicine – orally or through injection.

Varying forms of legal barriers to the provision of abortion services exist in many countries. Even in countries where these laws are relatively liberal, various requirements that have been created make it harder for adolescents to have access to safe abortion. For example, in some countries the consent of the husband, parent or guardian is needed for the abortion if the woman is below a certain age. Generally speaking, abortion-related mortality is highest in countries where abortion is legally restricted and reproductive health service provisions are not widely available. It must be noted that even where laws and policies are not restrictive, societal views and the – real or perceived – attitudes of health-care workers act as obstacles to access (*6*).

The way in which service-delivery is organised affects the extent to which adolescents have access to sexual and reproductive health information and services, including safe abortion when needed. Later in this handout, we will describe what actions need to be taken in order to improve the diagnosis and management of unsafe abortion in adolescents. For information on how to overcome barriers to the provision and utilisation of health services to adolescents, please refer to the module D. *Adolescent-friendly health services*.

The magnitude and severity of problems related to unsafe abortion among adolescents vary from country to country, and within communities in the same country.

Factors determining magnitude and severity include the extent to which:

- Reproductive health information and services are available and accessible to adolescents;
- Safe abortion services are available and accessible;
- Health-care providers are helpful and non-judgemental in their dealing with adolescents;
- Community norms permit open and frank discussion about sexuality in adolescents;
- National laws and policies facilitate the provision of reproductive health information and services that adolescents need.

3. THE CONSEQUENCES OF UNSAFE ABORTION

While the risks of mortality and morbidity from unsafe abortion are high for women of all ages, they are especially high for adolescents. The consequences are multiple, and can be conveniently categorized as medical, psychological, social and economic.

Mortality

Information on mortality due to unsafe abortion for women of all ages was presented earlier in this handout. The available data clearly points to the fact that three groups of women run a heightened risk of mortality from unsafe abortion. These are women of young age, those who have not yet had children, and women of lower socio-economic status. The risk of mortality is clearly far greater for adolescents than for adult women.

Medical consequences

The major short-term complications are cervical or vaginal lacerations, sepsis, haemorrhage, perforation of the uterus or bowel, tetanus, pelvic infection or abscess, and intrauterine blood clots. Post-abortal sepsis can rapidly develop into septicaemia; haemorrhage is a common complication that leads to or aggravates pre-existing anaemia. Both septicaemia and anaemia are common causes of death, especially in developing countries where life-saving antibiotics and safe blood transfusion services are less available. Physical injuries may vary from small genital lacerations to major perforations involving not only the reproductive organs but also urinary and gastrointestinal systems.

In order to save the lives of these young women, major emergency surgical interventions are needed. Paradoxically such interventions are least available in developing countries, where young people are least able to prevent pregnancy. Where they are available, they are least accessible to those who require them most: poor adolescents in rural areas. Thus, adolescents who resort to unsafe abortion often pay with their lives.

The major long-term medical complications (more than a month after the procedure) include secondary infertility (a particularly heavy life-long burden, in societies where a woman's status depends on her ability to have children), spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour.

Psychological consequences

These are less well-documented than physical consequences but are by no means insignificant. Long-term abortion-related psychological problems have been frequently reported, especially in young women pregnant for the first time. These include a sense of loss and reactions of grief. Some have also expressed guilt that extends beyond the abortion itself to guilt for having engaged in sexual relations, and for failing as a "real" woman by opting for abortion (*7*).

Social and economic consequences

The social and economic consequences of unsafe abortion are borne by the girl herself, her family, community and the society as a whole. The girls who survive may face a range of social problems. If it becomes known that they have undergone an unsafe abortion, they may have to leave school and face disapproving attitudes, even ostracism, from their community. Furthermore, they risk

being thrown out by their families. Girls who drop out of school, or are thrown out by the family, often marry early, get poorly paid jobs and are tempted or forced into prostitution. In short, the spiral of events stemming from their obtaining an unsafe abortion, greatly reduces their life chances.

In some countries where abortion is illegal, women – including adolescents – who have undergone an abortion illegally, may face imprisonment.

Throughout the developing world, the economic consequences of unsafe abortion are immense for both the community and the country. Treatment for the complications of unsafe abortion drains precious resources – often already in short supply – such as safe blood, other intravenous fluids, and antibiotics. Women recovering from unsafe abortion tend to stay in hospital three or four times longer than those recovering from safe abortion. Also, the long-term morbidity resulting from unsafe abortion incurs future health care and other costs. In addition, there are other significant costs. Investments made in education and training young women are lost. Human resources which could have contributed to the nation's development are lost. Unsafe abortion thus results in costs not only to individuals and families but to communities and societies.

4. Diagnosing unsafe abortion

In theory the diagnosis of unsafe abortion or its complications should not differ between adolescents and adult women. There is a history of a missed menstrual period(s) followed by an attempt to terminate the unwanted pregnancy, by oneself, with the assistance of a friend or a clandestine provider. In places where abortion is illegal, the illicit provider often merely induces bleeding and leaves it to the woman to go to a hospital for an evacuation later. In such circumstances, an adolescent may present with a history of vaginal bleeding and complications of sepsis and anaemia.

Unlike adult women, adolescents (particularly very young girls) are often not willing and sometimes not able to given an accurate history. This is especially so when they are accompanied by their parents, relatives or other persons because of fear and embarrassment at having had sexual relations.

Compared with adults, adolescents with an unsafe abortion are more likely to (*4*):

- Be unmarried and outside a stable relationship
- Be primi gravida
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate pregnancy
- Have resorted to illegal providers
- Delay seeking help
- Come to the health facility alone or with a friend, rather than with the partner
- Have ingested substances that interfere with treatment
- Have more entrenched complications.

It is important for health-care providers to bear in mind that unwanted pregnancy may be the real presenting problem, though other symptoms may be reported, and to observe the adolescent's demeanor and behaviour carefully. This will assist in ensuring that the diagnosis of unsafe abortion is not missed. It would be important to employ a gentle, reassuring manner, and to tactfully ask the girl's parents or guardians to wait outside the consulting/examining room. This will enable the health-care provider to have a private and confidential conversation with the girl.

5. Managing unsafe abortion

The clinical presentation will obviously depend the condition of the patient. In case infection has set in, the adolescent is likely to be feverish and dehydrated. The other likely clinical signs are: a swollen, tender abdomen, bleeding and foul-smelling discharge from the vagina, with some products of conception still in the uterus, tender adnexae, and fullness in the pouch of Douglas. In case treatment has been delayed, the adolescent is likely to be in shock with impending respiratory and circulatory failure.

The management of the patient will depend on the history and the findings of the examination. It should be based on the following principles (*8*):

- *Emergency resuscitation* may be necessary as many adolescents present in shock. In primary level facilities, health-care workers will need to be prepared to make referrals and arrange for transport to a referral facility with effective treatment.

- *Evacuation of the uterus* is necessary to remove all the products of conception.

  For inevitable or incomplete abortion, uterine evacuation is necessary. The technique chosen will depend on the length of gestation, stage of the abortion, uterine size and availability of skilled staff and supplies. If there are signs of infection, abdominal injury, cervical or uterine perforation, evacuation should be carried out only after broad-spectrum antibiotics effective against gram-negative, gram-positive and anaerobic organisms, as well as chlamydia, have been started.

  In the first trimester, vacuum aspiration is the surgical procedure of choice. In the second trimester, the risk of complications is higher. Because delay is so characteristic of adolescent abortion patients, many second trimester abortions are carried out in this age group. Early second trimester (12-14 weeks) procedures can be done by vacuum aspiration using larger cannulae. Curettage is also sometimes required. The treatment of incomplete abortion in the late second trimester (more than 14 weeks), by dilation and curettage or by uterotonics, should be done by experienced health-care workers. In addition, intravenous fluids and oxytocics, blood transfusion and facilities to perform abdominal surgery must be available as a back-up.

- *Management and prevention of complications* such as infection and injury. It is unfortunately true that complications are more frequent and more severe in environments where self-induced or otherwise unsafe abortions are common and where reproductive health services in general are lacking.

- *Arrangements for post-abortion care* must be put in place because adolescents are more easily "lost to follow-up" than are adults. Establishing a good rapport with the adolescent patient will facilitate follow-up. In any case, patients must be given information on danger signs to look out for, such as fever and chills, nausea and vomiting, abdominal pain and backache, tenderness to pressure in the abdomen, heavy bleeding and foul-smelling vaginal discharge. They must also be provided with information on sexuality and contraception for well-informed decision-making.

6. Preventing unsafe abortion

In many parts of the world, adolescent and adult women with unwanted pregnancies continue to resort to abortion, whether or not it is legal and safe. Prevention of such pregnancies must therefore be one of the key objectives in efforts to eliminate unsafe abortion. Communities, governments and health-care workers should endeavour to:

- Improve access to reproductive health information and services

  The need to improve adolescents' access to reproductive health information and services has been discussed in module C. *Adolescent sexual and reproductive health*. Specifically, there is an urgent need to expand the availability of a wide range of contraceptive methods to enable sexually active adolescents to choose the method that best suits their needs. The contribution that emergency contraception could make in preventing unsafe abortion needs to be clearly articulated. Adolescents need to know that this method is available, and where it could be obtained when needed. Information on ways and means of improving the accessibility and acceptability of health services is provided in module D. *Adolescent-friendly health services*. Further information on contraception is provided in module J. *Pregnancy prevention in adolescents.*

- Address laws and policies on access to safe abortion services and their application

  In many countries, legal barriers prevent adolescents from obtaining abortion services. It is important to press for legislative review and reform in these countries. Even in countries where abortion is legally available on demand, women experience difficulties in exercising their right to obtain these services. The reasons for this include local opposition or reluctance to applying national laws, and burdensome administrative requirements. These barriers are heightened when adolescents are involved. In such situations, it would be important for the relevant authorities to clarify the role that health-care providers are obliged to play in the provision of abortion services. This will help to ensure that available services are not withheld from adolescents who need them (*9*).

- Train health-care providers in comprehensive abortion care

  Health-care providers – both modern and traditional – need to be trained in comprehensive abortion care so that they can recognize the signs and symptoms of abortion-related complications and how to manage them effectively. They also need to be trained in post-abortion counselling. In this way, they can help adolescents deal with the many health and social issues that arise. In addition to building the knowledge and skills of health-care providers, it is important to help them examine their attitudes and beliefs, in order to prevent these factors from hindering the provision of care.

  The dilemma for service providers is often a complex one. On the one hand there are laws concerning the provision of abortion services, and on the other hand there are laws governing the treatment of minors. Both of these sets of laws can come together to pose barriers to the health and well-being of adolescents, especially young adolescents. The issuance of clear standard operating procedures and guidelines for the management of unsafe abortion, within the context of the prevailing laws and policies, will assist health-care providers in dealing with the legal and ethical dilemmas that they encounter.

- Involve communities in protecting and safe-guarding adolescents

  In addition to their role as service-providers, health-care workers have to play the important role as change-agents in their communities. They must work to involve communities in discussions on unwanted pregnancy, unsafe abortion and its consequences, and the contribution they could make to protecting and safe-guarding adolescents in the community (*10*).

SUMMARY

- Unsafe abortion is common among adolescents in many countries.
- By definition, it implies interference of pregnancy by persons without the necessary knowledge and skills, or in conditions that are not conducive to good health. It can be within or outside of the law.
- Adolescents obtain abortions for a broad range of reasons related to social, economic and cultural reasons.
- Adolescents undergoing unsafe abortions tend to be single, pregnant for the first time, and tend to obtain their abortions later in their pregnancies than adult women.
- They are more likely to have resorted to illegal providers and to have used dangerous methods for inducing abortion.
- They tend to present later, and with more entrenched complications.
- They tend to face more barriers than adults, in accessing and using the health services they need.
- They are less likely to come for post treatment follow-up.
- The management of unsafe abortion should include post-abortion counselling, addressing contraception in addition to other issues.

8. References

1. *Unsafe abortion: global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data.* WHO. Geneva, 1994 (document No. WHO/RHT/MSM/97.16).
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4. Olukoya A.A, Kaya A, Ferguson B J, AbouZahr C. Unsafe abortion in adolescents. *International Journal of Gynaecology and Obstetrics*. 2001; 75: 137-147.
5. Mundingo A I, Indriso C (Eds). Abortion in the developing world. WHO, *Vistaar Publications*, New Delhi, 1999.
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8. *Complications of abortion: technical and managerial guidelines for prevention and treatment.* WHO. Geneva, 1995.
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Orientation Programme on Adolescent Health for Health-care Providers

Annex 1

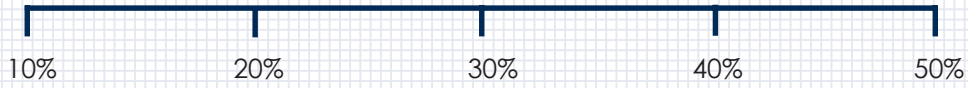
Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

In the developing world, roughly what percentage of all maternal deaths are caused by unsafe abortion?

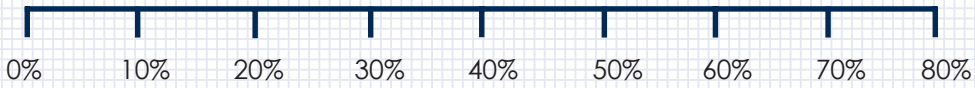
please mark your estimate with a spot anywhere along the line



SPOT CHECK 2

In the developing world, roughly what percentage of women who are hospitalized with abortion complications are under 20 years old?

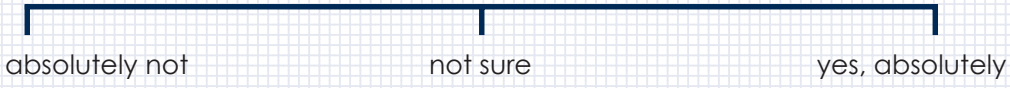
please mark your estimate with a spot anywhere along the line



SPOT CHECK 3

Some people say that if safe abortion services are made available and accessible to adolescents, it will encourage promiscuity. Do you agree with this?

please mark your answer with a spot anywhere along the line



SPOT CHECK 4

How confident do you feel about working with adolescents on the issue of abortion?

please mark your answer with a spot anywhere along the line

not very confident — ok — very confident

SPOT CHECK 5

A school-girl presents with complications due to unsafe abortion. Which of these best describes how you feel about her situation?

please answer with three spots

- I feel angry with her
- I feel angry with the boy or man who is responsible
- I feel pity for her
- I feel angry with the politicians for the restrictions on safe abortion
- I feel we have failed because she resorted to unsafe abortion
- I feel sadness that she didn't use safe abortion
- I feel pity for the life that has been aborted
- I feel angry with the person who did the abortion

SPOT CHECK 6

As health-care providers, what should we focus on to prevent unsafe abortion among adolescents?

please answer with three spots

- Train modern and traditional health-care providers in abortion care ○
- Support efforts to change the law to expand access to safe abortion ○
- Improve confidentiality for adolescents seeking abortion ○
- Improve access to safe abortion for adolescents ○
- Improve provision of contraception to all adolescents ○
- Encourage the authorities to stop untrained people carrying out abortions ○
- Emphasize abstinence from sex before marriage ○
- Encourage adolescents to go through with their pregnancies ○

SPOT CHECK 7

Realistically, is there more you could do with respect to unsafe abortion among adolescents?

please mark your answer with a spot anywhere along the line

no — perhaps — definitely

Orientation Programme on Adolescent Health for Health-care Providers

Annex 2

Case studies

Session 4: ACTIVITY 4-3

CASE STUDY 1

Nyako, a 14-year old school-girl, attended a boarding school on the outskirts of Kampala. One evening, she was admitted to Mulago Teaching Hospital with complaints of high fever and severe lower abdominal pain.

Nyako was brought to the hospital by one of her teachers. She had been found huddled up in bed and shivering in the school dormitory.

They were received by a nurse in casualty who asked Nyako a few questions about what had happened but did not get much information. Nyako was clearly very upset and mumbled or answered in monosyllables. The teacher, who appeared sympathetic to Nyako, told the nurse that another pupil had found Nyako very unwell in bed and that she had been terribly sick. She wondered if Nyako had eaten something and had a stomach upset.

The nurse thanked the teacher and asked her to wait while she took Nyako for an examination. Nyako was weeping while undressing and the nurse comforted her and asked if she would like to tell her a little bit about what had happened. Nyako confided that she had got pregnant, had had an abortion which had gone all wrong and, indicating the lower abdomen, said that her tummy hurt terribly.

The nurse called the doctor on duty and reported what Nyako had told her. On examination, the doctor found that her abdomen was tender with marked guarding. The uterus was bulky and there was a foul-smelling purulent discharge due to infected products of conception.

On further questioning, Nyako told the doctor that, seven days before, her best friend had taken her to an abortionist in a slum area of Kampala, who had inserted a rubber pipe deep into her vagina and instructed her to go to hospital when heavy bleeding started.

The doctor asked her about the date of her last period and how sure she was that she was pregnant. Nyako told him that her periods had started about two years ago but had always been irregular. She was having a love affair with a boy from a neighbouring school and they had started to have sex three months before. She was seven weeks late with her period and suspected she was pregnant. She did not do any test.

Following the abortion, bleeding had not, in fact been heavy but intermittent, with steadily increasing lower abdominal pain. The pipe dropped out after two days. Nyako had endured the pain and tried to keep going as best she could at school until that afternoon, when she could bear it no longer.

Despite the pain which was by then excruciating, the main concern Nyako expressed was that neither the school nor her parents should know about the pregnancy. She begged the doctor not to tell them. She also asked if she was going to die. The nurse reassured her, while the doctor went out to tell the teacher who had accompanied Nyako that she needed to be admitted to hospital for investigations.

She was admitted to the gynaecology ward with a diagnosis of septic incomplete abortion. She was started on parenteral antibiotics and taken to theatre for evacuation 12 hours later. Her temperature settled and she was put on haematinics. She was discharged after five days and given a return appointment to the gynaecology clinic a week later.

At the return visit she was given a cursory examination. She had apparently recovered completely; she was also extremely grateful to the doctor and nurse for not informing either the school or her parents except in vague terms about some abdominal disorder.

QUESTIONS FOR GROUP DISCUSSION

1. Who do adolescents turn to for advice and help when they have an unwanted pregnancy?

   - In the case of a "botched" illegal abortion, with serious consequences, where do they go?
   - How promptly do they seek help when problems arise?

2. How are adolescents treated if/when they go to a government health facility; a private practitioner or an illegal abortionist?

   - From an adolescent's point of view, what are the pros and cons of going to each of these places?

3. When seeing an adolescent in such circumstances, how can you make her feel at ease and encourage her to confide in you?

4. What are the things you need to be aware of when carrying out a physical examination of a young woman in such a situation?

5. What is the best way to communicate facts about abortion, its possible consequences and its implications, to adolescents?

   - Which of the adolescents' concerns must you address?
   - In this situation, what are the rights of minors to privacy and confidentiality?
   - What are the rights of parents to be informed and make decisions?

6. Do health-care workers deal with the social and psychological aspects of abortion effectively? What do they need to consider in order to deal more sensitively with these aspects?

7. What follow-up actions need to be undertaken following unsafe abortion?

   - How to coordinate with related services for contraception and STI prevention?
   - How can vital education and information on prevention best be provided?

CASE STUDY 2

Yolanda, an 18-year old girl had just completed her secondary school education. She went to the outpatient department of the district hospital in the town in which she lived, because she suspected that she was pregnant.

After waiting for several hours in a long queue, she was seen by a middle-aged male doctor. She told the doctor that she suspected that she was pregnant and wanted to have the pregnancy terminated. The doctor sent her for a pregnancy test at the hospital laboratory and told her to come back in two days.

The test confirmed that she was pregnant. On the next visit, she was examined and found to have a bulky uterus and to be 8-10 weeks pregnant. Yolanda again stated that she wanted the pregnancy terminated. The doctor asked her to explain why she could not continue with the pregnancy.

She explained that she had just completed her secondary school leaving certificate the year before and was due to go to nursing school in four months. She was the first-born in a family of six, both parents were school teachers and the father was a lay preacher at the local church.

She pleaded with the doctor to help her. She felt very ashamed about the pregnancy and could not bear the thought of giving up or postponing her nursing training, which would ruin her own employment opportunities and let her family down.

The doctor told her that termination of pregnancy was illegal under any circumstances. However, he offered to assist her at his private clinic. Yolanda saw the doctor privately and was told that the termination of pregnancy could be performed the following day for a heavy fee – to be paid before the operation. She had no way of doing this and left very frustrated.

Two months later, she was brought to casualty. By chance the same doctor was on duty at that time. She was wheeled in on a stretcher by her parents. They told him that she had been behaving strangely for the past several weeks. She had gone to visit an aunt up country 10 days before and stayed away one week. She had been extremely unwell for the past three days. Her parents suspected malaria. Yolanda herself was too unwell to provide any further information.

Physical examination revealed a very sick girl with marked pallor, jaundice, temperature of 36 degrees, rapid and weak pulse, and blood pressure 80/50 mm; the abdomen was tender and distended. There was foul smelling discharge from the vagina. The diagnosis of septic incomplete abortion with a foreign body in the vagina, causing septicaemic shock was made.

Resuscitation was started and the patient was admitted to the surgical ward. Broad spectrum antibiotics were prescribed but were out of stock. Only penicillin was available. The parents rushed out to buy the prescription that they were given. A blood transfusion was ordered; and the drip started.

Six hours later, there was no improvement; a surgical evacuation under anaesthetic (EUA) was planned. At EUA, a stick was found in the vagina, perforating through the pouch of Douglas into the abdominal cavity. There appeared to be leakage of faecal matter into the abdomen. The doctors decided to do a laparotomy and an evacuation. At laparotomy, they found uterine perforation, partial necrosis of the posterior wall of the uterus and perforation of the gut. They also found fulminating peritonitis and a pelvic abcess. Gut resection, colostomy, and subtotal hysterectomy were performed. The patient was taken to the intensive care ward where her condition steadily worsened. She died five days later.

Questions for group discussion

1. What important issues pertaining to health services (availability and accessibility) are highlighted by this case study?

2. In your experience and practice, how often does this sort of event occur?

3. What do we need to do (as health-care providers) to prevent such tragedies from occurring?

4. What do you need to be aware of when carrying out a physical examination on a young woman in such a situation?

5. How frequently do basic supplies and other resources for resuscitation run out in your experience?

6. What could have been done differently to save the young woman's life after she presented at the hospital?

Annex 3

Role plays

Session 5: ACTIVITY 5-3

ROLE PLAY 1

A 14-year old girl, dressed in her school uniform, comes during school hours, to see the duty medical officer in the casualty department of a district hospital.

She explains to the doctor that she thinks she is pregnant and wants a termination. She does not want to talk about who the father might be, even on probing.

She tells him that she is the first-born in a family with six children. She attends a local Catholic secondary school and lives with an uncle who is her local guardian and is paying for her upkeep. Her parents are poor farmers living in a rural area.

The girl believes that her future education and her relationship with her family will be irrevocably damaged by carrying through with this pregnancy. She says that she depends on the support of the duty medical officer to find a solution...

The doctor seems willing to consider assisting her, but the nurse on duty is a staunch Christian who believes that abortion is murder.

Roles: Doctor, nurse, 14-year old girl.

ROLE PLAY 2

A young woman (18 years) has died in hospital from septic incomplete abortion (see Case study 2) in the care of a certain middle-aged male doctor.

Two months before her death, the woman had come to the hospital seeking an abortion. She had met with this doctor who had told her that he would be prepared to perform the procedure in his private clinic, on payment of a heavy fee (and had then refused to do so because she did not have the money required). This doctor now has to break the news of her death to the family, and he has in his office both her parents and her sister.

The sister breaks down sobbing and in anger reveals what had happened two months earlier when her sister came to the hospital for help.

The doctor wants to comfort the family but, of course, his own part in the affair makes this very difficult. He feels torn between his own guilt, genuine sympathy for the family and his real concerns about safeguarding his position...

Roles: Doctor, young woman's parents and 21-year old sister.

ROLE PLAY 3

A manual vacuum aspiration (MVA) programme has recently been introduced in the gynaecology ward of a busy regional hospital. This means that evacuations can now be performed in the treatment room rather than in the operating theatre.

The value of post-abortion counselling and contraception has been stressed during staff training.

Three girls of secondary-school age who have just undergone medical termination of pregnancy are in the office of the nurse in charge, waiting to be discharged. The nurse has only a few minutes to devote to them.

As she begins talking to them about preventing future pregnancy, one of the girls says that she does not want to take contraceptive pills as she is sure that her parents will find them. She and her family live in small 2-roomed quarters and she has no privacy. The other girls immediately nod in agreement.

Roles: Nurse, three girls of secondary-school age.

ROLE PLAY 4

At 8 a.m. on a Monday morning, a gynaecologist at a regional hospital is summoned to see the Hospital Superintendent urgently.

The Superintendent is not in a laughing mood! He accuses the gynaecologist of performing abortions in the hospital, abortions which he says are illegal. His accusations are based on reports from the nurse in charge of the gynaecology ward.

The Superintendent has ordered the confiscation of the MVA instruments and instructed that henceforth all evacuations are to be performed in theatre under general anaesthesia.

The nurse in charge of theatre has been instructed to release instruments only for sharp curettage if she herself has confirmed that they are to be used in cases of incomplete abortion.

The gynaecologist is very angry now too and threatens to resign. He tells the Superintendent that he has carried out only 10 terminations of pregnancy in the last 12 months, following assessment and recommendation by a psychiatrist. The psychiatrist's notes have been duly recorded in the case sheets. He points out that he receives 10 cases of incomplete abortion daily. Most of these are induced outside and have high rates of complications. He challenges the Superintendent to do something about that. He then realizes that angry words will not solve the problem...

Roles: Hospital superintendent, gynaecologist.

Annex 4

Questions

Session 6: ACTIVITY 6-1

1. Given societal norms, laws and policies, what can health-care workers do to prevent unsafe abortion?

Specifically, how can they:

- improve access to reproductive health information and services?
- create a climate conducive to contraceptive use for all sexually active adolescents?
- involve communities in discussions of the issues of unwanted pregnancy and the consequences of unsafe abortion, as well of their role in enabling adolescents to prevent these problems and to cope with them when they occur?

2. Given societal norms, laws and policies, what can health-care workers do to reduce the consequences of unsafe abortion when it occurs?

Specifically:

- how can a young person's confidentiality be respected in public hospitals where records and notes are difficult to protect from inquisitive eyes?
- if there are medical complications, under what circumstances should we inform parents or guardians?
- how should we build our own capacity to provide comprehensive abortion care including post abortion counselling and contraception?

3. What can health-care workers do to generate supportive norms and stimulate policy review and reform?

Specifically:

- to what extent should health-care workers conform to community beliefs and values if these conflict with principles such as availability and accessibility?
- how could you use existing legal avenues to expand access to safe abortion while pressing for review of existing laws?
- how could you involve communities in discussions of the issues of unwanted pregnancy and the consequences of unsafe abortion, as well of their role in enabling adolescents to prevent these problems and to cope with them when they occur?