UNSAFE ABORTION
AND POST ABORTION CARE

Introduction

Every year, millions of pregnancies end in abortions, some spontaneously while others are induced. Induced abortion has been in existence through the ages, but it has been surrounded with an atmosphere of taboo that in some countries it occurs underground. Unsafe abortion is an issue which we have to confront if we are to prevent or reduce its occurrence.

Women who resort to unauthorized facilities and/or unskilled providers put their health and their lives at risk. Among the causes of maternal mortality in developing countries, unsafe abortion accounts for 13% of maternal deaths.

As obstetricians, we are familiar with the sight of a teenage girl who comes to the hospital for help because of profuse bleeding after having been to a traditional birth attendant who forcibly inserted an instrument into her womb to terminate a pregnancy. Now she lies dying at age 14! A 24 year old woman with one child has to undergo surgery and pelvic clean-up because of severe infection after a catheter has repeatedly been inserted vaginally. Another useless death.

Definition of unsafe abortion

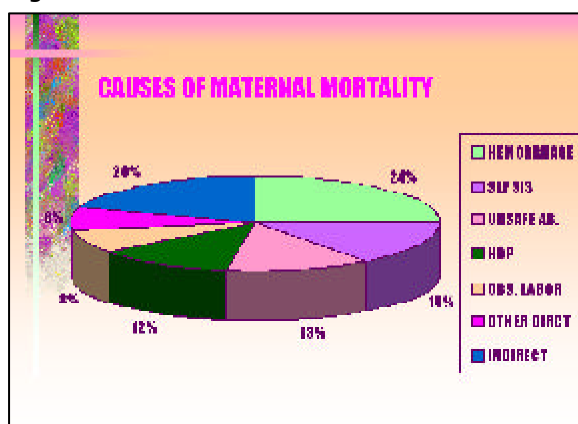
WHO refers to unsafe abortion as a procedure for terminating an unwanted pregnancy done by persons who may lack the necessary skills or conducted in an environment that lacks the minimal medical standards, or both. Unsafe abortions may

be performed by the woman herself, by non-medical persons, or by health workers in unhygienic conditions. Such abortions may be induced by the insertion of a solid object (usually root, twig or catheter) into the uterus, by improperly performed dilatation and curettage procedure, the ingestion of harmful substances or exertion of external force.

Scope of the problem

Women who resort to unauthorized facilities and/or unskilled providers put their health and their lives at risk. Among the causes of maternal mortality in developing countries, unsafe abortion accounts for 13% of maternal deaths

Figure 1: Causes of Maternal Deaths



Spontaneous abortions and abortions done under sanitary conditions by qualified persons who used the correct techniques are rarely fatal and seldom present complications.

Worldwide, it is estimated that around 53 million abortions are perfromed every year. With 140 million births a year, approximately one induced abortion takes place for every three births. Around 30 million or about 90% of the abortions take place in developing countries and 20 million of these are performed under unsafe conditions.

In a recent five-year period study, at least 86% of all induced abortions in Latin America and 96% performed in Africa were unsafe. Globally, about two out of five abortion procedures are unsafe and between 100 000 and 200 000 women die of unsafe abortion every year. More than 120 million women in developing countries who want to practise family planning fail to do so, which may contribute to the number of induced abortions.

Abortions performed by qualified persons using correct techniques and under sanitary conditions, as well as spontaneous abortions, are rarerely fatal and seldom present complications. However, the risk of death following complications of unsafe abortion procedures in developing countries is 1 in 250 procedures as against 1 in 3750 procedures in developed countries.

In Asia, 9 900 000 unsafe abortions occur every year with 500 000 in Western Asia. The incidence rate is 27 per 1000 women (15 to 49 years old), and the incidence ratio is 13 per 100 live births. The estimated number of deaths is 38 500 with a mortality ratio of 46/100 000 live births. Twelve percent of maternal deaths are due to unsafe abortion. For the Oceania region, the incidence ratio is 12/100 with a mortality ratio of 51/100 000 live births which account for 8% of the causes of maternal deaths.

Table 1: Global and regional estimates of incidence and mortality of unsafe abortion 1995-2000

	Estimated number of Unsafe abortions (1000s)	Estimated number of deaths due to Unsafe abortion	Case fatality rate (deaths per 100 unsafe abortion procedures)
World total	20,000	78000	0.4
More developed Regions*	900	500	<0.1
Less developed regions	19000	77500	0.4
Africa	5000	34000	0.7
Asia*	9900	38000	0.4
Europe	900	500	<0.1
Latin America and Caribbean	4000	5000	0.1
Oceania*	30	150	0.4

Abortion, 2nd Edition, WHO

Reasons for increase in abortion

It is estimated that the incidence of induced abortion is increasing globally. Among the reasons for this are the changing trends worldwide, such as the desire for smaller families and the shifts from rural to urban conditions. In a study by Rankole et al in 27 countries, women cited that the most common reason for having an abortion was to postpone or stop childbearing.

The second most common reason was socio-economic concerns including disruption of education or employment, lack of support from the father, desire to provide schooling for the existing children and poverty, unemployment or inability to afford additional children. In addition, relationship problems with a husband or partner and a woman's perception that she is too young constitute other important categories of reasons.

With a few exceptions, older women and married women are the people most likely to claim limiting childbearing as their main reasons for abortion. It seems that the decision to have an abortion is motivated by more than one factor. This research supports the view that improved contraceptive practice is an important means of reducing abortion. At present, there is a gap between contraceptive need and use. It has been estimated that 120 million women in the developing countries want to practise family planning but lack the means to do so.

- Evidence from demographic and health surveys carried out in 40 countries shows that a large number of women want no more children or want to space their births. Family planning services are frequently insufficient to meet the demand or may be inaccessible, unaffordable or there may be a range of social barriers that deter women and couples from using them. Studies show that many married women in developing countries do not have access to the contraceptive they want to space pregnancies or limit family size. The situation is worse for unmarried women, particularly adolescents who rarely have access to reproductive health information and counseling and frequently are excluded from contraceptive services. Studies by Gui, luo Lin et al in China found that non-use of contraceptives is a primary reason for unwanted pregnancy and abortion.

- Shifts from rural to urban residence where unmarried adolescent girls have less parental supervision and fewer traditional constraints, and have more exposure to media change and socio-demographic characteristics.

- Studies have also shown that unsafe abortion, either self induced or performed by an unqualified abortionist, is often sought by adolescent unmarried girls.

Recourse to unsafe abortion

In Romania, the number of abortion-related deaths increased sharply after November 1966 when the government tightened a previously liberal abortion law. The maternal deaths rose from 20/100 000 live births in 1965 to almost 100 in 1974 and 150 in 1983. When abortions were legalized again in December 1989, maternal deaths due to abortion dropped down again to about 60/100 000 live births.

However, even in countries where abortions have been legalized, many procedures are still performed outside the legal health systems. In India, for example, although abortion was legalized in 1972, an estimated 4.7 million abortions are performed annually outside the approved facilities. (ISSRF Newsletter, 2000). The identified reasons were "non-access to free or subsidized abortion services, unaffordable services, lack of confidentiality and ignorance of the legal status of abortion".

In general, women resort to unsafe abortion for the following reasons:

- Legal and administrative constraints. Only 22% of countries have abortion laws which allow the procedure on request. Six percent of the world's developing countries among them Albania, China, Cuba, the Democratic Republic of Korea, Tunisia, Viet Nam and most of the countries emerging from the former USSR allow them on demand. While these constraints may lead to unsafe abortion, studies have shown that mere legalization is not sufficient to reduce its incidence.

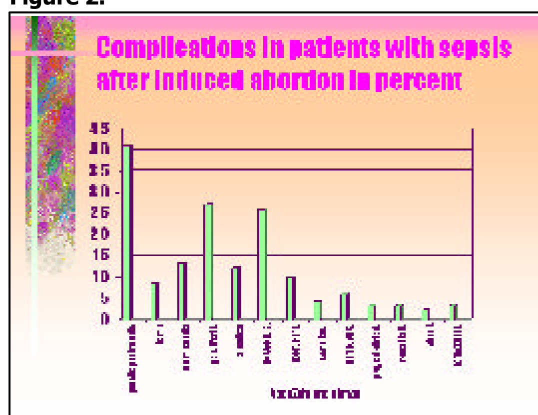
- Low governmental priority. Abortion services (where abortion is legal) are not accessible nor affordable to women who have low socio-economic status and who are more prone to have frequent and unplanned pregnancies.

- Attitude of service providers. Because of the legal, ethical and religious constraints, and their own personal views, some providers tend to appear unsympathetic to women with unwanted pregnancies. In a study in Sri Lanka, for example, 41% of the providers said that abortion was on the increase in their country because "these women were ignoring social values" "These women" then would rather avail of services clandestinely.

- The general policy of health facilities depends upon the legal status of abortion or on the officials of the health facilities.
- Non–use of contraceptives. The incidence of unsafe abortion is a reflection of the degree of unmet need in family planning.

Consequences of unsafe abortion

Figure 2.



The consequences of unsafe abortion place great clinical, material and financial demands on the scarce hospital resources of many developing countries. Aside from death, there can be life-threatening complications like sepsis, hemorrhage, uterine perforation and cervical trauma which can lead to problems of infertility, ectopic pregnancy, permanent physical impairment like PID, tubal occlusion and chronic morbidity which in turn, may lead to increased risks of spontaneous abortion and premature delivery. Death may occur due to gas gangrene and renal failure. In addition, the treatment of abortion complications in hospitals uses a disproportionate share of resources including hospital beds, blood supply and medication, as well as access to operating theaters, anesthesia and medical specialists.

Figure 2 shows the complications in patients with sepsis resulting from unsafe abortion as collected by AbouZhar with maternal deaths at 8%. A number of these patients had to undergo laparotomy. In a study in South Africa, hysterectomy was performed on 35 out of 647 patients. Eighteen of these women were pregnant for the first time.

Aside from the physical trauma, women suffer from psychological trauma and social guilt imposed by society. In a South African Study (Maforah, Medical Research Council), the compulsion among women to terminate pregnancy overrode the legal and religious considerations and demonstrated the isolation and loneliness of the women in their situation. They were willing to risk their lives just to rid themselves of the unwanted pregnancy. Most could not talk because of fear of being stigmatized and lack of trust. Some women did not even tell their partners about the pregnancy and the intention to abort because of fear of violent reactions. In a multi-centred study conducted in the Philippines, some service providers were reported to have scolded women for having submitted themselves to abortion which is considered a mortal sin by the Church.

Regardless of the ethical, moral and legal constraints a society places on abortion, women who have experienced abortion, especially unsafe abortion, should have access to high quality post-abortion care. This is easier said than done because policies of health facilities and attitudes of providers affect the care given to these women. Nevertheless, it is the right of every woman to have access to quality care.

Post-abortion care

Post-abortion care is a service delivery strategy built around three elements namely:

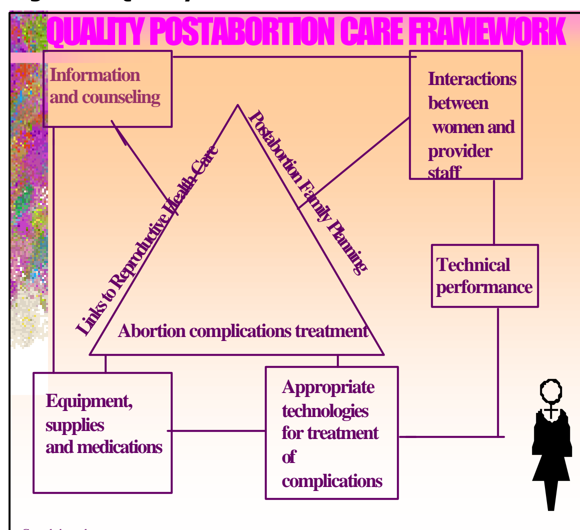
1) emergency treatment serrvices for incomplete abortion and related complications to reduce morbidity and mortality, implying the use of appropriate technologies;

2) post-abortion family planning to prevent unwanted pregnancy whereby services may be provided depending upon the physical and psychological condition of the woman at the time. Good counseling is mandatory prior to the patient's discharge from the health facility to insure informed choice in the use of a family planning method; and

3) comprehensive reproductive health services to improve women's overall health status.

Figure 3 shows the quality post-abortion care framework as formulated by IPAS, demonstrating the three important elements.

Figure 3: Quality Postabortion Care Framework



Greenslade et. al.

Abortion complication treatment refers to appropriate technologies in the treatment of complications. This would involve both medical and surgical interventions as necessary. Needless to say, it requires the availability of equipment, supplies and medications which are appropriate to the specific service delivery setting.

Technical competence is the proficiency with which all members of the health care team perform the tasks involved in post-abortion care. In this regard, there has to be an adequately trained staff with appropriate supervision. Protocols for treatment and referrals should also be available.

Interactions between Clients and Providers/Staff

This involves all the interactions that women have with providers and staff when they seek and receive abortion care. This requires support for women and their situation. Their attitude should be non-judgmental, with due respect to women's need for confidentiality and their ability and right to make an informed choice. It is also an opportunity to allow women to express their views, concerns and questions.

Post-abortion family planning and reproductive health care are additional services which women need to have. This care must be delivered in the context of the quality care framework. Contraceptive service may be provided or appropriate referral made as necessary.

Post-abortion clinical treatment

Usually, women come to health facilities with vaginal bleeding which turns out as a case of incomplete abortion. During clinical assessment, it is important to determine the presence of other complications like shock, sepsis, intra-abdominal injury or severe vaginal bleeding to be able to prioritize treatment. Patients should be stabilized prior to the evacuation of the uterus. Uterine evacuation can be done through vacuum aspiration or dilatation and curettage.

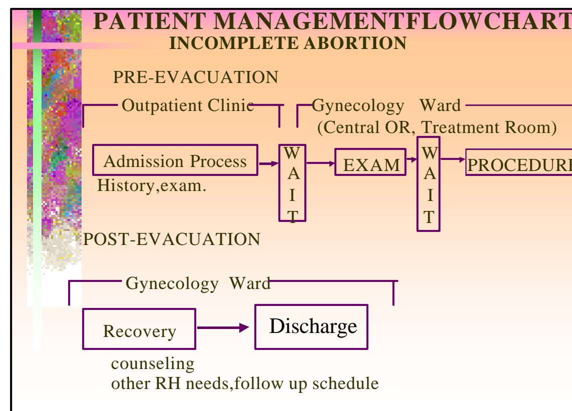
The patient may have other reproductive health needs which can be attended to at this time like screening for reproductive cancers or sexually transmitted infections. Counseling should be part and parcel of the clinical management where women can discuss their concerns with assurances of confidentiality.

Patient's management flow chart for incomplete abortion

Usually, patients present themselves at the Outpatient Clinic where they are admitted in the hospital for the evacuation procedure. Waiting time should be minimized especially if there are other existing complications which have to be treated as soon as possible to reduce morbidity and mortality.

After recovering from the procedure, counseling and screening for other reproductive health needs and service provisions should be available before discharge.

Figure 4: Patient Management Flowchart



Abernathy et al. A Guide to Assessing Resource Use for the Treatment of Incomplete Abortion, Carrboro, NC: IPAS, 1993

Manual vacuum aspiration versus dilatation and curettage

WHO recommends the use of manual vacuum aspiration because it is the less innocuous procedure which can be performed even by trained non-physicians. It can also be carried out in primary health facilities and has been proven to be more cost-effective. D&C requires a trained physician to do the procedure. As shown in Table II, more complications were noted in the D&C than MVA. This is significant considering the fact that 15% of pregnancies terminate in spontaneous abortions.

Table 2: Comparison of Complication between Manual Vacuum Aspiration and D&C (13 Studies)

Major complications reviewed	Complications MVA/100 procedures	Complications D&C per 100 procedures	Studies with lower Complication rates for MVA Over D&C
Excessive blood loss	0-15.7	0.5-28	10 of 13 (78%)
Pelvic infection	0.2-5.4	0.7-6	7 of 9 (78%)
Cervical injury	0-3.1	0.3-6.4	6 of 7 (86%)
Uterine perforation	0-0.5	0-3.3	10 of 12 (83%)

Greenslade et al 1993

Problems in management

A number of women delay seeking consultation until more severe complications have set in. During the initial interview, they usually deny having been subjected to an intervention which hinders early diagnosis. The denial is due to fear of legal and social sanctions.

There may be difficulty in clinical assessment due to lack of adequate technical competence and appropriate facilities. Another barrier to quality management is the judgmental attitude of some service providers who consider abortion as a sin and treat patients with indifference, going to the extent of delaying treatment or withholding analgesia.

Service providers may not have adequate counseling skills to understand the feelings and reactions of women nor to persuade them to accept a method that will prevent them from having another unwanted pregnancy.

Factors affecting post-abortion family planning acceptance

The opportunity for counseling is nil, considering that women are not mentally and psychologically receptive for family planning counseling and method delivery may not be possible due to logistical inadequacy. Some facilities may not be able to provide service.

The insensitive, often, punitive attitude of the staff may hinder acceptance of a family planning method. Tertiary facilities are more curative and crisis oriented and may not dedicate sufficient time for a more holistic care of patients. Women are generally not aware that fertility returns two weeks after abortion, so they would need the use of contraceptives earlier than postpartum women. The presence of complications will affect the timing and choice of contraceptives. IUDs are not immediately inserted in women with complications of infection.

Unsafe abortion is a major public health concern. One of the strategies to reduce it would be the establishment of expanded and improved family planning services. There is a need to determine the unmet need of family planning and develop strategies that will address women's concerns on why the contraceptive use is low.

A Bellagio Technical Working Group made the following clinical recommendations for women receiving abortion care:

1. All modern contraceptive methods can be used immediately after abortion care, appropriate client screening and informed choice.

2. Women should abstain from sexual intercourse until post-abortal bleeding stops and all complications are resolved.

3. Natural family planning is not recommended until a regular menstrual pattern returns.

In the 1994 ICPD, governments agreed that "in no case should abortion be promoted as a method of family planning". The Cairo Plan of Action urged all governments and relevant inter-governmental and nongovernmental organizations to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning. Prevention of unwanted pregnancies must always be given the highest priority and every attempt must be made to eliminate the need for abortion.

Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be made safe and accessible to women. Information on methods to be used and location of health facilities should be disseminated. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.

Dr. Forest Greenslade of IPAS recommends education of the health staff and continuous advocacy to professional communities, donor agencies and country partners to effectively address unsafe abortion. He further makes the following recommendations:

- Describe the problem of unsafe abortion accurately and consistently. Use language that highlights the public health nature of unsafe abortion, rather than concentrate on the sensitivity that surrounds the issue.
- Make use of existing technical resources as you begin programming to avoid "recreating the wheel". WHO recommends MVA as a cost effective method. This should be supported by donors in terms of equipment provision.
- Look past the clinical moment and make the provision of abortion care a comprehensive reproductive health experience. Women who seek assistance for abortion-related problems are not likely to be common users of health services and may not be willing or able to return for other care.

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