

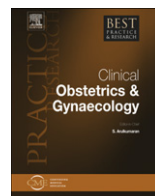


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Unsafe abortion – the current global scenario

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Unsafe abortion is prevalent in many developing countries, mostly in sub-Saharan Africa, Latin America and South and Southeast Asia, where abortion laws are more restrictive, the unmet need for contraception high and the status of women in society low. The main interventions for reducing the prevalence of unsafe abortion are known: better and more widely available family planning services, comprehensive sex education, improved access to safe abortion and high-quality post-abortion care, including contraceptive counselling and on-site services. Although these proposals have been included in statements and recommendations drawn up at several international conferences and adopted by the vast majority of nations, they have either been inadequately implemented or not implemented at all in the countries in which the need is greatest. A well-coordinated effort by both national and international organisations and agencies is required to put these recommendations into practice; however, the most important factor determining the success of such efforts is the commitment of governments towards preventing unsafe abortion and reducing its prevalence and consequences.

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The terms ‘safe abortion’ and ‘unsafe abortion’ are used to distinguish the difference in risk to women who undergo induced abortions. The World Health Organization (WHO)¹ defines ‘unsafe abortion’ as “a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both”.² In contrast,

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a medical or surgical abortion performed by a well-trained professional with the necessary resources and in a suitable medical environment is considered a 'safe abortion' because the procedure involves little risk to the woman.

Most unsafe abortions are performed in countries with legal restrictions to the procedure. However, some occur in countries where abortion is legal but access to safe legal abortions is limited. The opposite is also true, as many safe abortions are performed in countries where abortion is legally restricted. Therefore, it is important that usage of the terms 'safe abortion' and 'unsafe abortion' be clearly differentiated from usage of the terms 'legal abortion' and 'illegal abortion'.

According to the most recent statistics of the WHO³, of the 42 million induced abortions estimated to have occurred in 2003, 22 million corresponded to generally safe legal abortions and approximately 20 million to mostly unsafe illegal abortions.

Regional differences in unsafe abortion

Safe and unsafe abortions are not homogeneously distributed throughout the different regions of the world. Developed countries make up more than 20% of the world's population, but only half a million of the almost 20 million unsafe abortions performed worldwide annually take place in these regions of the world. This occurs because abortions in developed countries are mostly legal and safe, whereas abortions in developing countries, with the exception of China and a few other countries, are mostly illegal and unsafe. India is another densely populated country where abortion is legal; however, in India a large proportion of induced abortions are still performed in unsafe conditions outside the official health-care system.⁴

The most recent estimates of unsafe abortion rates by region refer to 2003 and show that the highest rates per 1000 women of 15–49 years of age are found in Africa and Latin America (29/1000), followed by Asia (11/1000), the rate for Asia being influenced by the inclusion of China. Considering subregions within each continent, the highest rate is found in Eastern Africa (39/1000), followed by South America (33/1000) and Western Africa (28/1000), Central Africa (26/1000), Central America (25/1000) and Southeast Asia (23/1000). The rate of unsafe abortion in the more developed regions is only 2 per 1000.³

Why unsafe abortion is still so prevalent in the world?

This is in fact three different questions. First, we have to ask why women get pregnant if they do not intend having a baby. The second question is, once they are pregnant then why is that pregnancy so unwanted that women choose to subject themselves to all the risks and suffering associated with unsafe abortion in societies where the practice is legally restricted or where safe abortion is of difficult access. Finally, the third question is why an abortion, which is one of the surgical or medical procedures with the lowest risk, should become risky or unsafe. We will try to answer each of these questions ahead.

Why women get pregnant if they do not intend having a baby

The most common reason women give for having an unintended or unwanted pregnancy is that they lack information about contraceptive methods or do not know how to access them.⁵ Another important cause of unwanted pregnancy is the woman's inability to exercise control over when and under what circumstances she will have sexual intercourse.

Each of these circumstances leading to abortion merits a more detailed discussion to fully understand its significance, thereby enabling practical interventions that may contribute towards preventing unsafe abortions to be proposed.

Lack of knowledge about contraceptive methods

Many women became pregnant against their will because they lack accurate information on how to prevent pregnancy. According to the Demographic and Health Surveys (DHS), a high proportion of women worldwide state that they have knowledge of at least one 'modern', highly effective contraceptive method, which includes all kinds of hormonal methods, intrauterine devices (IUDs), barrier

methods such as the diaphragm and the male or female condom, and male or female surgical sterilisation.

Examining the data from the most recent DHS, there were very few countries in which less than 90% of the women interviewed declared knowledge of at least one of these methods. The lowest percentage was found in Chad with less than 50% and in Mali with less than 75%.^{6,7} Knowledge of modern contraceptives is rapidly increasing in other less developed countries such as Mozambique, Guinea and Madagascar. While only 60–70% of women had known of at least one modern contraceptive in the previous DHS, over 90% declared that they knew of one such in the surveys carried out between 2003 and 2004.^{8–10}

The percentage of women with knowledge of modern contraceptives reaches virtually 100% not only in developed countries but also in some less developed countries such as Bangladesh, the Dominican Republic and Brazil.^{11–13}

These studies also show significant differences within each country, according to place of residence and socioeconomic status. The number of years of schooling is the main determinant of contraceptive knowledge. In almost every less developed country, 99% or more of women with secondary education or more declared knowing of at least one modern contraceptive method, while only 75% or less of women with no education in Cameroon and Bolivia knew of at least one modern contraceptive.^{14,15}

The difference may be even greater depending on how 'knowledge' of a method is defined. In the DHS, each method is named and the woman being interviewed states if she knows about it. This means that any woman who has heard of a method is included as 'knowing about' the method. It may be that her 'knowledge' is completely wrong. The information she 'knows', may be erroneous; she may have heard, for instance, that the IUD causes an abortion every month or that the pill causes infertility. Such false rumours may prevent women from using these methods.¹⁶

Studies that have investigated the accuracy of knowledge about contraceptive methods have shown discouraging results. A study carried out in the slums of Rio de Janeiro showed that 23% of women who used contraceptive pills were using them incorrectly.¹⁷ Other studies have shown that adolescents and women with little education who attempt to use periodic abstinence for fertility control do so with no accurate knowledge of the menstrual cycle or the fertile period.^{18,19} The basic knowledge of reproductive physiology among adolescents in some less developed countries may be so poor that they are unaware that girls are able to become pregnant the first time they have sexual intercourse.²⁰

Inadequate knowledge about contraception may affect the ability of women to protect themselves against unintended pregnancies in at least two ways: (1) they may opt not to use a method, incorrectly believing that it may have a negative effect (e.g., that IUDs cause cancer or that the pill causes infertility); and (2) they may use it incorrectly, inadvertently exposing themselves to the risk of pregnancy. As for knowledge of contraceptives in general, the accuracy of information is affected by education level, increasing the social disadvantage of women who have less opportunity to attend school.

In addition, sensationalist information often disseminated by the media about certain methods may have an impact on the number of abortions, even in developed countries. A good example was the reported increase in the risk of adverse vascular effects associated with the third-generation pill, depicted in the media as constituting a very significant risk. An evaluation conducted in Norway showed a subsequent dramatic decrease in the use of this method, which coincided with a 36% rise in the abortion rate among 15–24-year-old women.²¹

Lack of access to contraceptive methods

The best indicator of access to contraceptive methods is the unmet need for contraceptives. 'Unmet need' is defined as the proportion of women who do not want to get pregnant at that precise time or ever again and who are not using any contraceptive method. It has been estimated that 125 million women have unmet needs for family planning, mostly in the developing countries.²²

Looking at the unmet need for contraceptive methods in less developed countries, there would appear to be three stages. The first stage, in which the desire for fertility regulation is low and contraceptive use is therefore also very low, results in minimal unmet need. In the second stage, a higher percentage of women want to control their fertility and access to contraceptive methods varies widely. The highest proportion of women with an unmet need for contraception is to be found in this

stage. Finally, in the third stage, the percentage of women who want to control their fertility is highest, as is their access to modern contraceptive methods. At this stage, typical of developed countries, the proportion of women with an unmet need is low. The high unmet need for contraception in countries in the second stage may be one of the main factors that determine the prevalence of unsafe abortion. A study in Nepal found, for example, that for many women unsafe abortion was the only available method of fertility control.²³ Several factors contribute to unmet need: lack of knowledge, lack of availability of contraceptive methods and lack of the resources needed to obtain contraceptives; however, opposition from a partner and family or cultural pressure towards high fertility represent additional factors. Whatever the reason for the unmet need, it will be closely associated with unwanted pregnancy and consequently with abortion.

The highest abortion rates are observed in countries in Eastern and Central Europe that belonged to the former Soviet Union. Contraceptive prevalence was low because access to modern contraceptives was limited and there were legal restrictions to surgical sterilisation. The only easily accessible option for fertility control was abortion.^{24,25} Access to contraception has improved over the past 15 years. As a result, the abortion rate fell rapidly from about 91 per 1000 women of reproductive age in 1995 to just less than 50% of that figure, 45 abortions per 1000 women, in 2003.³ This is an excellent example of the effectiveness of improved access to contraception as a means of reducing abortion rates.

Failure of contraceptive methods

The use of contraceptives does not guarantee that a woman will not become pregnant. Methods fail because they are not infallible or because they are used improperly. The high failure rate of traditional methods such as periodic abstinence and *coitus interruptus* is more often the result of improper use than of the intrinsic ineffectiveness of the methods.^{26,27}

Similarly, although the effectiveness of the birth control pill is close to 100% in controlled clinical studies, the failure rates observed in population-based studies are closer to 8% per year of use.^{28,29} Several studies have shown that many pill users have not been instructed on proper use, frequently forget to take it or delay the initiation of a new cycle if they are away from their partner at the time. Most pill users are unaware that the chances of failure greatly increase if the pill-free interval is prolonged for even a few days.

There are virtually no user failures for methods that do not depend on user compliance, such as the Copper-T 380 and progestin-releasing IUDs and implants, which are among the most effective contraceptives available.^{30–32}

Lack of control in sexual relationships

Often women know about and have access to contraceptive methods but do not have control over their use every time they have sexual intercourse. In addition, they may not be using a method because they are not having sexual intercourse and are then unexpectedly forced to have sex without the means with which to protect themselves or the time in which to do so.

Far from being a rare event, sex against a woman's will is a rather common occurrence. Studies on sexual violence show a prevalence that varies from less than 10% to about 40% of women of child-bearing age.^{33–35} The differences in prevalence appear to be related as much to social distinctions between populations as to the various methods used to obtain the information and the different definitions of sexual violence.³⁶

Most studies are limited to the occurrence of rape, which is defined as imposed sexual intercourse using force or the threat of force. Their data do not include sexual coercion in exchange for obtaining or maintaining a job, passing an exam or satisfying other personal needs. Coercion is a much more frequent way of imposing sex than rape; however, the more subtle cultural imposition of unwanted sex and a woman's inability to make use of available protection during desired sex are even more relevant in determining unplanned pregnancy.^{37,38}

In a study carried out in one of the most developed regions of Brazil, 30% of the women interviewed reported having had sex physically imposed on them or having been coerced into sex, and an additional

32% reported having had sex against their will because they felt obliged to comply with their partner's desire.³⁹

Most studies also show that both adolescent and adult males believe that protection against pregnancy is the sole responsibility of the woman.⁴⁰ A study conducted in India among women who requested legal termination of pregnancy found that one-third of unwanted pregnancies could be attributed to the husband's unwillingness to use contraception or to improper or irregular condom use.⁴¹

Why is a pregnancy so unwanted that it ends in abortion?

No woman takes pleasure in having an abortion. For the majority of women, it is a very disturbing experience that they would much prefer to avoid.⁴² Women interviewed following a voluntary termination of pregnancy stated that they had been opposed to abortion until they had to face the choice between aborting and giving birth to an unwanted child. Many, however, continued to oppose abortion under any circumstances.^{43,44}

The most common reasons for women to decide to terminate a pregnancy can be grouped as follows: absence of the father, financial constraints, the inability to provide good parenting or interference with life prospects, conflict with prevailing social norms, health concerns and a lack of social support.

The absence of the father

The lack of a functional family unit or the absence of a partner who would assume his role as a father is a strong motivation to abort.⁴⁵ This happens not only among young, unmarried women but also among older women who may have been abandoned by a partner or may be in an unstable partnership.^{46–50}

Financial constraints

The lack of financial resources to support a future child or sufficiently care for existing children is a frequently declared reason for aborting.⁵¹ In fact, this financial insecurity is no more frequent in the poorest sectors than it is among the middle classes whose expectations for their children's future gain greater relevance.^{17,52}

Inability to provide good parenting/interference with life prospects

Particularly among adolescents, the feeling that they lack the maturity or preparation for motherhood is often expressed as their motive for seeking an abortion. The belief that pregnancy and motherhood would interfere with education and employment-related life prospects is a common reason for aborting.^{46,53} A study at a Brazilian university showed that 74% of students who became pregnant had abortions, whereas only 36% of female staff members in the same age group aborted their pregnancies.⁵⁴ Further analysis of qualitative aspects of the same study showed that the primary reason for aborting was inability to care for or educate the child.⁵⁵

Conflict with prevailing social norms

Newspapers around the world published the story of two women in northern Nigeria, both widows, who had each given birth to a baby, proof of their illicit sexual relationships. They were condemned to death by stoning for the crime of adultery.⁵⁶ Women who live in societies with such rigorous restrictions on extramarital sexual activity will often choose to abort a pregnancy that does not comply with the accepted norms.

The situation is not very different in many Western societies with restrictive social norms of their own. Transgressors do not risk being sentenced to death by stoning but they risk other forms of segregation that can destroy their social lives. In Latin America, extramarital childbirth is not socially acceptable among middle- or upper-class families. When there is no hope of arranging a marriage

before a pregnancy becomes evident, the only way to preserve both the family's honour and the social future of the pregnant woman is to abort.

Health concerns

Abortions for health reasons are most prevalent in impoverished countries.⁵⁷ This can be explained, in part, because other reasons for abortion occur less frequently in these countries and also because in societies that place great value on high fertility, only a threat to life can justify the decision to abort. For many women, the motivation behind their desire to preserve their own lives is the risk to their children's well-being if they should die, leaving them motherless.

Lack of social support

Except in some of the most highly developed countries, women worldwide are left alone to reproduce with very little support from society. Although, in theory, legislation in most countries protects women during pregnancy, labour and lactation, the laws are usually poorly written and rarely effective. In most cases, pregnant women struggle to maintain an income and spend long hours queuing to obtain basic, and sometimes inadequate, prenatal and delivery care. After delivery, they rarely find childcare facilities close enough to their place of employment to allow them to breastfeed and keep their jobs.

Thus, when a pregnant woman sees that her social group does not accept her pregnancy or a future baby, her partner may threaten to abandon her or may simply disappear, her employer may force her to decide between her job and having the baby, her school may not accept pregnant students or her family may not provide her with the support she expected. If society at large does not provide her with the support she needs, she may end up aborting her project of becoming a mother.

In all the above-described situations, the decision not to give birth showed a sense of responsibility, the desire to prevent a situation in which a child would be born into an unfavourable environment. The general conclusion is that, in most cases, the decision to abort is an expression of each woman's sense of concern about the responsibilities of motherhood or about the protection of her future or the future of her existing family.

Why abortions become unsafe

Induced abortions performed by a skilled professional, using an appropriate technique and in a hygienic environment are extremely safe, as illustrated by the death rate of 0.6 per 100 000 procedures in the USA.⁵⁸

Abortion becomes unsafe when it is performed by unskilled providers in clandestine and unhygienic conditions using dangerous procedures. Women are forced to resort to such abortion providers in countries in which the procedure is not permitted by law or where safe legal services are not universally accessible. Thus, there are basically two reasons for the existence of unsafe abortions: the persistence of restrictive laws and the incapacity of the government to provide safe services in countries in which abortion is legal.

Strategies to prevent and reduce the number of unsafe abortions and their consequences

Several interventions for addressing the problem of unsafe abortion are well known. These include (1) primary prevention: the promotion of contraception and sexual education to reduce the incidence of unwanted pregnancies; (2) secondary prevention: the promotion of safe abortion practices to reduce the need to resort to unsafe abortion; (3) tertiary prevention: post-abortion care and the management of abortion complications; and (4) prevention of the repetition of abortion in the same women through the provision of contraceptive counselling and services immediately after the abortion.

Promotion of contraception and sexual education

The International Conference on Population and Development (ICPD) of 1994 noted in its consensus statement that “All Government and relevant intergovernmental or non-governmental organizations are urged... to deal with the health aspects of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services”.⁵⁹

Considering that women fail to use contraception due to lack of information or incorrect knowledge about contraceptive methods, more effective means of providing information and education are required. Such information should be adapted to the characteristics of the population in which unmet needs are greater, which often includes rural and marginalised populations. The collaboration of traditional rural leaders is a basic requirement to ensure success in increasing the knowledge and use of contraception.

Depending on the characteristics of the population, the provision of contraceptive services may necessarily have to be free or heavily subsidised, otherwise it will remain inaccessible to large sections of the population in developing countries. Unfortunately, the concept that the rapid population growth has peaked worldwide is either incorrect or is being achieved through the practice of unsafe abortion, as in most of sub-Saharan Africa and many countries of South and Southeast Asia and Latin America. Nevertheless, the amount of resources allocated to providing information and contraceptive methods has almost dried up, leaving millions of women with no option other than unsafe abortion. Correcting that situation by renewing financial support for the provision of information and services in family planning will be necessary to reduce the very high rate of unsafe abortion in those countries.

In addition, if the goal is to reduce abortion, emphasis has to be placed on the use of highly effective and long-acting contraceptive methods such as medicated IUDs, implants and long-acting injectables. Injectables offer the advantage of not requiring medical intervention, although IUDs may be inserted equally well by non-medical professionals. Since these characteristics make them highly effective in reducing unwanted pregnancies and abortions, they should be given preference among the contraceptive methods available to women. Equally important is that women should know about these methods when choosing which contraceptive method to use.

The effectiveness of increased information and access to contraception in reducing unsafe abortion has been widely demonstrated.⁶⁰

Sexual education for young people is almost as important as family planning services and should be comprehensive and exempt from imposed values, teaching responsible sexual behaviour to young people of both sexes. The problem is that many parents oppose sex education in the erroneous belief that it would encourage young people to initiate sexual intercourse. Several studies have shown that the opposite is true, and that a properly imparted sexual education programme helps postpone the initiation of sexual activity, reduces the number of sexually active adolescents and prevents pregnancy among adolescents. Governments and non-governmental organisations (NGOs) interested in reducing induced abortion should make a concentrated effort to improve and expand comprehensive sexual education programmes in every country.

Promotion of safe abortion practices to reduce the need to resort to unsafe abortion

The 1994 ICPD consensus statement also said that “in circumstances where abortion is not against the law, such abortions should be safe”.⁵⁹ Unfortunately, 15 years after the Cairo ICPD Conference, in most countries with restrictive abortion law, women who comply with “circumstances where abortion is not against the law” still fail to obtain access to safe abortion services. Human rights activists should pay more attention to such violations of women’s rights and urge the governments concerned to urgently correct this anomaly that leads to the loss of thousands of women’s lives in the hands of backstreet abortionists.

A year later, the Beijing Conference on Women went one step further by recommending that governments review restrictive abortion laws. A few countries have acted on this recommendation, but there is still a long list of countries in which laws are so restrictive that most people interpret them as meaning that a woman is unable to obtain access to safe abortion under any circumstances. Governments and parliaments should understand that excessively restrictive laws are ineffective in reducing

the number of abortions, are unfair because they apply only to the poor and are the cause of suffering and high social costs. In addition, legalisation of abortion has been extremely effective in drastically reducing maternal deaths related to unsafe abortion and has shown that this change in legislation may be followed by a decrease rather than an increase in the rate of induced abortions.^{61,62}

Post-abortion care and the management of abortion complications

The 1994 ICPD statement noted that “In all cases, women should have access to high quality services for the management of complications arising from abortion”. Unfortunately, this may be one of the least considered and most neglected of the ICPD recommendations. Mistreatment of women consulting for complications of abortion is widespread, particularly, but not exclusively, in countries with restrictive abortion laws. A recent publication from Gabon offers the most dramatic illustration of the discrimination practised against women who have an abortion. They found that the average delay in providing care for women who died following eclampsia or post-partum haemorrhage was between 1.0 and 1.3 h, while for women who died following an abortion, this delay was 23.8 h.⁶³

The quality of the care provided to women consulting for abortion complications should be carefully audited. Human rights activists should pay greater attention to this issue and governments have an absolute obligation to ensure that women who abort receive the best quality care achievable in each health service. Women have abortions because society failed to provide them with information and access to effective contraception or failed to protect their pregnancy and motherhood. Health providers have no right to accuse, judge and condemn these vulnerable women.

Prevention of repeat abortion in the same woman through the provision of contraception counselling and services immediately following abortion

Finally, the 1964 ICPD statement also said that “Post-abortion counseling education and family planning services should be offered promptly, which will also help avoid repeat abortion.” Women who had induced abortions state that they do not intend having a baby and will go to the extreme of terminating their pregnancies to achieve that purpose. These women have a greater need of contraceptive counselling and services than the average woman because they are at a high risk of aborting a subsequent pregnancy.⁶⁴

Recently, the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the International Council of Nurses (ICN) and the United States Agency for International Development issued a consensus statement on ‘Family Planning: A Key Component of Post-Abortion Care’. The final sentence of this statement reads: “Policy makers and governments need to hear the voices of health professionals and to consider the evidence that support ... provision of family planning, especially in the same location as the post-abortion service. When quality of care is improved, lives are preserved, staff time is saved, costs are lowered and all benefit”. There is nothing more to add to such a recommendation.

Conclusion

Unsafe abortion is a major cause of maternal mortality and morbidity that almost exclusively affects the less developed countries and the poorest sectors of the population in those countries. The interventions to prevent and reduce unsafe abortion are known and a number of international statements have recommended that governments implement these interventions: (1) reduce unmet needs for family planning through expanded and improved contraceptive information and services; (2) universal sexual education that stimulates responsible sexual behaviour among young people of both sexes; (3) make safe abortion services available and accessible to the full extent of the law; (4) revise restrictive laws still remaining in countries with high unsafe abortion rates; (5) provide high-quality health services to women with complications of abortion; and (6) ensure that all women consulting for post-abortion care receive appropriate counselling and education, and that high-quality contraceptive services are provided at the same site.

The countries more severely affected by high rates of unsafe abortion and associated maternal death are generally among the poorest in the world. They need external support. However, any plan of action to prevent and reduce the number of unsafe abortions and their consequences should consider the recommendations of the Accra Agenda for Action to Achieve the Millennium Development Goals: Greater national ownership, less fragmentation of funding and more effective partnerships among international and national organisations and agencies, and between these entities and national governments.⁶⁵

Practice points

- There is very clear evidence that family planning programmes are effective in reducing the number of abortions.
- Broad-based, unbiased sexual education programmes can postpone sexual debut and decrease adolescent pregnancies and abortions.
- High-quality post-abortion care reduces abortion-related maternal mortality and severe morbidity.
- Women with abortion complications are at a high risk of repeat abortion and need contraceptive counselling and services more urgently than the average woman.
- Pregnancy terminations, performed by skilled professionals using appropriate techniques and in a hygienic environment, are as safe as an injection of penicillin.
- Legalisation of abortion is followed by a dramatic reduction in abortion-related mortality and is not associated with any increase in the rate of induced abortions.

Research agenda

- Strategies for providing contraceptive information and services to rural communities and other marginalised groups.
- Effectiveness of simpler approaches to comprehensive education on responsible sexual behaviour.

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