



Adolescents, unwanted pregnancy and abortion

Policies, counseling and clinical care



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Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive-health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive-health choices.

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Executive Summary

The problem of unwanted adolescent pregnancies

While governmental and nongovernmental organizations (NGOs) are increasingly addressing prevention of adolescent pregnancies, a notable gap exists in policymaking and programming to address the *consequences* of unwanted adolescent pregnancies,¹ including abortion-related care.

Our first and foremost goal should indeed be to reduce unwanted adolescent pregnancies as much as possible. Nevertheless, eliminating teen pregnancy completely will be impossible because of cultural factors, adolescents' lack of knowledge about sexual and reproductive health, their lack of access to contraceptives, contraceptive failures, and the consequences of sexual assault. While many adolescents may choose to carry unplanned pregnancies to term, this document is concerned with the needs of adolescents who wish to terminate unwanted pregnancies. Where safe, legal abortion is available, adolescents may not know about it or they may face barriers in accessing high-quality care. This document does not "promote" abortion for adolescents, but acknowledges that abortion is legal for some circumstances in most of the world. It demonstrates that lack of access to safe abortion endangers young women's health and lives when they resort to unsafe methods to terminate their pregnancies. The fact that abortion remains a medical procedure surrounded by controversy should not prevent us from addressing this area of adolescent health care, since doing so will enable us to prevent avoidable morbidity and deaths among young women.

Accordingly, this document seeks to provide direction on policies, counseling and clinical care that can help prevent unwanted pregnancies and offer abortion-related care that is tailored to adolescents' needs. Some of the proposed recommendations are not only applicable to adolescents but are useful for the treatment of all women, but the issues highlighted are of special importance in making health care "youth-friendly". The topic of adolescent abortion care has been largely neglected in the international health arena, and no widely available documents have summarized accumulated experience on which recommendations can be based. Ipas hopes that the proposed recommendations in this document can serve as a point of departure for establishing standards regarding care of adolescents who choose to terminate their pregnancies.

This document was designed to serve persons responsible for formulating and implementing policies and health-care services for adolescents and young people. They include policymakers, policy advocates, medical care providers and counselors within the governmental, private and NGO sectors who work with adolescent issues or treat adolescent clients.

Unsafe abortion

Less than 5% of the poorest young people worldwide use modern contraceptive methods (UNFPA, 2003). On average, younger women are more fertile than older women; about 10% of pregnancies each year occur among teenagers (Senanayake & Faulkner, 2003; UNICEF, 2002). UNFPA reports that 10-14% of young unmarried women around the world have unwanted pregnancies (UNFPA, 2003) and at least 2-4.4 million abortions occur among adolescent women in developing countries each year (Treffers, 2002). Because adolescents are less likely to have information about abortion or resources to access safe services, they more often use unsafe methods when they try to self-induce an abortion, for example, by inserting objects into the vagina or uterus, using drugs or other toxic substances, or self-inflicting bodily harm to induce miscarriage. They also seek out unqualified providers and have abortions in unhygienic circumstances. Adolescents may more often delay seeking care for abortion-related complications due to lack of transportation, lack of knowledge about where postabortion care can be obtained, fears of censure from their parents and health-care providers, fear of legal repercussions, or lack of money to pay for services.

Women of young age, nulliparity and low socioeconomic status are at an increased risk of suffering morbidity and mortality due to unsafe abortion in comparison to other women. Where induced abortion is highly restricted by law, adolescents have the highest risks of suffering serious complications from unsafe abortions. Among women admitted to hospital for treatment of unsafe abortion complications, those aged under 20 years account for 38-68% of cases in many developing countries (Olukoya et al., 2001). These complications include cervical or vaginal lacerations, sepsis, hemorrhage, bowel or uterine perforation, tetanus, pelvic infections or abscesses, chronic pelvic inflammatory disease and secondary infertility.

Reproductive rights, laws and abortion

The UN Committee on the Rights of the Child, which monitors State compliance with the Convention on the Rights of the Child, has stated that governments must take measures to combat unsafe abortions among adolescents, urging “States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education” (Committee on the Rights of the Child, 2003).

In countries where abortion is permitted by law for a variety of indications, the majority of women who terminate pregnancies are married adults and already have children. However, in absolute terms, large numbers of adolescents also end their unwanted pregnancies. In some countries, laws establish specific ages before or after which abortion is legally permitted; other laws make more vague references to young or old age as an indication for allowing termination of pregnancy. Establishing specific ages before and after which abortion is legally permitted can eliminate barriers for adolescents who meet the requirements; however, it can limit access for adolescents who do not meet the specific age stipulations. Laws that are vague may leave interpretation up to the service provider or a judge; this may enable some adolescents to obtain a legal abortion but could potentially cause confusion for providers on how to apply such provisions or enable some providers to refuse to terminate a pregnancy.

Ideally, any young woman who faces an unwanted pregnancy should be able to count on her parents or guardians for support. It will be easier for an adolescent to confide in the adults who care for her if they have an open, loving and nonjudgmental relationship and if she does not fear negative repercussions such as censure, punishment, abandonment or coercion when seeking a solution to her problem.

While the support of parents, guardians or partners is desirable for young women facing unwanted pregnancies, some adolescents unfortunately fear involving their caregivers in decisionmaking around unwanted pregnancies; this may especially be the case when they have suffered sexual assault, particularly by family members. In such cases, young women may prefer to seek guidance from other adults, such as other family members or social welfare and health professionals. Nevertheless, this option is made difficult by laws that require parental consent for adolescent abortion. Such laws are in place in 24 countries. In some cases, laws requiring parental consent have judicial bypass options whereby teenagers who cannot or who do not want to involve their parents can obtain permission from a judge or administrator for the abortion. However, this procedure can be daunting and difficult for adolescents, particularly those with few resources and lacking supportive social networks.

Many countries permit adolescents to receive testing and treatment for sexually transmitted infections without parental notification or consent; many also consider adolescents who are mothers to be capable of making decisions regarding their children’s medical care. Since young women are considered mature enough to make decisions for their children, they should also be considered mature enough to make decisions about their own reproductive health. Where parental consent requirements and judicial bypass provisions are in place, service providers can mitigate the negative effects for adolescents by assisting them to navigate the legal system. For example, clinic staff can advise the young woman on where she needs to go to obtain a bypass, help her with necessary paper work, and accompany her to see the judge.

Given the increased vulnerability of adolescents to the consequences of unsafe abortion, respected professional agencies and associations, such as the American College of Obstetricians and Gynecologists and the Commonwealth Medical Trust, have declared that adolescents should have access to safe, legal abortion. The American Academy of Pediatrics has stated that: “Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care.... Minors should not be compelled or required to involve their parents in their decisions to obtain abortions, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults” (American Academy of Pediatrics, 1996).

The policy framework

Enhancing young people's access to sexuality and reproductive health information and services is essential to reducing unwanted adolescent pregnancies, and thus unsafe abortions. However, the service interventions recommended to accomplish this often require policy reforms, as national and local regulations often restrict such measures. Advocating for young people's rights to information and services can aid in policy change, resulting in the implementation of important service interventions. National and local policies need to mandate and enable the following interventions:

- prevention of unwanted pregnancies through provision of comprehensive sexuality education, elimination of barriers to adolescents' access to contraceptives and making emergency contraception easily accessible to adolescents
- provision of information on the risks of unsafe abortion and possibilities for safe, legal abortion through sexuality education and informational materials
- provision of comprehensive postabortion care that includes counseling on, and provision of, contraceptive methods and referrals to other reproductive health services
- provision of safe induced abortion services by: ensuring that local opposition to abortion and/or lack of knowledge does not impede implementation of laws that permit termination of pregnancy; eliminating unnecessary administrative requirements and medical regulations that impede adolescents' access to safe, legal abortions; and ensuring that abortion-related care is affordable and accessible for adolescent clients
- incorporating principles of youth-friendly services in facilities that offer abortion-related care to adolescents.

Psychosocial care

Many adolescents who seek an abortion have never had a pelvic examination, especially in developing countries where gynecological care before pregnancy is rarely sought. An adolescent's pregnancy might result from a first act of sexual intercourse, possibly forced or traumatic, or be due to sexual abuse that has left her hymen intact. Such possibilities are important for counselors to consider.

While providers may have numerous clients to see each day, quality of care is improved when sufficient time is taken to make adolescent patients feel comfortable and to address at least their most urgent needs in an adequate manner, since this may be the first time they have had any experience with reproductive health care services. In addition, they may process information differently than adults and may lack basic information to contextualize the information they receive; counseling adolescents therefore may require different approaches and more time than is usually allocated to adult clients. This document offers suggestions for such counseling, including examples of how questions may be phrased.

It is particularly important that counselors ensure confidentiality and privacy during sessions with adolescents seeking postabortion care or an induced abortion. It is further important that counselors inform all adolescent clients about their legal rights, as well as any legal obligations that providers might have to report certain issues to other authorities, such as sexual abuse or detected STIs.

When addressing contraception, the counselor should discuss a number of issues, including when the young woman's fertility will return, whether or not a patient who has had a miscarriage will want to become pregnant again quickly or will want to postpone this for some time, and which contraceptives will be most appropriate in meeting the young woman's needs. Information should also be given on emergency contraception and use of female and male condoms to prevent HIV/STI infection.

Counseling and clinical care

Most aspects of clinical care are the same for adult and adolescent patients, particularly in the case of teenagers 16-19 years old. However, clinicians can take special care when attending adolescents, both in preparing them for treatment and during the procedure itself. This document provides examples of such youth-oriented measures and recommendations for setting standards. For example, the pediatric dosages for drugs used in medical abortion have not yet been definitively established; if providers record the dosages they find most effective in adolescents, these data can contribute to evidence-based recommendations in the future.

Adolescents who have had an induced abortion should receive verbal, and if possible written, information in their vernacular language on signs and symptoms that might indicate a need for immediate follow-up care. It is important to give the young woman telephone numbers and addresses to which she can turn for emergency care or follow-up after an abortion (e.g., clinics, hotlines). Where resources are available, the counselor can give the young woman a packet of information including materials on contraception and contact information/referrals to agencies that can provide needed legal assistance and support groups for young women in her situation (e.g., survivors of sexual assault or women living with HIV).

After clinical treatment is completed, clinicians and counselors should be sure to ask young women about how they experienced the care given, since adolescents who are not treated sympathetically may be less likely to return for a follow-up examination. Investigating adolescent clients' satisfaction can also help providers maintain the quality of their services. This may be done through voluntary client exit interviews or by encouraging adolescents to write feedback letters.

Conclusion

Unwanted pregnancy in adolescents is an issue that must not be ignored. Many pregnant adolescents will want or need to end a pregnancy to avoid risks to their lives and health, psychological trauma, and socioeconomic turmoil. Because adolescents face certain risks in pregnancy and abortion not experienced by older women, special care should be taken to address their needs.

Implementation of the proposed recommendations can assist policymakers and care providers in meeting the special needs of adolescents faced with unwanted pregnancies and the decision to have an abortion. Moreover, documenting the impact of measures in the policy and service provision arenas can serve as a first step towards establishing evidence-based norms for adolescent abortion-related care.

Preface

“We are determined to eliminate all forms of discrimination against the girl child throughout her life cycle and to provide special attention to her needs in order to promote and protect all her human rights, including the right to be free from coercion and from harmful practices and sexual exploitation. We will promote gender equality and equal access to basic social services, such as education, nutrition, health care...”

United Nations General Assembly, 2002

With the words above, leaders of the world’s nations joined together in 2002 at the United Nations General Assembly Special Session on the Child to affirm that adolescent girls need special attention in policymaking and service provision (UN General Assembly, 2002). One area in which such attention is especially warranted is that of too early and unwanted pregnancies and their consequences. While governmental and nongovernmental organizations (NGOs) are increasingly addressing prevention of adolescent pregnancies, a notable gap exists in policymaking and programming to address the consequences of unwanted adolescent pregnancies, including abortion-related care.

Our first and foremost goal should indeed be to reduce adolescent pregnancies insofar as possible. Nevertheless, eliminating them completely will be impossible because of cultural factors, adolescents’ lack of knowledge about reproductive health, their lack of access to contraceptives, contraceptive failures, and the consequences of sexual assault. Many adolescents who have unwanted pregnancies do not want to carry them to term. This document does not “promote” abortion for adolescents but acknowledges that abortion is legal for some circumstances in most of the world. It demonstrates that lack of access to safe abortion is endangering young women’s health and lives when they resort to unsafe methods to terminate their pregnancies.

The fact that abortion remains a medical procedure surrounded by controversy should not prevent us from addressing this area of adolescent health care, since doing so will enable us to prevent avoidable morbidity and deaths among young women. This document seeks to provide direction on policies, counseling and clinical care that can help prevent unwanted pregnancies and offer abortion-related care that is tailored to adolescents’ needs. Some of the proposed recommendations are not only applicable to adolescents but are useful for the treatment of all women, but the issues highlighted are of special importance in making health care youth-friendly, that is, adapted to meet the needs and wishes of adolescent clients.

Why is this document needed?

Many resources related to adolescent sexual and reproductive health tend to neglect termination of pregnancy, perhaps due to fears that addressing it might be construed as promoting abortion. However, avoiding discussion of abortion does not eliminate its causes or incidence. Rather, it contributes to a silence that endangers the health and lives of young women who decide not to carry their pregnancies to term. This document seeks to fill that gap by summarizing available data and recommendations on abortion-related policies and care cited in the literature and by experts in the field. Ipas hopes that the proposed recommendations can serve as a point of departure for establishing an evidence base of accumulated experience and standards regarding care of adolescents who choose to terminate their pregnancies.

For whom is this document intended?

This document was designed to serve persons responsible for formulating and implementing policies and health-care services for adolescents and young people in both industrialized and developing countries. They include policymakers, policy advocates, medical care providers and counselors within the governmental, private and NGO sectors who work with adolescent issues or treat adolescent clients.

How is this document organized?

The Introduction begins with an overview of adolescent pregnancy and the risks it entails for girls and young women. It goes on to discuss reproductive rights for adolescents as outlined in international policy statements and presents information on unsafe and induced abortion among adolescents, including information on laws in selected countries.

The Policy Framework section describes measures that can be taken to: prevent unwanted pregnancies among adolescents, provide adolescents with information on abortion, make comprehensive postabortion care available, and enable adolescents to access safe, legal induced abortion services.

The Counseling and Clinical Care section presents recommendations on psychosocial and clinical care collected from various sexual and reproductive health sources. Topics addressed include: pre- and post-procedure counseling for postabortion care and induced abortions, counseling specific to induced abortion care, and clinical care before, during and after abortion procedures.

The Appendices include citations from human rights documents on adolescent reproductive health, summaries of national-level laws pertaining to adolescent abortion, and training and counseling tools. A final section provides a list of useful resources for policymakers, researchers, counselors, care providers and adolescents themselves.

How can this document be used?

This document provides information and resources for advocacy, policy formulation, and implementation of psychosocial and clinical care; it also offers materials that can be used in training providers on abortion care for adolescents. We hope that the recommendations presented here can be further tested in practice so that eventually evidence-based standards and guidelines can be more firmly established and customized for different settings.

While those working in adolescent reproductive health must remain committed to reducing too early and unwanted adolescent pregnancies insofar as possible, they must also acknowledge that such pregnancies occur and need to be managed in ways that serve girls' and young women's best interests. Ipas hopes that this document will help policymakers and program implementers ensure that girls and young women who choose to terminate unwanted pregnancies can readily obtain high-quality, comprehensive health care.

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Introduction

Adolescent pregnancy

Background information

Adolescents aged 10-19 years comprise about one-fifth of the world's population, which is equivalent to 1.2 billion young persons (UNFPA, 2003). About 87% of these young people live in developing countries and, in 2000, 22.5% of the world's youth were surviving on less than US\$1 per day (UNFPA, no date). In the Latin America/Caribbean region, 15 million young people are living in extreme poverty; this is also the case for 51 million youth in East Asia and the Pacific, 60 million in sub-Saharan Africa and 106 million in South Asia (UNFPA, no date).

Less than 5% of the poorest young people worldwide use modern contraceptive methods (UNFPA, 2003). On average, younger women are more fertile than older women (Nevada State Health Division, 2001), and about 10% of pregnancies each year occur among teenagers (Senanayake & Faulkner, 2003; UNICEF, 2002). The worldwide average rate of births per 1000 young women aged 15-19 years is 65, with average rates of 25 in Europe, 56 in the Middle East and North Africa, 59 in Central Asia, 78 in Latin America, and 143 in Sub-Saharan Africa (Treffers, 2002). About 14 million young women of 15-19 years give birth every year (UNFPA, no date).

Most reports on adolescent pregnancy refer to women aged 15-19 years. Nevertheless, many girls reach puberty at a younger age and are therefore able to become pregnant. The Pan American Health Organization (PAHO) reports that in the Latin American and Caribbean region, menarche occurs on average between the ages of 9-11 years and that first sexual intercourse may occur within two years of a girl's first period (Schutt-Aine & Maddaleno, 2003). It may take place earlier, however; in the last few years, cases of pregnancies in girls as young as 8-10 years have been reported in Brazil and Costa Rica (BBC, 1998; López Vigil, 2003). A 1992-1993 study in the United States among girls aged 3-12 years who visited pediatricians found that 48.4% of black and 14.5% of white girls were in puberty² by the age of 8 years; the average age at menarche was 12.2 and 12.9 years, respectively (Conard & Blythe, 2003). The authors of that study proposed establishing new guidelines for health-care providers on defining precocious (premature) puberty, a recommendation that would be relevant in other countries as well.

Adolescent girls have both intended and unintended pregnancies. Through planned pregnancies, they often fulfill a wish to be able to love, nurture and raise a child. Girls who marry young may begin childbearing soon after marriage because of familial and societal expectations; globally, most adolescent pregnancies occur within marriage (UNICEF, 2002; Greene et al., 2002). Unmarried adolescents may see motherhood as a way to achieve adult status or as a strategy to get a sexual partner to care for or marry them.

While some adolescent pregnancies are planned, the rates of unplanned pregnancies among adolescents can be very high; for example, in the Latin America and Caribbean region, 35-52% of adolescent pregnancies are unplanned (Schutt-Aine & Maddaleno, 2003). Unplanned pregnancies are the result of various factors, including a lack of knowledge about menstruation and pregnancy, a lack of access to, and knowledge about how to use, contraceptives; difficulties in using contraceptives because of a partner's or family objections; contraceptive failure; and sexual assault.

Worldwide, up to one-third of women report their first sexual experience as being forced (Jewkes et al., 2003). Estimates of the number of pregnancies resulting from coerced sex vary. A US study that followed over 4,000 women for three years found a 5% rape-related pregnancy rate among women aged 12-45 years; pregnancies reported as a result of sexual assault by rape victims in Mexico and Ethiopia affected 15-18% and 17% of women, respectively (Jewkes et al., 2003). Many women suffering sexual assault are adolescents who are raped by perpetrators known and often related to them (Holmes et al., 1996; Garza-Aguilar & Diaz-Michel, 1997; Martínez-Ayala et al., 1999); they face particular challenges in addressing and managing the consequences. Considerable numbers of adolescents are living without the support of one or both parents, such as young people who are in migrant families or who are refugees. In addition, at least 13 million

children worldwide have been orphaned due to AIDS, and estimates of the number of street children range from 100-250 million (UNFPA 2003). These adolescents are particularly vulnerable to sexual exploitation and sexual assault.

"A rights-based approach would not separate teenage pregnancy from other aspects of sexual and reproductive health as the risk of infection and coercion are also key to the individual whether or not they are at risk of unwanted pregnancy."

Senanayake & Faulkner, 2003

Adverse outcomes of adolescent pregnancy

Even when pregnancies are planned, they may have adverse consequences for adolescents. In some countries, adolescent motherhood is linked to poverty. For example, in Honduras, where adolescents account for 15% of all births, associations have been found between adolescent maternity, being a female head of household and low income levels (United Nations, 2004). Girls who marry young are likely to have children in quick succession, without sufficient birth spacing to protect their health (UNICEF, 2002). Studies in various countries have documented that pregnant adolescents are less likely to seek prenatal care than older women (Reynolds & Wright, 2004). A World Health Organization (WHO) literature review concluded that considerable numbers of adolescents do not receive adequate prenatal care because they attempt to hide pregnancies, are embarrassed or dissatisfied with health services, and encounter financial barriers (Treffers, 2002).

The same review found that pregnant teenagers are not more likely than women aged 20 years or older of the same parity to suffer from pregnancy-induced hypertension, and that they do not generally have more complicated labor than older women (Treffers, 2002). Nevertheless, pregnancy during adolescence does carry potential health risks. Conditions such as anemia, iodine deficiency and malaria, which may contribute to adverse pregnancy outcomes, are found frequently among young women living in underprivileged circumstances. Adolescents younger than 15 years are more likely than older women to have miscarriages and stillbirths (Senderowitz et al., 2002). In addition, adolescent births are often first births, which are riskier than second-fourth deliveries (Center for Communications Programs, 1995); for example, women are more susceptible to malaria during their first pregnancies (Reynolds & Wright, 2004). An adolescent younger than 17 years may not yet be physically mature; when her pelvic bones and birth canal have not fully developed, the pelvis may be too narrow to accommodate the baby's head and she may suffer prolonged or obstructed labor, increased risks of hemorrhage and infection, or permanent danger to her bladder and bowels (Eure et al., 2002; Senderowitz et al., 2002; Treffers, 2002). Young women who are malnourished and have small pelvic widths are especially susceptible to vesico-vaginal and recto-vaginal fistulas as a result of obstructed labor; fistula is most common in very poor countries of Africa where child marriage is common (Geoghegan, 2004). In nine African countries it was found that many affected women are younger than 20 years, some even being as young as 13 years (Bacon, 2003). Reports of fistulas in young women have also come from Central America (McNaughton, 2004).

The United Nations Children's Fund (UNICEF) has stated that deaths during childbirth are twice as likely for teens aged 15-19 years than among women aged 20-24 years (UNICEF, 2000). In Mali, the maternal mortality ratio is 178 per 100,000 births in women aged 15-19 years compared to 32 for women aged 20-34 years. In Togo, the respective rates are 286 and 39, and in Guatemala the rate is 35 for women aged 15-19 years compared to 5 for those 20-24 years old (Mathur et al., 2003). Girls aged 10-14 years may be five times more likely to die during childbirth than women 20-24 years old (Holschneider, 1998).

According to studies in industrialized countries, younger adolescents tend to have a higher prevalence of adverse pregnancy outcomes such as premature births and low birth weight babies than older women (Satin et al., 1994; Fraser et al., 1995; Jolly et al., 2000). The babies of young mothers may also suffer high mortality rates (UNICEF, 2002). A US study on women aged 12-29 years having their first child found that the risk of death was greater for babies born to mothers 15 years or younger than for mothers aged 23-29 years; the rates of postnatal deaths potentially due to neglect or abuse were highest among the younger age group (Phipps et al., 2002).

Reproductive rights and abortion

Article 24 of the Convention on the Rights of the Child, which has been ratified by all UN member states except Somalia and the United States, established the right of children and adolescents to health care (United Nations, 1990). The UN Committee on the Rights of the Child, which monitors State compliance with that Convention, has expressed its concern that “early marriage and pregnancy are a significant factor for health problems related to sexual and reproductive health” and has said that governments should provide adolescents with access to information on contraception and the dangers of early pregnancy without requiring prior consent from parents or guardians (Committee on the Rights of the Child, 2003). The Committee further stated that governments must take measures to combat unsafe abortions among adolescents, urging “States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education” (Committee on the Rights of the Child, 2003).

In developing a new conceptual framework to address adolescent sexual health and development, PAHO has taken such recommendations into account. In describing sexually healthy adolescents, they say that such young people will “practice abstinence or use contraceptives effectively to avoid unintended pregnancy...[and] act consistent[ly] with one’s own values in dealing with an unintended pregnancy” (Schutt-Aine & Maddaleno, 2003).

Excerpts from other human rights documents relevant to adolescents’ reproductive health can be found in Appendix 1.

Unsafe abortion

In 2000, 94 girls aged 15-19 years participated in focus groups in rural Kenya to express their views about premarital pregnancies and HIV/STIs. They indicated that such pregnancies are usually unwanted and that a common way of dealing with them was to have a clandestine abortion, either self-induced or by a licensed or unlicensed medical practitioner found at the local marketplace. The techniques used included drinking concoctions made of animal dung or herbs, inserting crude tools into the vagina and overdosing on antimalarial drugs (Nzioka, 2004). A 2002-2003 research project in Kenya with secondary school students in Nairobi found that only 14% of students knew that pregnancy can be legally terminated in Kenya to preserve a woman’s or girl’s health, yet 45% of students reported knowing of a peer who had had an abortion (Mitchell et al., 2003).

Such scenarios are being repeated worldwide. The United Nations Population Fund (UNFPA) reports that 10-14% of young unmarried women around the world have unwanted pregnancies (UNFPA, 2003). It is currently estimated that at least 2-4.4 million abortions occur among adolescent women in developing countries each year (Treffers, 2002). The reasons that adolescents terminate pregnancies, even when abortion is prohibited by law include (Olukoya et al., 2001; Moore et al., no date):

- becoming pregnant as a result of incest or sexual abuse
- becoming pregnant due to lack of contraceptive use or contraceptive failure
- fears of upsetting parents or bringing shame to the family
- fears of expulsion from the family home, school or jobs
- lack of a stable relationship
- fears of difficulty in finding a marriage partner (in areas where men prefer to marry virgins)
- lack of financial means to care for a child
- a desire to complete their education or achieve other goals
- already having a young child for which to care
- disliking the man who caused the pregnancy or having a poor relationship with him.

Women of young age, nulliparity and low socioeconomic status are at an increased risk of injury and death due to unsafe abortion in comparison to other women. Where induced abortion is highly restricted by law, adolescents have the highest risks of suffering serious complications from unsafe abortions (Treffers, 2002). If a teenager decides to opt for an abortion, she might only do so at a later stage of pregnancy when the risk of

complications is higher (Olukoya et al., 2001). Adolescents may postpone having abortions until after the first trimester because they do not recognize or acknowledge the pregnancy, they fear the abortion procedure or parental reactions, or they need time to find money to pay for the procedure (Paul et al., 1999). Because of school or work commitments and lack of experience with the health-care system, young women may also find it difficult to find, and make appointments with, service providers. Clinicians in the United States have noted that clients who seek abortions at 12-18 weeks of pregnancy tend to be younger than those who seek abortions earlier in pregnancy (Castleman, 2003). The Women's Reproductive Rights Assistance Project in Los Angeles, California, which provides financial assistance to women seeking abortions, found that, in 2003, girls aged 10-17 years had the highest percentage of pregnancies over 20 weeks when they sought an abortion, often because the pregnancies were discovered at a late stage; a similar project in Seattle, Washington, found that 80% of the girls aged 12-17 years who they helped in 2002-2003 were in their second trimester when they sought assistance to terminate their pregnancies (Towey & Poggi, 2004).

Adolescents differ from adult women regarding induced abortion in the following ways:³

- Because adolescents are less likely to have information about abortion or resources to access safe services, they more often use unsafe methods when they try to self-induce an abortion. They may insert objects into the vagina or uterus, use drugs or other toxic substances, or attempt to induce a miscarriage through bodily harm (e.g., throwing themselves down a flight of stairs).
- Adolescents will more often resort to treatment by unskilled providers.
- Some young women do not recognize pregnancy at earlier stages. For this reason and because of fears of stigmatization and discrimination, lack of money to pay for an abortion, and attempts to initially self-induce an abortion, adolescents tend to delay seeking abortion-related care from qualified providers.
- Adolescents may more often delay seeking care for abortion-related complications due to lack of transportation, lack of knowledge about where postabortion care can be obtained, fears of health-care providers' attitudes, or lack of money to pay for services.
- Adolescents are likely to experience isolation and emotional stress because of a frequent lack, or perceived lack, of support from their parents or partners.

Thirteen studies from seven sub-Saharan African countries showed that 39-72% of women treated for abortion-related complications were adolescents (Holschneider, 1998). The Society of Gynaecologists and Obstetricians of Nigeria estimates that about 10,000 (50%) of the Nigerian women who die from unsafe abortions each year are adolescents, and abortion complications are responsible for 72% of all deaths among teenagers below the age of 19 years (Raufu, 2002).⁴

"Yemmi Samta [a woman in Ethiopia] didn't know that her 14-year-old-daughter, Saron, was pregnant until she found her unconscious and bleeding profusely on the dirt floor of her ramshackle house. Samta begged a neighbor to load Saron onto a donkey cart and take her to the nearest clinic, 12 miles away. But the girl died on the way from septicemia, a form of blood poisoning, and loss of blood caused by an illegal abortion. 'I held her and pleaded to God not to take her,' Samta recalled. 'God took her to his arms, and I saw the life go from her body.'" (Anonymous, 2003)

One study in Indonesia showed that 40% of village women seeking abortions were young unmarried women (Hardee et al., 2003). In India, where abortion is legally permitted in the first 12 weeks of pregnancy, it was found that 50% of maternal deaths among girls aged 15-19 years were due to unsafe abortions (Advance Africa, 2003). One-third of women who develop serious abortion-related infections in Latin America and the Caribbean are adolescents (Diaz, 1999); in Argentina and Chile, more than one third of maternal deaths among adolescents are due to complications of unsafe abortions (Miranda, 2003; Schutt-Aine & Maddaleno, 2003, United Nations, 2004).

Women younger than 20 years account for 38-68% of patients admitted to hospitals for treatment of unsafe abortion complications in many developing countries (Olukoya et al., 2001). These complications include: cervical or vaginal lacerations, sepsis, hemorrhage, bowel or uterine perforation, tetanus, pelvic infections or abscesses, chronic pelvic inflammatory disease and secondary infertility (WHO, 1994; Olukoya et al., 2001). Furthermore, many new cases of HIV infection are occurring among adolescents and young adult women, especially in African countries that impose legal restrictions on termination of pregnancy. It is not unreasonable to assume that the severity of post-abortion complications may be higher in HIV-positive young women whose immune systems are already compromised.

Induced abortion

In countries where abortion is permitted by law for a variety of indications, the majority of women who terminate pregnancies are married adults and already have children. However, in absolute terms, large numbers of adolescents also terminate unwanted pregnancies. It has been reported that 35% of pregnant teenagers in the USA choose to terminate pregnancies (Dudley, 2003). In Vietnam, one study found that 37% of pregnancies among young women in 2000 ended in abortion (Khuat, 2003), while a survey in Taiwan reported that 90.8% of extramarital pregnancies among women aged 15-30 years were terminated (Wu, 2003).

"Abortion is legal in Latvia but our job is to decrease the number of unwanted pregnancies which lead to abortion through sex education and information. Every week, questions like 'I am pregnant. I want to know where can I go for abortion and how much it costs' are received in our hot e-mail."

*Lasma Lidaka, Latvia's Association for Family Planning
and Sexual Health (IPPF, 2003)*

Age and legal abortion

Most countries permit abortion by law for at least some indications, such as pregnancies resulting from rape and incest, pregnancies that may endanger a woman's health or life, or pregnancies involving fetal abnormalities; in more than 50 countries, abortion is available to women at their request, at least in the first trimester (Center for Reproductive Rights, 2003).

In some countries, laws establish a specific age before or after which abortion is legally permitted; other laws make more vague references to young or old age as an indication for allowing legal termination of pregnancy. **Austria's** Penal Code specifies a number of circumstances under which abortion can be legally provided, including pregnancy of a woman younger than 14 years of age (Austria, 1974). In addition to a number of other grounds, **Finland's** law permits abortion at a woman's request "if she was less than 17 or more than 40 years of age at the time of conception, or has already had four children" (Finland, 1970). The decision to perform an abortion is made by the operating physician up to the 12th week of pregnancy for adolescents younger than 17 years seeking to terminate their pregnancies. Although the Finnish law prohibits abortion beyond the 12th week of pregnancy unless the woman's health is endangered, it makes an exception for women under the age of 17, in which case the State Medical Board can authorize abortion up to the 20th week. However, the law imposes potential barriers by stating that before an abortion is carried out, the father of the fetus, the woman's guardian, and, if the case may be, the physician or director of any public institution of which the pregnant woman is an inmate, "shall be given an opportunity of stating their opinion, if this seems justified in the particular case."

The Penal Code of **Liechtenstein** permits termination of pregnancy by a physician when the pregnant woman “has not at any time been married to the man who impregnated her and was not [yet] at the time of conception fourteen years old” (Liechtenstein, 1987). Termination of pregnancy is also allowed to protect the life and health of the woman. The law potentially places restrictions on adolescents’ access to services by stipulating that anyone who “publicly, with the intention to promote abortion offers his own or someone else’s services or announces, recommends or exhibits means, devices, or procedures or otherwise makes them accessible” will face a fine or imprisonment up to one year. Such stipulations can make identifying services difficult, especially for adolescents who already face challenges in accessing reproductive health care.

Establishing specific ages before and after which abortion is legally permitted can eliminate barriers for adolescents who meet the requirements; however, it can limit access for adolescents who do not meet the specific age stipulations. Laws that are vague may leave interpretation up to the service provider or a judge; this may enable some adolescents to obtain a legal abortion but could potentially cause confusion for providers on how to apply such provisions or enable some providers to refuse to terminate a pregnancy. For example, the Crimes Act of **New Zealand** permits abortion up to the 20th week of gestation for a broad range of circumstances; pregnancies occurring “near the beginning or the end of the usual child-bearing years” may be considered to constitute a threat to a woman’s health (New Zealand, 1961). Abortion is also permitted beyond the 20th week if the person doing the procedure believes it is necessary to protect a woman’s life or physical or mental health.

Even where abortion is not available on request or the law does not specify young age as an indication for pregnancy termination, a mental health indication could be interpreted to apply to a young woman or adolescent who wishes to terminate a pregnancy on the grounds that denial of services may jeopardize her mental health. In Great Britain, the Bourne decision of 1938 set such a precedent when a physician was acquitted of a criminal act for performing an abortion for a young adolescent. The presiding judge found that if the patient, a rape survivor, was forced to carry the pregnancy to term, it “would make the woman a physical or a mental wreck” (Childbirth by Choice Trust, 1995). In British Commonwealth countries, the Bourne decision could be used as a precedent for applying the health indication to permit abortions for adolescents; however, some Commonwealth countries have declared the decision to be inapplicable (United Nations, 2002).

Some laws specifically discuss age as part of their mental health indication for legal abortion. **Hong Kong’s** Offenses against the Person Ordinance permits abortion if two registered medical practitioners are of the good faith opinion that the abortion is necessary to preserve the life or physical or mental health of the pregnant woman, or in the case of fetal abnormality (Hong Kong, no date). The Ordinance states that in determining the risk to the woman’s health, “account may be taken of the pregnant woman’s actual or reasonably foreseeable environment” and gives a few examples, including pregnancy in a woman under the age of 16 or pregnancy as the result of rape. The Termination of Pregnancy Act of **Zambia** permits abortion to preserve the life and physical and mental health of the pregnant woman, as well as the health of her existing children. In determining the potential injury to health, consideration can be given to a pregnant woman’s “actual or reasonably foreseeable environment or of her age” (Zambia, 1972).

Parental consent and consultation

Ideally, any young woman who faces an unwanted pregnancy should be able to count on her parents or guardians for support. It will be easier for an adolescent to confide in the adults who care for her if they have an open, loving and nonjudgmental relationship and if she does not fear negative repercussions such as censure, punishment, abandonment or coercion when seeking a solution to her problem.

Unfortunately, some adolescents do not have such relationships with their caregivers and do fear involving them in decisionmaking around unwanted pregnancies. In such cases, they may prefer to seek guidance from other adults, such as other family members or social welfare and health professionals. Nevertheless, this option is made difficult by laws that require parental consent for adolescent abortion; such laws exist in 24 countries (Appendix 2).

In the **United States**, the Supreme Court *Roe v. Wade* decision protects women’s right to abortion under the right to privacy, making any state law that prohibits abortion unconstitutional. However, states can impose regulations on the provision of abortion services, such as implementing waiting periods, limiting the stage of pregnancy in which an abortion can be obtained, and requiring parental involvement. Up to the end of 2003, 44 states had adopted laws requiring young pregnant women to obtain parental consent or to notify

one or both parents before having an abortion. In nine of those states, these laws are either enjoined or not enforced, and many provide for a court bypass if a minor, usually a woman under the age of 18, is unable to notify her parents or obtain consent. Ten states with parental involvement laws offer alternatives, including notification of or consent by another relative, physician-authorized waiver, or special counseling requirements, and many states allow for exemption in the case of an emergency (Center for Reproductive Rights, November 2003).

A few countries encourage, but do not require parental involvement (Appendix 2). In **France**, minors⁵ seeking abortion are obliged to see a trained, qualified counselor and obtain a document attesting to the consultation. At least one week after counseling, the minor must then present consent for the procedure from a parent or her legal representative. However, if the minor wishes to maintain confidentiality or has not obtained consent, she can choose to terminate her pregnancy and receive any associated medical treatment and care at her request if she is accompanied by an adult of her choice (France, no date). Laws of other countries – including Equatorial Guinea, Kuwait, Nicaragua, Saudi Arabia and Syria – do not mention adolescents but could be interpreted as requiring parental consent for abortion.

Some countries mention the special needs of adolescents in their abortion laws. **South Africa's** Choice on Termination of Pregnancy Act, which emphasizes reproductive choice and human rights in its preamble, permits abortion within the first 12 weeks of pregnancy upon request, up to the 20th week to protect the life and physical and mental health of the woman, in cases of rape, incest or fetal abnormality, and on socioeconomic grounds, and beyond the 20th week if the woman's life and health are at risk or in case of severe fetal abnormality (South Africa, 1996). The law states that "in the case of a pregnant minor," the provider "shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of pregnancy shall not be denied because such minor chose not to consult them." The law defines a minor as a female under the age of 18 and designates rape to include statutory rape as defined by the Sexual Offences Act.

Advocacy for adolescents' access to safe, legal abortion

Given the increased vulnerability of adolescents to the consequences of unsafe abortion, respected professional agencies and associations have declared that adolescents should have access to safe, legal abortion (American College of Obstetricians and Gynecologists, 2003; Commonwealth Medical Trust, no date A & B). In the United States, Medical Students for Choice aims to ensure that women of all ages have access to safe legal abortion by making reproductive health care, including abortion, part of standard medical education and residency training (Medical Students for Choice, no date).

"Girls in developing countries may frequently be expelled from school if they become pregnant following which they will have to earn money from available sources, which may be limited to commercial sex, drug peddling or other occupations hazardous to their health. Too often their only recourse is to unsafe abortion. Health professionals should try to help girls to avoid these adverse consequences to their health by providing them with family planning counselling and services whenever necessary, and with safe termination of pregnancy whenever it is appropriate and permitted by law."

The Commonwealth Medical Trust (No date B)

Young people are also advocating for such access. In the United States, members of Spiritual Youth for Reproductive Freedom lobby university campus decisionmakers to adopt pro-choice policies and to ensure that student health clinics provide information on contraception and abortion services (Spiritual Youth for Reproductive Freedom, no date). In Mauritius, where abortion may only be permitted to save a pregnant woman's life, 500 students participated in a mock parliamentary debate on a "Termination of Pregnancy Bill". The Minister of Health and Quality of Life opened the session, which took place in September 2002, and the Minister of Women's Rights, Child Development and Family Welfare gave the keynote address. The debate was televised, stimulating discussion in the print and broadcast media, and the "bill" (adopted by 56 of the 72 youth parliamentarians) was delivered to the Speaker of the National Assembly (Touré & Melesse, 2003). In November 2003, the International Planned Parenthood Federation (IPPF) Youth Working Group,



comprising representatives from Belgium, Brazil, Bulgaria, China, Colombia, Denmark, the Dominican Republic, India, Kenya, Lebanon, Malaysia, Namibia, the Philippines, and Sri Lanka, met to discuss how family planning associations (FPAs) around the world can address abortion care for young women. Their recommendations included ensuring that the topic of young people and abortion be included in the international advocacy agenda, urging FPAs to integrate issues concerning young people and abortion in their quality of care programs, and developing minimum standards on what FPAs should do regarding young people and abortion (Braeken et al., 2003).

The policy framework

An increasing emphasis among policymakers in many countries on abstinence-only sex education can mask the problem of teenage pregnancy and its adverse consequences. Reproductive health experts therefore recommend forming broad coalitions from a cross-section of society to acknowledge and manage adolescent pregnancy in relation to education, unemployment, culture, and physical and mental well-being (Olukoya et al., 2001). A number of policy measures can be taken to address too early and unwanted adolescent pregnancies and unsafe abortions: they include preventing unwanted pregnancies and provision of information on abortion, comprehensive postabortion care, and safe, legal induced abortion services.

Preventing unwanted pregnancy

Statistical data show that there is an urgent need to implement policy measures that can contribute to preventing unwanted pregnancies and consequent abortions, especially unsafe abortions (Olukoya et al., 2001; NARAL Pro-Choice North Carolina, no date A & B). The following elements can contribute to appropriate policies.

Comprehensive sexuality education

Research on abstinence-only sex education programs, which bar discussion of contraceptive options, has shown that such programs do not have a significant impact in promoting behaviors that prevent unintended pregnancies. For example, a US study on programs in which youth pledge to remain virgins until they marry showed they abstained from sex for 18 months on average but were one-third less likely than non-pledging peers to use contraceptives when they did become sexually active (Bearman & Brückner, 2004). On the other hand, comprehensive sexuality education, which discusses the benefits of both delaying sexual intercourse and of using condoms and contraceptives when adolescents become sexually active, has been shown to contribute to adolescents delaying the onset of sexual intercourse, reducing the number of their sexual partners and increasing use of contraceptives, including condoms (Schutt-Aine & Maddaleno, 2003; SIECUS, 2004).

An important measure is therefore to advocate for and establish policies mandating that comprehensive sex education be offered to all adolescents. This is especially important in countries where conservative groups are influencing policymakers and legislators to endorse abstinence-only over comprehensive sexuality education, even when the majority of citizens may actually favor the comprehensive approach. For example, in the United States, comparison of two nationally representative surveys conducted in 1988 and 1999 showed that sexuality education in public secondary schools became increasingly abstinence-focused even though a majority of teachers (78-93%) believed that such education should include information usually included in comprehensive sexuality education (Darroch et al., 2000). A 2003 nationally representative survey of the general public and parents in the United States showed that only 15% of respondents believed that school programs should teach only about abstinence (National Public Radio et al., January 2004).

In The Netherlands, the emphasis in comprehensive sexuality education is pragmatic rather than moralistic. By the time they are 17 or 18 years old, about half of Dutch youth have begun to have sexual intercourse and adults acknowledge that they are sexually active. The focus of sexuality education is accordingly on promoting responsibility for one's own behavior and health and responsibility for one's sexual partners. Adolescents are able to access contraceptives (including emergency contraception), counseling, HIV/STI diagnosis and treatment, prenatal care and safe, legal abortions through their family doctors and special clinics. The results of this approach are that 85% of Dutch youth use contraceptives during their first sexual experiences, the pregnancy rate for girls aged 15-19 years is low (14.1 per 1,000 women), and the abortion rate is one of the lowest in the world (8.6 per 1,000 pregnant women).

Braeken et al., no date

Elimination of legal and regulatory barriers to the provision of contraception

A second important policy measure is the elimination of legal and regulatory barriers to the provision of contraception to teenagers, including emergency contraception. Such barriers include provisions that prohibit adolescents from obtaining contraception and condoms at health clinics, pharmacies and schools, and that mandate parental notification or consent when teenagers attempt to access contraceptives. It is particularly important that adolescents receive contraceptive counseling following abortion-related care.

Emergency contraception should be available at all levels of the health-care system and, where possible, as an over-the-counter medication. Studies in the United States have shown that increased use of emergency contraception contributed substantially to an 11% decrease in abortion rates from 1994-2000 (Jones et al., 2002).

Youth-friendly services

It is further essential to advocate for health services designed to meet adolescents' needs. It may be assumed that adolescents will more likely seek sexual and reproductive health care when they are able to access youth-friendly services characterized by a welcoming, non-judgmental setting that offers a range of services such as sexuality education; contraceptive counseling and provision; HIV/STI diagnosis, testing and treatment; pregnancy testing and information about abortion. A youth-friendly service will also have information materials available on youth programs that address issues such as self-esteem and self-respect, decisionmaking, and negotiation in romantic and sexual relationships.

The Planned Parenthood Association of Ghana (PPAG) established a Young and Wise Centre in Accra in January 2001 that includes a youth clinic, counseling unit, main hall, library and computer center and offers educational, artistic and entertainment activities in addition to health care. Trained young people manage the Centre, which offers HIV counseling and testing, STI testing and treatment, contraceptive services including emergency contraception, pregnancy testing and postabortion care. The Centre served 2,646 clinic clients during its first eight months.

Moya, 2002

In Lima, Peru, the Peruvian Institute for Responsible Parenthood (INPPARES) set up Youth Empowerment Stations (YES!) in four low-income neighborhoods to reach marginalized youth. Young people designed the stations, which are staffed by peer educators who produced information, education and communication (IEC) materials and educational games covering issues such as self-esteem, decisionmaking, conflict resolution, relationships, sexuality, HIV/STIs and contraceptives. They also helped design and produce a CD-ROM that gives users the chance to make decisions in the story of an unmarried couple that becomes pregnant.

Senanayake & Faulkner, 2003

Provision of information on abortion

Because of the controversies surrounding abortion, this topic is often avoided in information and education for adolescents or it is addressed only in terms of the dangers of unsafe abortions. For example, in the United States, the influence of anti-abortion advocates has made it appear that most people are against informing adolescents about the possibility of pregnancy termination. However, a nationally representative survey of sexuality education teachers in 1999 found that 89% believed that students should have received factual information about abortion by the time they reach grade 12, while 84.4% thought schools should have taught students about ethical issues related to abortion by that grade (Darroch et al., 2000). A 2003 nationally representative survey of the general public in the United States, which included an over-sampling

of parents, showed that 85% of respondents believed that it was appropriate to address the topic of abortion in middle and high schools; 91% of respondents believed the topic was appropriate for middle schools and 83% believed this for high schools (National Public Radio et al., 2004).

Policies should ensure that steps are taken to inform young people about abortion in a factual and neutral manner and permit the following measures:

- Incorporation of information on pregnancy termination in sexuality education for young people. Even in countries where legal abortion is highly restricted, adolescents should be told when pregnancies can be legally terminated, even if this is only in cases of rape and incest. It should be emphasized that unsafe abortions increase morbidity and mortality risks, while safe and early abortion is a very low risk procedure. Such information can help combat myths about safe, legal abortion, which is especially important to ensure that young women are not prevented from accessing this service because of mistaken beliefs.
- Enabling adolescents to gain access to reproductive health services that combine neutral counseling on pregnancy diagnosis and pregnancy outcome options (parenting, temporary foster care, adoption, abortion). If the adolescent decides to continue her pregnancy, she can then be referred to prenatal care.
- Provision of information to providers about the indications for which abortion is legally permitted with a focus on adolescents' needs (for example, judicial bypass options).
- Ensuring that social welfare and health care professionals, counselors and peer educators can provide referrals for safe, legal abortion care and that adolescent health services offer such care.

"We do not have access to contraception. We are stigmatized if we have a child before marriage. We do not have the right to abortion. What a dilemma! How can we not die if we are exposed to risky abortions? How can we not resort to abortion if a child before marriage is a sacrilege? How can we avoid having children when there are no contraceptive services?...We wish to affirm that one of the best weapons in the fight against risky abortions among the young is to respect our rights, starting with the right to information."

Brison Ebaya, Association for Changes in Behaviour in the battle against HIV/AIDS and for education in SRH [sexual and reproductive health] for the young. Kinshasa, Democratic Republic of Congo (IPPF, 2003)

Provision of comprehensive postabortion care

Postabortion care to treat incomplete abortions and the complications of unsafe abortions is widely recognized to include five essential components: treatment of complications; counseling; contraceptive services; provision of, or referrals for, reproductive health services; and community and service partnerships to ensure that services meet community expectations and needs (Postabortion Care Consortium, 2002).

To ensure that all women, including adolescents, have access to postabortion care, the public health system must ensure that appropriate policies and services are in place and that health providers implement them. A study carried out in 1999-2000 asked health professionals in 49 developing countries to rate 81 maternal and neonatal health services in their countries. According to these experts, the least accessible service for women was safe abortion; treatment of post-abortion complications ranked a low 78 out of 81 with regard to accessibility for women in rural areas and 17 out of 81 for women in urban areas. The experts rated official approval for treatment of post-abortion complications as the second lowest policy priority (Bulatao & Ross, 2002). A 2002 assessment of the policy environment regarding adolescent health services in Jamaica found that post-abortion counseling scored lowest among eight program components (Wynter et al., 2003).

"I am concerned about the dangers of unsafe abortion. Abortions performed by unskilled persons in unsanitary conditions can result in infections, infertility, and even death. The cultural and religious aspects within our community and the lack of legislation on the matter are the biggest obstacles to accessing safe abortion services. To my knowledge there has never been a project to raise awareness about issues of abortion in our area. Some NGOs have done programmes on HIV/AIDS but have never touched abortion. Maybe it is a sensitive topic but the health and legal systems have a lot to do, to make people aware of the dangers of unsafe abortions, and to reduce the occurrence of unsafe abortions."

Hamza Mohammed, Nigeria (IPPF, 2003)

Fortunately, some countries are addressing postabortion care in their guidelines on adolescent sexual and reproductive health. In Pakistan, NGOs such as Marie Stopes International and the Behbud Welfare Association support provision of contraceptive services and postabortion care for young women (Hardee et al., 2003).

By the year 2000, The National Program for Comprehensive Health Care for Adolescents (PRONAISA) of the Dominican Republic had established 37 units exclusively dedicated to adolescent health. The regulations governing these units oblige them to respect adolescents' rights as recognized internationally and in local legislation, to guarantee confidential care, and to educate and counsel adolescents on pregnancy prevention and contraceptive methods, as well as risk factors of unintended pregnancy. Although abortion is permitted by law only to save a woman's life, the regulations address clinical care for women who have abortions without complications, treatment of women with abortion complications, and postabortion care including contraceptive counseling (Secretaría de Estado, 2000). The national norms on family planning state that persons of any reproductive age are entitled to request and receive family planning services, and special attention should be given in education and service provision to adolescents (Secretaría de Estado, 2001).

At all levels, it is important to ensure that postabortion care counseling addresses contraception and HIV/AIDS. Information on contraception should take into account that adolescents may be: more apt to use a method that can be concealed (e.g., injections, contraceptive patches), more likely to use a method that does not require a daily regimen, and more likely to discontinue certain methods based on their side-effects (WHO, 2003A). Such counseling should also include information on emergency contraception and male and female condoms as the only contraceptive methods that can prevent HIV/STI infection.

The City Council of Lusaka, Zambia, developed an action plan in 1996 to improve reproductive health information and services for youth by decentralizing services and integrating programs. Collaborative relationships were established with Anti-AIDS Clubs at 10 primary and secondary schools served by seven clinics; peer educators were trained and community groups were informed about the project. The peer educators collected monthly data on clinic services provided to youth, including information on prenatal care, STI screening and treatment, family planning, and referrals for abortion complications. Among the 18,000 young people served within an 18-month period, 3,268 sought STI screenings, 4,126 accessed prenatal care and 100 young women received postabortion care. Contraceptive use, including emergency contraception, increased.

Advance Africa, 2003

Provision of safe, legal induced abortion services

WHO recommends that health authorities assess where legal abortion services are available (for example, at the primary, secondary and/or tertiary levels of care) so that steps can be taken to ensure that at least first-trimester abortions can be performed at lower level health facilities (WHO, 2003B). Experts in adolescent health recommend that action be taken at four levels to ensure that adequate abortion-related care is available for adolescents (Dickson-Tetteh, 2000; Olukoya et al., 2001):

- Community level: ensure that community members, traditional birth attendants and other community health workers have basic knowledge of family planning, can recognize signs and symptoms of abortion complications, and can provide information on referral centers within the health-care system.
- Primary care level: ensure that professionals can provide information and counseling on sexuality and fertility regulation, and have the ability to carry out pain control and resuscitation if needed.
- Secondary care level: ensure that health professionals can diagnose abortion complications and provide appropriate definitive care that may include surgery and/or blood transfusion. They should be skilled in the use of both manual vacuum aspiration and laparotomy.
- Tertiary care level: ensure that health professionals are trained and prepared to handle conditions requiring more complex diagnosis and treatment (e.g., diseases of blood coagulation, tetanus, renal failure, gangrene and bowel injury).

Even where abortion is widely permitted or permitted for young women specifically, regulatory barriers such as high fees, parental consent requirements, mandatory waiting periods, facility requirements, mandatory approval by a committee, and conscientious objection exemptions can impede young women's access to safe and legal abortion services. The following measures are needed to make safe, legal abortion care available and accessible to adolescents (Senderowitz, 1997; WHO, 1997; Dickson-Tetteh, 2000; Olukoya et al., 2001; Treffers, 2002; Khuat, 2003; WHO, 2003B; Commonwealth Medical Trust, no date B; Moore et al., no date; NARAL Pro-Choice America, 2002).

A first step is to **ensure that local opposition to abortion and/or lack of knowledge does not impede implementation of laws that permit termination of pregnancy**. In Ghana, it was found that hospital staff were often unfamiliar with legal provisions permitting safe abortions and that they were turning girls who requested legal abortions over to the police (Greene et al., 2002). To overcome such barriers, the health system should help service providers clarify their own values about abortion so that they do not form an obstacle to care. (Appendix 3 offers sample exercises that can be used in training.)

Health authorities should further inform providers about the law and establish and implement policies and protocols that enable them to provide legal abortion-related care without fears of being prosecuted. In Nepal, Planned Parenthood of New York City worked with the Family Planning Association of Nepal to organize an Advocacy Roundtable with representatives of the government, women's rights advocates and reproductive health providers to discuss how to implement the new law that decriminalized abortion (Margaret Sanger Center International, 2003). Vietnam's National Strategy on Reproductive Health for 2001–2010 stresses the importance of counseling and medical assistance for adolescents and youth, including provision of contraceptive methods, safe abortions, and treatment of reproductive tract infections (Hardee et al., 2003).

It is important to **eliminate requirements for parental or spousal consent** for abortion in the case of mature adolescents. The support of parents, guardians or partners is desirable for young women facing unwanted pregnancies. However, it is not always forthcoming, especially in cases of sexual assault by family members.

In most cases, adolescents do involve their parents and guardians in their decisionmaking about unplanned and unwanted pregnancies. A 1991 nationally representative survey in the United States investigated abortion decisionmaking among 1,519 unmarried adolescents in states without parental involvement laws (Henshaw & Kost, 1992). The study showed that only 39% had an abortion without the knowledge of either parent; 54% of this group were already 17 years old, 43% were employed, 15% lived apart from their parents and 9% already had a baby. Among the adolescents younger than 15 years, 90% of their parents knew about the abortion. The same study showed that 30% of the teens who did not involve their parents had experienced family violence, feared such violence or were afraid they would be forced to leave home.

Parental consent requirements, or adolescents' perceptions of them, can unnecessarily delay young women from seeking treatment. The Alan Guttmacher Institute calculated that second-trimester abortions among adolescents in Missouri increased by 17% after that state enacted its parental consent law (ACLU Reproductive Freedom Project, 2001).⁶

The Convention on the Rights of the Child states in Article 12(1) that "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (United Nations, 1990). Legal experts state that as a rule: "adolescents capable of freely choosing to be sexually active without parental control are equally capable of receiving reproductive health counseling and care without parental consent" (Cook & Dickens, 2000).

Legal experts have pointed out that in most countries adolescents have usually gained certain legal rights before they reach the nationally defined age of majority, for example, rights to drive and to make decisions regarding their own children's welfare (Cook et al., 2003). The UN Convention on the Rights of the Child states that persons legally responsible for children should "provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention;" such rights include the right to access health services "for the treatment of illness and rehabilitation of health" (United Nations, 1990).

Some countries do enable adolescents to exercise their right to access health care without parental consent. In Kenya, the national guidelines on voluntary HIV counseling and testing (VCT) state that "mature minors" (individuals younger than 18 years who are parents, married, pregnant, or engaged in behavior that puts them at risk) do not need parental consent for VCT (Finger, 2002). In Great Britain, young women who are considered legally competent can give consent for medical procedures. Women younger than 16 years of age are encouraged to involve a parent or supportive adult, but a physician can perform an abortion if s/he thinks it is in the patient's best interests and deems the young woman capable of giving informed consent (Royal College of Obstetricians and Gynaecologists, 2001). In other countries, laws accept that minors who become mothers can be considered of majority age (Cook & Dickens, 2000). In the United States, all states permit minors to consent to confidential STI diagnosis and treatment (Conard & Blythe, 2003); 46 of 50 states permit mothers younger than 18 years to place their children for adoption without their parents' consent (Dudley, 2003); young mothers can also make decisions about the medical care of their children. Since young women are considered mature enough to make decisions for their children, they should also be considered mature enough to make decisions about their own reproductive health.

"...the American Academy of Pediatrics (AAP) reaffirms its position that the rights of adolescents to confidential care when considering abortion should be protected.... Adolescents should be strongly encouraged to involve their parents and other trusted adults in decisions regarding pregnancy termination, and the majority of them voluntarily do so. Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care.... Minors should not be compelled or required to involve their parents in their decisions to obtain abortions, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults."

*Committee on Adolescence,
American Academy of Pediatrics, 1996*

In some cases, laws requiring parental consent have judicial bypass options whereby teenagers who cannot or who do not want to involve their parents can obtain permission from a judge or administrator for the abortion; however, this procedure can be daunting and difficult for adolescents, particularly those with the least resources and lacking supportive social networks. In the United States, studies in two states showed that some judicial officials were unprepared to implement bypass procedures because they were not even aware of them, despite the fact that the laws had been in place for several years (Planned Parenthood Federation of America, 2003). In such cases, adolescents may resort to abortions in unsafe circumstances.

Where parental consent requirements and judicial bypass provisions are in place, programs can mitigate the negative effects for adolescents by assisting them to navigate the legal system. For example, clinic staff can advise the young woman on where she needs to go to obtain a bypass, help her with necessary paper work, and accompany her to see the judge.

It is further important to **eliminate unnecessary administrative requirements and medical regulations** concerning provision of abortion care, such as approval for induced abortions by specialists or more than one health-care provider. The law on termination of pregnancy in **Israel** states that abortion can be approved if “the woman is under marriage age or has completed her fortieth year,” and accepts the consent of a minor without the approval of her representative, once the risks have been explained to her. However, provision of abortion services is conditioned on the approval of a committee of three people: an obstetrician-gynecologist, another medical practitioner and a social worker; women can appeal committee decisions, but this requirement could potentially lead to unnecessary delays in care (Israel, 1997).

Abortion services can be made more affordable and accessible for adolescents by providing free services, fees based on a sliding scale or subsidized fees. It is also advisable to determine whether financial arrangements can include payment over time. Where adolescents are possibly covered by their parents’ health insurance, it is helpful if providers determine how the costs of the procedure will be paid. If the young woman wishes to maintain confidentiality regarding abortion care, the provider should inform her if there is a chance that her parents/guardian will receive an itemized statement or bill that reveals what kind of treatment she received (Conard & Blythe, 2003).

New Zealand’s Contraception, Sterilisation, and Abortion Act of 1977 established an Abortion Supervisory Committee; one of its tasks is to make recommendations regarding maximum fees that may be charged for abortion services. The Committee is also charged with ensuring that staff in institutions licensed to provide abortions “take all reasonable and practicable steps to ensure that sufficient and adequate facilities are available throughout New Zealand for counseling women who may seek advice in relation to abortion” (New Zealand, 1997). Regulations such as these can help break down barriers to adolescents’ access to services, though they need not be written into laws.

A sufficient number of health-care providers should be trained in each community to **provide youth-friendly abortion care**. If some providers do not wish to perform legal abortions because of conscientious objection, the health system must ensure that they fulfill the obligation to provide referrals to providers who are willing to comply with the law.

Measures can be taken to make services more accommodating for adolescent clients; it is particularly helpful if youth-friendly services (YFS) are defined through facilitated dialogues between young people and service providers. Such a project carried out by Ipas in Nigeria and Vietnam contributed to a sense of empowerment among the young people; YFS components identified by the youth and providers included (de Bruyn, 2003):

- nonjudgmental, non-critical, respectful and patient provider attitudes
- provider competency in both counseling and clinical procedures
- a friendly and warm service environment
- guaranteed privacy and confidentiality
- service availability at hours convenient to young people, including provisions for emergencies
- provision of adequate and easily understandable information on sexual and reproductive health, including IEC materials, preferably in the local language.

Ipas staff in Vietnam further commented that the visual appearance of a youth-friendly clinic can be important in helping adolescents feel comfortable; decorating with posters, photos and flowers can give the space a warmer atmosphere. Where possible, the order of service rooms should follow the service steps/client flow so that the visit is more efficient and confidentiality can be enhanced. All staff, including receptionists, guards, cleaning staff and pharmacists, should be trained to treat to their adolescent clients in a friendly manner.

Counseling and clinical care

When an adolescent first discovers her pregnancy and seeks counseling and care, the service provider should enable her to consider all of her legal options, which may include carrying the pregnancy to term and parenting the child or giving the baby up for adoption, temporary foster care, or terminating the pregnancy if that is her desire. The counselor should ask her if there are other people that she wants to involve in her decisionmaking process, including her parents or guardians. If she wants to inform her parents/guardians but seems anxious about doing so, the counselor should offer her support for this. However, providers should be aware that some research has shown that parental reactions can increase or decrease an adolescent's abortion-related distress, with negative reactions being more detrimental to the young woman's psychological state than a lack of parental support because she did not tell her parents about the abortion (Paul et al., 1999).

While interviewing the adolescent, the counselor must make sure that her decisions regarding her pregnancy have not been coerced. If she seems indecisive, she should not be rushed into a decision, but be informed of the timeframe – determined by law or the best interests of her health – within which such decisions should be made. Depending on the option she chooses, the counselor should provide her with further referrals. If she chooses to carry the pregnancy to term, this must include a referral to prenatal care; the counselor can also inform her about other services that are locally available, which might include parenting classes, possibilities of financial assistance, and child care facilities that will enable her to continue her education or employment. If she chooses to have the child adopted, the counselor can assist her in finding information on how to accomplish this. If she chooses to terminate the pregnancy, the counselor can inform her of her legal options and about where a safe, legal abortion is available.

If the pregnancy was unplanned, the counselor or provider should gauge the young woman's knowledge about pregnancy, contraception and STI prevention. The service provider should offer her appropriate information and provide her with a contraceptive method if possible. If the young woman decides to carry the pregnancy to term, the provider should be sure to tell her about the importance of condom use to prevent HIV/STI infection of herself and the child she will bear. She should also be told about prevention of mother-to-child transmission of HIV programs and offered a referral to such a program. The following recommendations pertain to the treatment of young women and girls seeking to terminate their pregnancies.

Psychosocial care recommendations

While providers may have numerous clients to see each day, quality of care is improved when sufficient time is taken to make a woman feel comfortable and to address at least her most urgent needs in an adequate manner. This is especially true for adolescents seeking abortion-related care, since this may be the first time they have had any experience with reproductive health care services. In addition, adolescents may process information differently than adults and may lack basic information to contextualize the information they receive; counseling adolescents therefore may require different approaches and more time than is usually allocated to adult clients (Pathfinder International, no date). Guidelines on adolescent reproductive health care from the Dominican Republic's Secretariat of Public Health recommend that providers spend at least 30 minutes on counseling and 20-40 minutes for a general clinical consultation (Secretaría de Estado, 2000).

It is particularly important that counselors ensure confidentiality and privacy during sessions with adolescents seeking postabortion care or an induced abortion. Counselors should inform all adolescent clients about their legal rights, as well as any legal obligations that providers might have to report certain issues to other authorities, such as sexual abuse or detected STIs.

Pre-treatment counseling for both postabortion care and induced abortion⁷

Some elements of pre-treatment counseling will be similar for young women seeking postabortion care or an induced abortion. Adolescents in either situation may experience a wide range of emotions that can affect their responsiveness during counseling (Senderowitz et al., 2002). For example, the young woman may be worried about being seen at the health facility or feel intimidated at having to discuss an intimate problem

with a person of authority. An adolescent, especially when unmarried, may feel sad, ashamed or guilty for having become pregnant or for having an abortion, or she may be afraid of being misunderstood, judged or criticized. Because she may be very nervous, it is helpful if a counselor first asks her if she is ready to talk and needs to do anything to prepare for the conversation (e.g., tell her where the toilet facilities are in case she needs to use them).

Paying attention to the following points can facilitate pre-treatment counseling:

- Sit in a chair facing her, without a desk or table between you.
- Ensure that others cannot overhear the conversation.
- Do not interrupt the session to talk to others, either in person or on the phone.
- If the young woman is very apprehensive, offer her the option of having a trusted family member or friend present during the examination and, if possible, during the procedure. If she is alone, she may appreciate the support of a staff-member during the treatment.
- Use her name during the conversation to show that you care about her as a person.
- Try to gauge the young woman's feelings from her body language so that you can respond to them (e.g., if she turns away from you, ask if she is feeling uncomfortable about the question).
- Take care to show a nonjudgmental attitude, both verbally and non-verbally; for example, refrain from asking questions that begin with "why" because such questions can seem to indicate blame.
- When possible, ask open-ended questions to encourage the young woman to speak. However, remember that cognitive abilities are still developing in adolescents and that younger girls may still tend to think more concretely than abstractly. For example, it may be helpful to prompt younger clients to respond by giving them examples when asking questions ("Are you worried about pain?" instead of "Is anything worrying you about the abortion procedure?").
- Use simple words – preferably in the client's vernacular language – to offer explanations and ask questions.
- Ask one question at a time and wait for her to respond. Give her time to think and answer, allowing a few moments of silence if necessary.
- Tell her that it is all right to answer a question later if she cannot answer it at the moment.
- If necessary, repeat questions and offer possible different responses in order to encourage the young woman to speak.
- Refrain from interrupting her when she is speaking.
- Answer any questions she may have right away, instead of saying that you will address them later.

The counselor can help the client feel a bit more comfortable by first introducing her/himself, congratulating her for taking the initiative to seek care, and reassuring her that any information she provides is voluntary and confidential. It may be helpful to begin with some neutral questions related to the young woman's age, whether she is attending school or working, and whether she likes her studies or work. If she appears reluctant to talk, simple statements ("I understand it may be difficult to talk with someone you don't know") or gentle prodding questions may help her begin talking.

Once a conversation has begun, it can be useful to explore the young woman's prior experience with reproductive health care, her knowledge about how pregnancy occurs and her possible worries related to the procedure (e.g., misconceptions that abortion causes infertility or cancer). Given the high incidence of sexual assault suffered by adolescents, the counselor can also pose some questions related to this. Finally, the counselor can discuss with the young woman whether she will have support after the procedure and where she can go for assistance. Examples of questions related to these aspects of counseling are provided in Appendix 4.

Counseling specific to induced abortion care⁸

During the initial counseling session with an adolescent who is seeking an induced abortion, it is important that all options open to her be discussed: continuing the pregnancy and choosing to mother the child, place it in temporary foster care or putting it up for adoption, or terminating the pregnancy. Many clients will already know that they want an abortion but the counselor should verify that each young woman feels comfortable with her decision. If she is hesitant, the counselor should have referral information available, for example, for specialized counseling if she is having a difficult emotional experience, for prenatal care if she chooses to continue the pregnancy, for adoption agencies if she is considering this option, and for court officials if she will need to obtain a judicial bypass to avoid involving her parents.

As part of the youth-friendly service approach, it is useful to inform the adolescent client about the steps of the examination and abortion procedure; this includes telling her about the clinic rooms she will visit, whom she will meet, and what services she will receive. This may be done when she first registers for services but all staff should be helpful in guiding her through the procedures. If she chooses to have a medical abortion that will be completed outside the hospital or clinic setting, the counselor should stress the importance of the follow-up visit to check on her health and help her consider how she can overcome any barriers that might make the follow-up visit difficult.

Informed consent

In areas where parental consent or notification is required, abortion providers should be familiar with the stipulations of the law. If the adolescent client is worried about informing her parents, the counselor can help the young woman plan how to inform them or consider obtaining permission from a judge in lieu of parental consent if that is legally possible (Paul et al., 1999).

It is important to ensure the adolescent provides informed consent for the abortion after the counselor has discussed the following issues with her:

- the stage of the pregnancy
- options available to her: carrying the pregnancy to term and motherhood, temporary foster care, adoption, termination of the pregnancy
- the possible consequences of carrying the pregnancy to term or terminating it
- the voluntary nature of her decision – the counselor should ensure that parental or partner coercion is not involved
- the benefits and disadvantages of choosing abortion by aspiration or medications according to her specific circumstances
- possible complications of available abortion methods (e.g., failed abortion, incomplete abortion, infections)¹³
- tests needed according to local protocols (e.g., pregnancy test, ultrasound, STIs)
- the benefits and risks of available anesthesia and pain relief methods
- legal requirements for pregnancy termination such as obtaining parental or judicial consent, reporting of STIs or sexual abuse
- permission to treat her in case of complications or an emergency.

Counseling before the procedure

Some young women who choose to terminate a pregnancy will never have had a pelvic examination before. This may be more likely for younger adolescents and adolescents in developing countries where gynecological care before pregnancy is rarely sought. An adolescent's pregnancy might have been due to a first act of sexual intercourse, possibly forced or traumatic, or due to sexual abuse that has left her hymen intact. If the counselor determines that the young woman has never had a pelvic examination before, s/he should explain how it will be done and might consider showing the patient a speculum and asking her if she wants to touch it.

The American Medical Women's Association points out that young women who have experienced familial disapproval of sex and abortion may find pregnancy termination problematic (American Medical Women's Association, 1997B). Other practitioners believe that adolescents may be more likely than adults to consider abortion a crime because they tend to see things in extremes (Paul et al., 1999). The counselor can help a young client work through her emotions by acknowledging that such feelings are not uncommon among women who have abortions and by helping her consider other perspectives. For example, if she feels that she is killing a baby, the counselor might ask her whether she believes that a fetus could live independently outside her body. If she is afraid of committing a sin, the counselor can indicate that many religious authorities do not condemn abortion and that many women of various faiths have had abortions that they did not regret. The counselor can also help her consider how she thinks she will feel after the abortion, mentioning that women who have coped well with abortion are those who made the decision themselves without being pressured into it, who remembered their reasons for terminating the pregnancy and those who have had someone to support them. If the young woman remains distressed, the counselor can help her consider alternatives, such as carrying the pregnancy to term or making the baby available for adoption.

Because of myths surrounding abortion and information she has about the consequences of unsafe abortions, a young woman may be fearful of dying or of becoming unable to become pregnant again in the future. It is important for the counselor to ask what she has heard about abortion and to reassure her that induced

abortion carried out according to legal and medical regulations is a very safe procedure and that it will not affect her future fertility or cause cancer (WHO, 2000).

The counselor should further describe which abortion methods are available for her stage of pregnancy. Reproductive health experts often use the term “medical abortion” to describe procedures using drugs such as mifepristone and misoprostol. However, this term may be confusing to adolescents since they may think that any type of abortion performed by health-care professionals is a medical abortion. It may be useful to use different terminology in counseling, such as “abortion caused by medications” or “the abortion pill”.

In the case of abortions during the first 12 weeks of pregnancy, the counselor should explain the characteristics of available treatment options and the need to screen out contraindications for either aspiration abortion or abortion using medications. For adolescents, it is important to stress that aspiration abortion has a higher rate of successful completion and is a quicker process. For young adolescents who are unable to tolerate a pelvic examination or who have a very tight cervix on examination, abortion induced by medications may be a reasonable alternative.

Post-treatment counseling for both postabortion care and induced abortion

After treatment of complications or after an abortion is completed, the clinician or counselor should ask the young woman about her experience during the procedure, since adolescents who do not receive sympathetic care may be less likely to return for a follow-up examination. It is also important to ask the patient if she has someone to whom she can turn for emotional support and to offer her information about where additional counseling is available.

Some young women may have questions about resuming sexual activity and using tampons, a female condom or a diaphragm. When addressing contraception, the counselor should discuss a number of issues, including when the young woman’s fertility will return, whether or not a patient who has had a miscarriage will want to become pregnant again quickly or will want to postpone this for some time, and which contraceptives will be most appropriate in meeting the young woman’s needs. Information should also be given on emergency contraception and use of female and male condoms to prevent HIV/STI infection. If possible, the counselor should provide the young woman with a contraceptive method or a referral that will enable her to easily access the method of her choice.

Other topics that might be addressed are the patient’s knowledge about how she became pregnant and issues related to violence (Appendix 4). The counselor can also ask the young woman if she would like to have a counseling session together with her partner. If these topics were addressed in pre-procedure counseling, the counselor can simply ask if the young woman has any further questions about a specific topic.

Post-procedure support

Some young women who have had an abortion might find it supportive to talk with peers in their situation. In Mexico, the Population Council piloted a “postabortion workshop” that included the topics of self-awareness and self-esteem, psychosocial issues (e.g., concepts of maternity related to gender, grief), sexual education (including contraception), and life-skills (e.g., negotiation in relationships with families and partners) (Martínez et al., 2003).

Clinical care recommendations⁹

Few health-care providers have documented whether and how they treat adolescent patients differently in providing clinical aspects of abortion-related care. An exception is a recent study in Cuba that investigated use of misoprostol for abortion up to 9 weeks of pregnancy in adolescents younger than 18 years (Velazco et al., 2000). It was found that a dose of 800 µg given vaginally every 24 hours up to a maximum of three doses produced complete abortion in 88.7% (133/150) of patients. The frequency of nausea, vomiting and diarrhea was statistically significantly higher than in adult patients, indicating that perhaps greater attention should be given to explaining possible side effects to younger patients.

Most aspects of clinical care are probably the same for adult and adolescent patients, particularly in the case of teenagers 16-19 years old. WHO recommends that vacuum aspiration be used rather than dilatation and curettage for first-trimester abortions; medical abortion is also an option (WHO, 2003B). The Society of

Obstetricians and Gynaecologists of Canada state that vacuum aspiration with local anesthesia is more advantageous than abortion with general anesthesia except in “very young women who are extremely difficult to examine” (Boroditsky, 1996). WHO states that general anesthesia is not recommended as it increases the clinical risks and moreover can increase the costs of the procedure for the woman (WHO, 2003B). It is further useful to take the following points into account, especially in the case of younger (9-15 years) and nulliparous patients.

Preparation for the procedure

- If the pregnancy resulted from sexual assault, the young woman may be especially afraid of any genital touching. If she has come for an induced abortion but seems overcome with fear, the clinician can ask whether she wants him/her to continue with the examination after explaining that once the abortion is begun, it must be completed. If the patient seems reluctant, the clinician can either suggest that she talk again with the counselor or that the abortion can be postponed until she feels better able to cope with the procedure.
- It is important to remember that adolescent patients may not be able to give an accurate past medical history, such as knowing whether they have drug allergies or when they had their last menstrual period since periods can be irregular in young adolescents.
- Patients undergoing an abortion should be checked for anemia so that proper precautions may be taken; women with severe anemia who undergo medical abortion must be followed very closely (Burke, 2004). It has been estimated that about 27% of adolescents in developing countries are anemic (Senderowitz et al., 2002), so particular attention should be paid to this during the pre-procedure workup.
- It is important to establish uterine size but physical examination may be inadequate in young patients with firm abdominal musculature. Where possible and feasible, confirmation of the stage of pregnancy may be obtained through use of ultrasound (Roche & Park, 2002).
- Cervical preparation before aspiration abortions using pharmacological agents such as misoprostol or osmotic dilators can be beneficial for young patients since they shorten the abortion procedure (WHO, 2003B).
- Dosages of medications and fluids to be administered may need to be adjusted to take into account the adolescent’s age and/or weight. The pediatric dosages for drugs used in medical abortion have not yet been definitively established (Roche, 2003); if providers document and publish the dosages they find most effective in adolescents, these data can contribute to evidence-based recommendations in the future.

During the procedure

- At the start of the procedure, the patient should be advised of her pain control options. The clinician can also ask her how she usually copes with pain to determine whether that would be possible during the abortion. For instance, the clinician can offer her something to hold on to. The young woman should also be urged to tell the health provider if anything hurts so that more pain relief can be given.
- It can be helpful for the clinician to tell the patient about how long the procedure will take and to tell her that she can ask for the procedure to be stopped up until a specific time, after which the abortion must be completed so as not to put her well-being at risk. It may also help to advise the patient intermittently about time to completion of the procedure (e.g., “we are about half-way done”).
- The clinician should not immediately touch her genital area but begin by touching her leg and then telling her that s/he will next touch her labia.
- To make the examination easier, the clinician could begin with a smaller size speculum for the pelvic examination and then switch to a larger speculum for the abortion procedure.
- It is helpful to use a warmed speculum for the examination and abortion procedure.
- When inserting the speculum, the clinician can ask the young woman to bear down and take slow, deep breaths since this makes insertion easier.
- During the procedure the patient may want to be informed of how each step may make her feel. It is important to warn her that she may experience some discomfort and/or pain during the examination or treatment; for example, the clinician may say something like: “You may feel some cramping now.”
- It is helpful if the clinician or the assistant asks the patient from time to time how she is doing during the procedure and whether she has any questions.
- In an adolescent patient with a very small cervix, it may be difficult to pick a site for the tenaculum. To decrease the chance of cervical tears, the clinician may choose to use ovum forceps, such as Bierer, Hern, Sopher or Vu-Moore forceps (Castleman, 2003).

After the procedure

- Adolescents who have had an induced abortion should receive verbal, and if possible written, information in their vernacular language on signs and symptoms that might indicate a need for immediate follow-up care.
- Young women should be warned to come back for treatment if they notice any of the following symptoms: bleeding that lasts longer than 2 weeks in the case of aspiration abortion; fever, chills, weakness, nausea, vomiting, muscle aches, tenderness when pressure is applied to the abdomen, abdominal pain, cramping, backaches, prolonged or heavy bleeding, foul-smelling discharge from the vagina, or a delay in the return of menstruation for more than six weeks. In case of a medical abortion, the patient should be counseled to use pads instead of tampons and told about the level of bleeding to be expected: a pad completely soaked every hour for 4 hours during the days of the procedure and lighter bleeding 7-12 days (or up to 4 weeks) after the procedure (Paul et al., 1999).
- While reassuring her that complications are unlikely, it is important to give the young woman telephone numbers and addresses to which she can turn for emergency care or follow-up after an abortion (e.g., clinics, hotlines). The counselor should also discuss with her what transportation she can use and that she should not hesitate to go to the hospital if an emergency should arise.
- Where resources are available, the counselor can give the young woman a packet of written information including materials on contraception and contact information or referrals to counseling, agencies that can provide needed legal assistance and support groups for young women in her situation (for example, survivors of sexual assault or women living with HIV).

Monitoring and evaluation of services

Investigating adolescent clients' satisfaction can help providers maintain the quality of their services. This may be done through voluntary client exit interviews or by encouraging adolescents to write feedback letters. The Hanoi Youth House in Vietnam does this by posting the following statement: "If you are satisfied with anything in our clinic, please tell your friends. If you are not satisfied with anything in our clinic, please let us know." Feedback can be placed in "letter boxes" situated in convenient areas such as the waiting area and recovery rooms. Formal evaluations of services are also desirable although they require additional resources not available to all service providers.

Conclusion

Unwanted pregnancy in adolescents is an issue that must not be ignored. Many pregnant adolescents will want or need to end a pregnancy to avoid risks to their lives and health, psychological trauma, and socioeconomic turmoil. Because adolescents face certain risks in pregnancy and abortion not experienced by older women, special care should be taken to address their needs. The following list summarizes key points to be taken into consideration.

Policy, advocacy and research

- Support making comprehensive sexuality education available in schools and through out-of-school programs for young people. This includes ensuring that young people receive information on the risks of too early pregnancy and unsafe abortions, information about contraceptive methods, and possibilities for accessing postabortion care and safe, legal abortion.
- Eliminate legal and regulatory barriers to the provision of contraception to teenagers, including emergency contraception.
- Ensure that local opposition to abortion and/or lack of knowledge on the part of providers and legal authorities does not impede implementation of laws that permit termination of pregnancy.
- Work to prevent and eliminate parental consent laws for adolescents seeking abortion.
- Eliminate unnecessary administrative requirements and medical regulations that impede adolescents' access to safe, legal abortions.
- Maintain statistical data on the barriers adolescents encounter in accessing legal abortions and the types of complications treated in adolescents presenting for postabortion care in order to support advocacy on making abortion care available and accessible for adolescents.
- Collect data on the stage of pregnancy in relation to abortion clients' ages, together with information on why women have later rather than early abortions, to determine whether adolescents experience greater barriers to accessing services than adults.
- Document both female and male adolescents' experiences with abortion and abortion care so that policies and services can be improved by meeting the needs they express.
- Document procedures used in counseling and providing adolescent clients with abortion-related care in peer-reviewed journals so as to gather data that can be used to provide an evidence base for future recommendations.
- Provide statistical and qualitative data on abortion-related care for adolescents to policymakers at the national level and to UN Treaty Monitoring Committees for human rights conventions at the international level so that they have an evidence base for addressing unsafe abortion and the need to make abortion care safe and legal.
- Support young people interested in advocating for reproductive choice by providing venues for them to speak out and resources (funds, documentation, etc.) for their activities.

Service provision

- Ensure that contraceptives are available and accessible to female and male adolescents.
- Acquire and make available sexual and reproductive health information and educational materials that staff can use during counseling and that adolescent clients can take with them.
- Ensure that abortion-related care is guided by the principles of youth-friendly services, taking into account special considerations that may be needed in providing psychosocial and clinical care.
- Ensure that abortion and postabortion care is comprehensive, including counseling on, and provision of, contraceptive methods and referrals to other reproductive health services.
- Ensure that staff are available to help adolescent clients access judicial bypass procedures if they do not want to involve parents/guardians in places where parental consent requirements are in place.
- Ensure that abortion-related care is affordable and accessible for adolescent clients.
- Consider ways in which adolescents' partners can be involved in counseling when this is something the young women want.

Implementation of the above-mentioned recommendations can assist policymakers and health care providers in meeting the special needs of adolescents with unwanted pregnancy. Moreover, documenting the impact of measures in the policy and service provision arenas can serve as a first step towards establishing evidence-based norms for adolescent abortion-related care.

Appendix 1:

Citations from human rights documents

Convention on the Rights of the Child

“States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” – Article 24

“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” – Article 12(1)

The Committee on the Rights of the Child

“In light of articles 3, 17 and 24 of the Convention, States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent.” – General Comment No. 4, paragraph 28

“Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.” – General Comment No. 4, paragraph 31

Human Rights Committee (International Convention on Civil and Political Rights)

“States parties should give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undertake life-threatening clandestine abortions.” – General Comment No. 28, paragraph 10

“The Committee...needs to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape. The States parties should also provide the Committee information on measures to prevent forced abortion or forced sterilization.” – General Comment No. 28, paragraph 11

“Another area where States may fail to respect women’s privacy relates to their reproductive functions, for example...where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.” – General Comment No. 28, paragraph 20

The CEDAW Committee (Convention on the Elimination of All Forms of Discrimination against Women)

“States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.” – General Recommendation No. 24, paragraph 27

“Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.” – General Recommendation No. 24, paragraph 11

“While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence.” – General Recommendation No. 24, paragraph 12(d)

“The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women’s rights to have access to health care. For example, States parties should not restrict women’s access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.” – General Recommendation No. 24, paragraph 14

“When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion.” – General Recommendation 24, paragraph 31(c)

Appendix 2: Summary of country-level legal indications for adolescent abortion

The indications shown below were in effect as of the end of 2003.

Countries specifically requiring parental consent:

Albania
Barbados
Bosnia and Herzegovina
Croatia
Czech Republic (consent if the minor is under 16 years and parental notification if she is 16 -18 years of age)
Denmark (except when justified by “circumstances”, which are not defined in the law)
Greece
India
Italy (except when considered “inadvisable”, a term not defined in the law)
Jamaica (by official Government interpretation rather than stipulated in the law)
Libya
Luxembourg
Macedonia, Former Yugoslav Republic of
Norway
Panama
Poland
Portugal
Serbia
Slovakia (consent if the minor is under 16 years and parental notification if she is 16-18 years of age)
Slovenia
Taiwan
Turkey
USA (some states require consent and some notification)

Country where parents or a guardian shall participate in an application for an abortion with the minor unless special reasons oppose it:

Iceland

Countries specifically stating that no consent is required; all encourage such consent, except Israel:

France
Guyana
Israel
South Africa

Countries where a minor must have special counseling:

France
Switzerland
USA (some states)

Countries whose laws do not mention minors, but could be interpreted as requiring parental consent for minors:

Equatorial Guinea
Kuwait
Nicaragua
Saudi Arabia
Syria

Countries in which being a minor is grounds for an abortion or can be considered in determining other grounds for an abortion:

Austria
Hong Kong
Finland
Iceland
Israel
Liechtenstein
New Zealand
Zambia

Appendix 3:

Training tools on adolescent pregnancy and abortion

The following exercises can be incorporated into training to help health-care providers explore their own feelings, attitudes and knowledge regarding adolescent pregnancy and abortion.

Exercise 1: “What if?”

Expected results

Participants have reflected on adolescents’ access to means to deal with unwanted pregnancy (emergency contraception and safe legal abortion)

Time required: 30 minutes

Materials required: handouts with scenarios for participants, pens/pencils

Instructions

1. Give the participants a handout with the scenario below and ask them to sit in pairs.¹⁰

You maintain a close relationship with your extended family, including your sister’s children. One day, your favorite niece, a 16-year-old girl who was diagnosed as HIV-positive, comes to you saying that she has become pregnant after being raped. You offer her support but she feels desperate and says that she will seek the services of an unqualified abortion provider. How would you react?

- A. You explain to her the dangers of unsafe abortions, try to persuade her to have the baby anyway and offer her financial support to raise the child.
 - B. You seek out family, friends and colleagues for the name of a health-care provider who can perform an abortion as safely as possible for your niece.
 - C. You approach the staff of a clinic or hospital and ask them to provide her with a pregnancy termination as permitted by law because she was raped.
 - D. Other:
2. Give the participants 5 minutes to answer the question briefly on their sheets of paper.
 3. Ask the participants to take 10 minutes to share their response with the partner.
 4. Ask volunteers to tell about their responses in the plenary group and ask if anyone wants to comment on different responses.
 5. Explain to the participants that the purpose of thinking about a scenario like this is to remind ourselves that reproductive health problems for adolescents can affect young women whom we know personally and that we should address such issues as if all affected adolescents were our daughters or relatives. It also highlights how important it is for people to know when abortion is legally allowed.

Exercise 2: Janice's story¹¹

Expected results

- Participants recognize how their feelings and attitudes might influence care given to adolescents seeking postabortion or induced abortion care.
- Participants review legal issues connected with provision of postabortion and induced abortion care for adolescents.

Time required: 1 hour

Materials needed

- Handouts with the discussion scenario and a sample scenario from a country where abortion is legally permitted
- Handouts with locally applicable legal provisions related to adolescents and abortion care
- Handouts with citations from international human rights documents related to adolescents and reproductive health (see Appendix 3)
- Flipchart and marker

Instructions

1. Divide the participants into small groups of about 5-6 people.
2. Give each participant a handout with the discussion scenario. If you are conducting the exercise in a country with many legal indications for abortion, point out that this scenario could still hold true for adolescents who live in areas far from abortion clinics. You could provide a handout afterwards describing such a scenario (for example, Johnson, 2004).

Janice, a 14-year-old girl living in a low-income city neighborhood, felt unable to talk with her parents about contraception. However, she felt under pressure to have sex with her 17-year-old boyfriend, John. He told her that having sex would prove that they loved one another and that she wouldn't get pregnant if they used condoms. Her girlfriends also warned her that she might lose John if she didn't agree to be intimate with him. One day, she finally agreed but unfortunately the condom broke when they were having intercourse. After a couple months, she realized that she hadn't had her period and that she was probably pregnant. Still afraid to speak with her parents, she confided in a girlfriend who told her about a person who provided clandestine abortions. Janice went to this person, who performed the procedure in unsanitary conditions; she became infected and when she finally went to the health clinic for help, her health was seriously endangered. The physicians on duty were able to treat the complications and told her she must not have sex again until she was married.

1. Do you know of any teenage girls who found themselves in a situation similar to that of Janice? What happened in those cases?
2. What are some of the possible consequences if Janice had proceeded with the pregnancy?
3. What are some of the other possible consequences that Janice might have suffered from the unsafe abortion?
4. Are there any circumstances under which Janice could have had a safe, legal abortion? (If the participants do not know all the indications for legal abortion, describe these and give them a handout on this.)
5. If a young woman like Janice asked you for advice about what to do about her pregnancy, what would you say to her?

3. Ask the participants to take about 15 minutes to read the scenario and answer the questions.
4. Reconvene the small groups into a large group and take 15 minutes to read out the questions, asking the participants to volunteer answers from their small group discussions, summarizing the responses on the flipchart.
5. Ask the participants to list factors that might prevent them from giving high-quality abortion-related care to adolescents; write these on the flipchart.
6. Ask the participants to brainstorm possible solutions to the barriers identified.

(continued on next page)

7. End the exercise by noting the following points:
 - Both early pregnancy and unsafe abortions may produce short- and long-term health problems for an adolescent; maternal mortality is also a possibility in both cases.
 - Becoming a young parent can lead to socioeconomic problems for an adolescent girl; she may also face rejection and abandonment by her parents or partner, an inability to continue her education or paid employment, and difficulties in providing the kind of care she would want to give her baby.
 - Health-care providers have a duty to know locally applicable legal provisions related to abortion and adolescents.
 - Health-care providers are ethically and legally obliged to provide postabortion care to all women, including adolescents.
 - Health-care providers are ethically, and sometimes legally, obliged to enable adolescents to gain access to safe, legal abortion care.

Appendix 4:

Sample questions during counseling¹²

The following questions are examples of how providers may broach different topics with adolescent clients experiencing unwanted pregnancy in a non-judgmental and youth-friendly manner.

Starting the conversation

- Are you going to school or working?
- What is it that you like and dislike about your studies/work?

Encouraging a client to speak

- I understand that it can be hard for you to talk about why you have come. This often happens to people who come here for the first time.
- I understand that it isn't easy to talk to someone you have just met; I feel the same way sometimes.
- Sometimes when someone comes to see me against her will and she doesn't want to be here, it is difficult to talk. Is that what is happening now?
- If you feel upset and want to cry, it's ok since it's good and normal to express your feelings.
- Can you tell me more about what you mean when you say....?
- How do you feel about this pregnancy?
- What options are you considering for dealing with this pregnancy? Would you like me to describe the options open to you?

Assessing prior experience with reproductive health services

- Have you visited a doctor before? What did the doctor do that was good or helpful? What did the doctor do that was not good or that made the experience difficult?
- How are you feeling about seeing the doctor?
- Has anyone examined your genital area before?
- How are you feeling about having a pelvic examination?
- Have you experienced any symptoms such as genital sores and rashes or vaginal discharge? (If so, explain that these may indicate the presence of an STI that may need treatment so that an STI test will be done.)
- (For postabortion care clients): You don't have to tell me about why you had an abortion but the more you can tell me about what happened during the abortion, the better we will be able to help you.
- (For clients seeking an induced abortion): Have you had a pregnancy test? If not, what makes you think you are pregnant?
- (For clients seeking an induced abortion): Have you had an abortion before? If so, what happened to you then and how did you feel physically and emotionally afterwards?

Assessing a patient's possible concerns about abortion

- Sometimes we hear people say that abortion causes infertility or causes diseases like cancer but this is really not true. What other things about abortion have you heard that you would like to ask about?

Exploring sexual assault issues

- Has anyone ever touched you in a way that made you uncomfortable?
- Has a member of your family or a friend of the family ever made you undress or touch them sexually?
- Has anyone ever pressured or forced you to have sex?
- Would you like to speak to someone about such issues? (The counselor can then provide the client with information and contact details for further counseling by someone experienced in dealing with rape and incest.)

Exploring the client's situation regarding support

- Has anyone tried to pressure you into having an abortion?
- Who has come with you to the health facility today? Does that person know why you have come?
- How would you describe your relationship with other members of your family? How do they treat you?
- Does anyone in your family know that you have had/are having an abortion? How have they helped you deal with this?
- Have you told anyone else that you had/are having an abortion? If so, how do you think they will give you support?
- Is there someone that you trust with whom you can talk about this? Would you like me to help you tell that person (e.g., a parent, other family member, family doctor)?

Post-procedure counseling

- How did you feel during the procedure?
- Is there anything that happened during the procedure that you want to talk or ask about?
- We usually discuss with clients how pregnancy occurred since we find that this is a confusing topic for many people. Would it be ok with you if we talked about that? (If the client says yes): Can you tell me a bit about how pregnancy occurs?
- Would you like some information about different contraceptive methods?
- (After an explanation about available contraceptives has been given): Which contraceptive method do you think you could use?
- Do you know where you can obtain the contraceptive method of your choice?
- [If the counselor can provide a method]: Would you like me to provide you with a contraceptive method?
- Would you like to take home some emergency contraception pills?

Resources

The websites listed here were all accessible as of 5 April 2004. Some of the documents are only available on the Internet.

For researchers and policymakers

Background information

- *The world's women 2000: trends and statistics*. United Nations. 2000
This UN report is a statistical source book that provides a comprehensive analysis of women's status in different parts of the world regarding issues such as health, education, work, human rights and politics.
<http://unstats.un.org/unsd/demographic/ww2000/index.htm>

Information related to adolescents

- *The state of the world population 2003: making 1 billion count: investing in adolescents' health and rights*. United Nations Population Fund. 2003
This report discusses challenges faced by adolescents around the world, emphasizing the need to invest in meeting their needs. It includes sections on the importance of reproductive health and the relationship between reproductive health and poverty, as well as education and employment issues.
UNFPA, 220 East 42nd Street, New York, New York 10017, USA; e-mail: hq@unfpa.org
<http://www.unfpa.org/swp/2003/>
- *Bulletin of the World Health Organization*, 2000, Vol. 78, No. 5.
Specifically devoted to reproductive health, this Bulletin contains several pdf versions of articles addressing maternal mortality and morbidity around the world, including the article, *Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links* by A. Langer, G. Nigenda, & J. Catino, which offers statistics on adolescents in Latin America and the Caribbean.
<http://www.who.int/docstore/bulletin/tableofcontents/2000/vol.78no.5.html>
- *Adolescent and youth reproductive health in the Asia and Near East Region. Status, issues, policies, and programs*. Hardee K, Pine P, Taggart Wasson L. The Policy Project. October 2003.
This policy paper summarizes findings from research in 13 countries on adolescent and youth reproductive health issues, policies, and programs, including abortion-related policies and services.
The Policy Project, Futures Group International, 1050 17th St., N.W., Suite 1000, Washington, DC 20036, USA; e-mail: policyinfo@tfgi.com
<http://www.policyproject.com>
- *Fast facts*. UNFPA
This website offers facts relating to adolescents worldwide regarding HIV/AIDS, early marriage and childbearing, living on the margins, education and work.
UNFPA, 220 East 42nd Street, New York, New York 10017, USA; e-mail: hq@unfpa.org
<http://www.unfpa.org/adolescents/facts.htm>
- *Adolescents*. Ipas
This website provides an overview of international adolescent reproductive health issues and provides links to Ipas's adolescent-related publications and research projects, as well as links to the websites of other organizations that focus on young people's reproductive health and rights.
Ipas, 300 Market Street, Suite 200, Chapel Hill, NC 27516, USA; e-mail: ipas@ipas.org
http://www.ipas.org/english/womens_rights_and_policies/adolescents/

- *Gender or sex: who cares?* Ipas and Health & Development Networks, 2002.
This resource includes a manual and training-of-trainer notes for conducting workshops for adolescents, young peer educators and adults who serve youth on gender and sexual and reproductive health. The resource pack provides activities and educational materials regarding how gender stereotypes contribute to problems such as violence, HIV/STIs, unwanted pregnancy and unsafe abortion. Both the manual and training notes are available in English and Spanish and can be downloaded from the Ipas website. The website page also has a section for feedback from those who have used the resource pack and information on how to order printed copies of the manual.
Ipas, 300 Market Street, Suite 200, Chapel Hill, NC 27516, USA; e-mail: ipas@ipas.org
http://www.ipas.org/english/womens_rights_and_policies/adolescents/gender_manual.asp
- *Abortion denied.* The Feminist Majority Foundation. 1990.
This video presents information on ethical and legal issues regarding the consequences of requirements in the United States on parental consent and notification and judicial bypass procedures.
Feminist Majority Foundation, 1600 Wilson Blvd, Suite 801; Arlington, VA 22209, USA
<http://www.feminist.org/>

For counselors and clinical care workers

Abortion-related services

- *A clinician's guide to medical and surgical abortion.* Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PH. New York, Churchill Livingstone, New York. 1999.
This commercially published guide provides overall guidance on abortion care.
- *Surgical abortion education curriculum.* M. Gold and Planned Parenthood of New York City. 1996.
One of the sample role-plays in this curriculum is about counseling a 15-year-old with a positive pregnancy test.
Planned Parenthood of New York City, Margaret Sanger Square, 26 Bleecker Street, New York, NY 10012, USA; e-mail: choicevoice@ppnyc.org
<http://www.ppnyc.org/services/training.html>
- *Reproductive Health Initiative Model Curriculum.* Second edition. Reproductive Health Initiative. American Medical Women's Association. June 2003.
This curriculum is designed to assist medical students, medical school faculty, and other health-care professionals by filling educational and clinical training gaps and addressing under-recognized or ignored areas of reproductive health medical education.
American Medical Women's Association, 801 N. Fairfax Street, Suite 400, Alexandria, VA 22314, USA; e-mail: info@amwa-doc.org
<http://www.amwa-doc.org/Education/RHI/Curriculum/main.htm>
- *Counseling the postabortion client: a training curriculum.* EngenderHealth. 2003.
This training curriculum includes case studies using adolescent clients.
EngenderHealth, 440 Ninth Avenue, New York, NY 10001, USA; e-mail: info@engenderhealth.org
<http://www.engenderhealth.org/res/offc/pac/counsel-curr/index.html>
- *Intervención post-aborto para adolescentes. Temas y técnicas participativas.* A. Martínez, S. García, R. Schiavon et al. October 2003.
This training resource in Spanish describes how to structure post-abortion support interventions for adolescents. It includes exercises and tools for a workshop that discusses possible emotional and physical consequences of abortions, self-esteem and self-efficacy issues, HIV/STIs and contraceptive methods.
Population Council, Oficina Regional para América Latina y el Caribe, Panzacola 62, Villa Coyoacán, México DF 04000; e-mail: disemina@popcouncil.org.mx
<http://www.popcouncil.org>

Adolescent-related resources

- *Adolescent seeking family planning*. JHPIEGO.
This webpage provides a sample role-play on counseling adolescents who seek contraceptive services. Reproductive Health Online, JHPIEGO Corporation, 1615 Thames Street, Baltimore, MD 21231-3492, USA; e-mail: info@jhpiego.net & reproline@jhpiego.net
<http://www.reproline.jhu.edu/english/5tools/5role/adolescent.htm>
- *Youth-friendly services: a manual for service providers*. EngenderHealth. 2002.
This manual contains a useful handout listing characteristics of a youth-friendly reproductive health service.
EngenderHealth, 440 Ninth Avenue, New York, NY 10001, USA; e-mail: info@engenderhealth.org
<http://www.engenderhealth.org/res/offc/qi/yfs/index.html>

For adolescents

General information on sexuality and reproductive health

- *Activate*. IPPF, United Kingdom.
This is a workbook for young people on sexual and reproductive health.
International Planned Parenthood Federation (IPPF), Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom; e-mail: info@ippf.org
<http://www.ippf.org/activate/index.htm>
- *Birth control and contraception for teenagers*. Avert, United Kingdom
This website provides information on various contraceptive methods.
AVERT, 4 Brighton Road, Horsham, West Sussex, RH13 5BA, United Kingdom; e-mail: info@avert.org
<http://www.avert.org/cpills.htm>
- *Go ask Alice! Sexual health*. Columbia University, USA
This website gives adolescents the chance to pose questions about sexual health and to view previous questions and answers on a variety of topics.
Alice! Lerner Hall, 2920 Broadway, 7th Floor, MC 2608, New York, NY 10027, USA
<http://www.goaskalice.columbia.edu/Cat7.html>
- *The Hormone Factory*. Australian Research Centre in Sex, Health & Society, Faculty of Health Sciences, La Trobe University, Australia
This website provides information on various aspects of sexual and reproductive health.
Australian Research Centre in Sex, Health & Society, Faculty of Health Sciences, La Trobe University 1st floor, 215 Franklin Street, Melbourne 3000, Victoria, Australia; e-mail: arcs@latrobe.edu.au
<http://www.thehormonefactory.com/topic.cfm?categoryid=3&topicid=29>
- *Like it is*. Marie Stopes International, United Kingdom
This site gives young people access to information about all aspects of sex education and teenage life, including menstruation, teenage pregnancy, sexually transmitted infections, sex and sexuality, peer pressure, contraception, emergency contraception and puberty. It also contains a help and advice section that provides additional informational web links.
Marie Stopes International, 153-157 Cleveland Street, London, 6QW, United Kingdom; e-mail: info@mariestopes.org.uk
http://www.likeitis.org.uk/q_and_a.html
- *TeensHealth*. The Nemours Foundation, USA
This website offers information on the body as well as aspects of sexual health and substance abuse.
<http://www.kidshealth.org/teen/index.html>

Resources including references to abortion care

- *The facts. Abortion.* Brook Advisory Centres, United Kingdom
This website is from a British NGO that provides free and confidential sexual health advice and services specifically for young people under 25 years. The site includes information on teens' reproductive rights and sexual and reproductive health; including HIV/STIs, contraception and abortion.
Brook Advisory Centres, 421 Highgate Studios, 53-79 Highgate Road, London NW5 1TL, United Kingdom; e-mail: admin@brookcentres.org.uk
<http://www.brook.org.uk/content/>
- *CHOICES. Choosing a contraceptive.* Bridging the Gap Foundation, USA
This site offers 29 updated descriptions of contraceptives and other reproductive choices for females, including information on pregnancy termination.
<http://www.managingcontraception.com/choice.html>
- *Dr. Drew.* USA
In addition to several sexual and reproductive health topics, information about abortion can be accessed by typing the word "abortion" under the website's search function.
<http://www.drdrew.com>
- *How you get pregnant and Abortion.* Coalition for Positive Sexuality, USA
This site offers teens candid educational information on sex and pregnancy while encouraging a positive view of sexuality.
Coalition for Positive Sexuality, P.O. Box 77212, Washington, DC 20013-7212, USA
<http://www.positive.org/JustSayYes/pregnancy.html>
<http://www.positive.org/JustSayYes/abortion.html>
- *Information for teens about abortion.* Childbirth by Choice Trust, Canada
This website answers questions about abortion.
Childbirth by Choice Trust, 344 Bloor St. West, Suite 502, Toronto, Ontario, Canada, M5S 3A7; e-mail: info@cbctrust.com
<http://www.cbctrust.com/homepage.html>
- *Love Life.* South Africa
Information about abortion can be accessed by typing in the word "abortion" or termination of pregnancy under the site's search function.
Love Life, 174 Oxford Road, Melrose 2196, P.O. Box 45, Parklands 2121, South Africa; e-mail: talk@lovelife.org.za
<http://www.lovelife.org.za/kids/index.html>
- *One Life.* BBC Radio, United Kingdom
This website for teens includes a page that describes different abortion methods and legal regulations governing abortion in the United Kingdom.
BBC Worldwide Limited, Woodlands, 80 Wood Lane, London W12 0TT, United Kingdom; e-mail: onelife@bbc.co.uk
<http://www.bbc.co.uk/radio1/onelife/health/sex/pregnancy3.shtml>
- *Sex, Etc.* Rutgers University, USA
This website for teens, by teens, uses a youth-friendly format to provide information on various aspects of sexuality, including teen pregnancy and abortion, as well as other issues facing teens. The site includes stories, message boards, frequently asked questions, ask the experts page, and a glossary of terms.
Network for Family Life Education, Center for Applied Psychology, Rutgers University, 41 Gordon Road, Suite A, Piscataway, NJ 08854-8067, USA; e-mail: sexetc@rci.rutgers.edu
<http://www.sxetc.org/>

- *Stepping out.* Family Care International, Nairobi and New York. 1999.
 This video series and accompanying discussion guide provide basic information about human reproduction and how adolescents can protect themselves against unwanted pregnancy and HIV/STIs. It includes exercises that explore unwanted pregnancies and unsafe abortion and advises that young women facing unwanted pregnancies should seek counseling to learn about safe, legal options that are available to her.
 Family Care International, 588 Broadway, Suite 503; New York, NY 10012, USA; e-mail: fcipubs@familycareintl.org
 Family Care International/Kenya, P.O. Box 45763, Riverside Court Flat #3, Riverside Drive, Nairobi, Kenya; e-mail: fcikenya@AfricaOnline.co.ke
- *Teen Growth. Q&A/Articles.* USA
 This website, developed by a team of pediatricians, was chosen by adolescents in the USA as a site of interest. Two pages on the site provide information on abortion and address the question of whether having an abortion more than once is risky.
http://www.teengrowth.com/index.cfm?action=info_advice&ID_Advice=2318
http://www.teengrowth.com/index.cfm?action=info_advice&ID_Advice=6263&category=sex&catdesc=Sex&subdesc=Pregnancy
- *Teenwire.* Planned Parenthood Federation of America, USA
 This website provides reproductive and sexuality health information to teens, relevant current events and pop culture discussions, as well as advice on various topics including relationships, peer pressure and body image. A section on abortion is included in the *Ask the experts archives*.
 PPFA, 434 West 33rd Street, New York, NY 10001, USA; e-mail: twstaff@ppfa.org
<http://www.teenwire.com/index.asp>

Resources useful for advocacy on reproductive rights

- *Advocacy kit.* Advocates for Youth, USA. 1996.
 This kit provides in-depth information on how to improve adolescent reproductive health and sexual health programs and policies by organizing at the state and local levels. It includes information on building coalitions, conducting needs assessments, planning public education campaigns, working with the media, educating policymakers, and responding to opposition.
 Advocates for Youth, 2000 M Street NW, Suite 750, Washington, DC 20036, USA; e-mail: questions@advocatesforyouth.org
<http://www.advocatesforyouth.org/publications/advocacykit.pdf>
- *Success stories – Audrey Simpson.* Just do something website of Common Purpose graduates
 This web page describes how the Family Planning Association of Northern Ireland has succeeded in offering abortion counseling in addition to pregnancy testing and sexual health counseling for adolescents.
<http://www.justdosomething.net/xsp/xsc.asp?url=/home/skills/law/campaigning/audrey-simpson>
- *Deceptive anti-abortion crisis pregnancy centers.* NARAL Pro-Choice America, USA
 This fact sheet provides information on pregnancy centers in the United States that appear to be pro-choice but actually are anti-abortion.
 NARAL Pro-Choice America, 1156 15th Street, NW, Suite 700, Washington, DC 20005, USA; e-mail: can@ProChoiceAmerica.org
<http://www.prochoiceamerica.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=1589>
- *Generation Pro-Choice.* NARAL Pro-choice America, USA
 This site addresses young US women who support access to birth control, sex education and abortion, and who have never lived in a time when abortion was illegal. It encourages the members of this generation to get other young people involved in the fight to protect the right to privacy and a woman's right to choose.
 NARAL Pro-Choice America, 1156 15th Street, NW, Suite 700, Washington, DC 20005, USA; e-mail: can@ProChoiceAmerica.org
<http://www.prochoiceamerica.org/generation/walk/>

- *Walk in her shoes*, NARAL Pro-Choice America, USA
This site shares the stories of women and girls confronting unwanted pregnancy and the challenges they faced.
NARAL Pro-Choice America, 1156 15th Street, NW, Suite 700, Washington, DC 20005, USA; e-mail: can@ProChoiceAmerica.org
<http://www.prochoiceamerica.org/generation/walk/>

- *Be a voice for choice!* Planned Parenthood Federation of America, USA
This article provides guidance for young people in advocating for improved sexuality education and services, including ways to start a group, identify allies, and making a plan for change.
PPFA, 434 West 33rd Street, New York, NY 10001, USA; e-mail: twstaff@ppfa.org
<http://www.teenwire.com/index.asp> (click on "Taking Action", scroll to the bottom and click on "Taking Action" again, select *Be a voice for choice!* from the list of articles)

Endnotes

1. The focus in this document is on “unwanted” rather than “unplanned” or “unintended” pregnancy, since some young women will want to carry a pregnancy to term even if she did not plan to become pregnant.
2. Puberty in girls begins when hormones trigger growth and change in the ovaries; it is accompanied by growth and maturation of other internal and external reproductive organs and the start of menstruation (menarche). It is a process that takes several years, ending in medical terms when the menstrual cycle has been established and is regular. Precocious puberty occurs when these developments begin before eight years of age (Larson, 1996).
3. This box draws on the following sources: Olukoya et al., 2001; WHO, 1997; Khuat, 2003.
4. The paper did not specify whether this was of all teenage deaths or deaths among female teenagers.
5. Criteria to determine the status of an “emancipated minor” – that is, a teenager who is free from parental control – vary in different legal settings but may include attributes such as living away from the parental home, being married, having graduated from high school, being a member of the armed forces and being pregnant (Cook et al., 2003; Bennett et al., 2004).
6. The percentage represents a calculation made by the Alan Guttmacher Institute based on data from Pierson VH. 1995. Missouri’s Parental Consent Law and Teen Pregnancy Outcomes, as cited in ACLU Reproductive Freedom Project, 2001.
7. The recommendations in this section are based in part on the following sources: Gold et al., 1996; American Medical Women’s Association, 1997A; Paul et al., 1999; Secretaría de Estado, 2000; Olukoya et al., 2001; Senderowitz et al., 2002; WHO, 2003B.
8. The recommendations in this section are based in part on the following sources: American Medical Women’s Association. 1997B; Paul et al., 1999; Stewart et al., 2002.
9. The recommendations in this section are based in part on the following sources: Gold et al., 1996; American Medical Women’s Association, 1997B; Paul et al., 1999; Olukoya et al., 2001; Stewart et al., 2002.
10. The idea for this exercise was adapted from Habitat for Humanity International, 2002-2003.
11. This exercise was adapted from Brazier et al., 1999.
12. The questions in this Appendix are based partly on the following sources: Paul et al., 1999; Stewart et al., 2002; Martínez et al., 2003; Reproductive Health Initiative, 2003.
13. Complications are uncommon after safely induced abortions; however, ethics – and in some countries legal stipulations – require that possible complications of abortions be discussed with all clients.

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