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Abortion Across Social and Cultural Borders

Fertility Regulation—Family Planning and Abortion

FERTILITY control is practised in all societies. The need to regulate the number and timing of births is universal as are the methods used since ancient time to do so, either by prevention or by termination of pregnancy. Historically, fertility decline has been achieved by means of cultural and social norms for marriage and family life. Traditional methods such as breastfeeding and withdrawal, and induced abortion have been in practise for a long time. Condom, men's contraceptive has a long history, but not until recently, highly effective pharmacological contraceptives for women have been available. In fact, the demographic transition in many countries in Europe, Australia and North America occurred long before oral contraceptives or other modern methods were heard of. Nevertheless, family planning programmes and fertility surveys of today focus on oral contraceptives, IUDs and other modern methods, neglecting the widespread use of traditional contraceptive methods and induced abortion as birth control measures.

Abortion must be considered when studying the demographic transition. Induced abortion has been instrumental for the fertility decline in Japan and Eastern Europe. Slowing down the rate of population growth in China is partly due to postponement of marriage and the first child and partly due to the access to services for fertility control, including abortion (Henshaw 1990).

Abortion and contraceptive practices differ from country to country. The practice of abortion is conditioned by cultural and societal views on sexuality and reproduction, current legislation and its application, and access to reliable contraceptives and safe abortion services. Depending on where a woman lives, her abortion experience may range from a safe, legal method for termination of an unwanted pregnancy to a dangerous, painful and criminal act.

Traditionally, main reasons for choosing abortion are social-economic constrains or the protection of family honour. To protect themselves and their family poverty or to conceal

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an illegitimate pregnancy, women always have and always will resort to abortion even if it is dangerous or forbidden.

Abortion services, mainly separated from family planning services, are available in some countries and insufficient or totally lacking in others. In societies where information and services on contraceptives are scarce or prohibited, abortion has been extensively used as birth control measure, irrespective of its legal status.

If both contraceptives and abortion facilities are available, people will use contraceptives as their first choice. Even where contraceptives can be obtained, however, there will always be situations in which women have to resort to an abortion. Contraceptives fail and human relations break. Abortion is needed as a back-up to contraception in order to avoid giving birth to an unwanted child.

Abortion as a Health Issue

Induced abortion is also a health issue with far-reaching consequences for women's health and social life. Worldwide, one pregnancy in four ends in abortion. Forty to sixty million abortions occur every year and at least half of them are illegal and/or performed under unsafe conditions (Henshaw, 1990). Each year 500,000 women die in during maternity. Up to 200,000 of these maternal deaths are due to unsafe abortions. Practically all maternal deaths from abortion and from other causes occur in the developing world (Roystone and Armstrong, 1989).

Many times more than maternal deaths, women suffer from complications—injuries, perforations, hemorrhage, infections from unclean instruments, toxic reactions from drugs or injected solutions. Many women who survive experience difficulties in their sexual life, complicated deliveries, chronic pelvic pain, incontinence and infertility. Generally speaking, the abortion-related mortality is highest in countries where abortion is legally restricted, where reproductive health services are insufficient, and where the overall maternal mortality is high. In contrast, in a country where abortion is legal and services are adequate, no woman who opts for an abortion needs to risk her health or fertility (Sundstrom, 1993).

Even within a country the disparity is striking. Wherever abortion is forbidden, safe services are available for those who can pay. Women with money and connections can seek privately or go abroad for a safe abortion. Typically, the poor, the young and the less educated women have to resort to unsafe, obscure and painful procedures.

Legal Status of Abortion

Most countries have laws and regulations to control reproduction and to regulate the practices of pregnancy termination. In the 1950s, abortion was illegal in most countries, except for some Scandinavian and East European countries, the Soviet Union and Japan. Since then, however, a number of countries, including the USA, China, India and most European countries, have changed their laws to permit abortion on request or for broad range of medical and

social reasons (Dixon-Miiller, 1990). It may be noted that in Europe, Catholic Italy has abortion on request, while Poland adopted in 1993 a very restrictive abortion law.

Many developing countries still have hard-line abortion laws, long after their former colonisers have liberalized their own legislation. Latin America, Sub-Saharan Africa and the Arabic countries have the most restrictive laws. India, Zambia and Uruguay are among the few developing countries in which abortion is allowed for both social and medical reasons.

In China and Vietnam, abortion is promoted as a means to control population growth, and public health services for abortion and contraceptives are provided in the public health system.

In USA determined opponents to the constitutional right to abortion from 1973, led by religious and pro-life movements, have tried to restrict access to abortion both in the USA and internationally. When less successful in the industrialized world, these groups have moved their anti-abortion campaigns to developing countries (Dixon-Miiller, 1990). In Sub-Saharan Africa, in Latin America, the Philippines and other Asian countries, the Catholic Church exerts strong pressure on weak governments to refrain from legalizing abortion or providing contraceptives to prevent unwanted pregnancies. While Catholic countries such as France and Italy allow abortion on request, the Pope's influence over the former communist countries in East Europe has become stronger. The Polish parliament has banned both abortion and the use and provision of contraceptives. Hungary, Czechoslovakia and Republics of the former Soviet Union have laid restrictions on contraception and/or abortion and increased the cost for services.

One notable exception is that of Romania, where abortion was legalized in 1990 after 25 years of very restrictive policy. The immediate effect in terms of better reproductive health for women was striking. Within one year the maternal mortality dropped by half to the same level as before abortion was criminalized in 1996.

The Need for Services

The legal status of abortion does not always ensure access to services. Rather, it is the application of the laws, which determines whether a woman will have a safe or an unsafe abortion. For instance, in Latin America safe abortion services are available at numerous clandestine clinics for those who can afford them. In Indonesia, where abortion is also illegal, abortions are performed in teaching hospitals as part of medical training. In Bangladesh, services are provided for menstrual regulation before a pregnancy is confirmed even though abortion is strictly forbidden, as in most Muslim countries. On the other hand, though abortion is legal in India and Zambia, women are driven to clandestine procedures since service are insufficient to meet the demand (Dixon Miiller, 1988).

Fertility and Abortion in Different Contexts

The circumstances and the health risks in relation to abortion differ considerably between countries and within countries in the world today. The consequences for women concerned

are influenced by a number of variables, including attitudes to sexuality and family life, religious and cultural beliefs, legal status of abortion and quality of health services.

To illustrate the variations, the abortion situation in some selected countries will be described. Background variables on fertility and maternal health are presented in Table 1. The figures are from different sources, some more, some less reliable. Data on fertility rates and economic development are survey data from the 1990s (the World Bank, 1993), maternal mortality from WHO publications (Roystone and Armstrong, 1989; WHO, 1995). Reliable data on legal abortion are reported from North America and Scandinavia (Henshaw, 1990; Sundstrom, 1993), East Europe (David, 1992) and Vietnam (Goodkind, 1994). Estimates of illegal abortions are based on hospital-and community based studies in Latin America (Singh and Wulf, 1991) and Africa (Coeytaux, 1988; Kwast *etal.*, 1986). The figures from the former Soviet Union include both legal and illegal (performed outside the public health system) abortions (Popov, 1991).

The Total Fertility Rate (TFR)—the number of children a woman on average will have during her life time, given the present birthrate—is compared with an estimated Total Abortion Rate (TAR)—the average number of abortion per woman.

The countries are listed in order of overall Maternal Mortality Ratio (MMR), from less than five maternal deaths per 100,000 births in the North to 600 in Sub-Saharan Africa. The Gross National Product (GNP), shows an opposite trend with the lowest GNP in countries with highest MMR. The exception is Vietnam, where MMR is about one fifth of that in other low income countries, and one half of the mortality in Brazil.

TABLE 1: FERTILITY, ABORTION, MATERNAL MORTALITY IN SELECTED COUNTRIES

Country	*GNP*	*MMR*	*Ab-M*	*TFR*	*TAR*	*Abortion*
Sweden	25100	*<5*	0	2.1	0.6	Legal
USA	24750	10	<5%	2.2	0.8	Legal
Hungary	3450	20	1%	1.8	1.2	Legal
USSR	3220	50	30%	2.4	5.4	Legal
China	1538	60	10%	2.4	1.2	Legal
Vietnam	350	110	10%	3.7	2.5	Legal
Brazil	2940	200	25%	3.0	2.3	Illegal
Bangladesh	220	570	20%	4.3	1.2	Illegal
Kenya	340	600	30%	6.6	0.9	Illegal
Ethiopia	110	600	50%	7.0	0.9	Illegal

GNP = Gross National Product, per capita, US$
MMR = Maternal Mortality Ratio: Number of deaths related to pregnancy and childbirth/100.000 live births
Ab-M = Percentage of maternal mortality due to abortion
TFR = Total Fertility Rate: Number of births/woman during her lifetime
TAR = Total Abortion Rate: Number of abortions/woman during her lifetime

Family Patterns

The countries represent different stage of demographic transition. Sweden, the USA and Hungary have since long had a total fertility rate around two. The maternal mortality ratio in these countries is low, abortion is legal and safe abortion services are easily accessible for most of the women. The abortion rate varies, reflecting variations in information and services on contraceptives. Sweden has a long tradition of sex education in the school curriculum, while, both in Hungary and USA, education on sexuality, reproduction and contraception has low priority. The higher abortion rate in the USA compared to Sweden is mainly because of the high rate of teenage abortions. In Sweden young people are expected to prevent unwanted pregnancies, and also have the knowledge and means to do so, while the American teenagers are expected 'just to say no'.

China, Vietnam and Brazil have experienced a rapid fertility decline in the last century and report fertility rates around three children per woman. In China the low rate has been achieved by propagating the strict one child policy, high age of marriage (ideally 25 or more, in reality 22.4) and the provision of reliable contraceptives and legal and safe abortions. Abortion is used as one of several methods for family planning after the birth of the first or second (if any) child. In Brazil, like in China and Vietnam, a high number of abortions have contributed to the rapid fertility decline. Unlike in these countries, however, abortions in Brazil are illegal and very often performed under unsafe conditions, resulting in a high abortion related maternal mortality.

In Bangladesh, Kenya and Ethiopia the fertility rate is high, four to six children per woman. Most pregnancy terminations are illegal and/or unsafe and despite the relatively low abortion rates in relation to births, more than one third of the very high maternal mortality is due to unsafe abortions.

The Abortion Situation in Selected Countries

Sweden—Legal Abortion and Reliable Contraceptives

In Sweden the total fertility rate is 2.1 children per woman, which is high today for a country in Europe. The total abortion rate is 0.6. This means that a woman on average gives birth to two children and that every second woman will have an abortion during her reproductive life. People have access to modern contraceptives and abortion on request. Contraceptives are used during long periods before and after the childbearing years. Most abortions are performed early in the pregnancy, and the procedure is one of the safest in gynaecological care. Accordingly, in Sweden, the morbidity from abortion is very low and the mortality is nil.

In terms of sexuality and reproduction, the 1960s was a transition period in the Swedish society. The issues of sexual equality and gender roles were raised, the labour market was opened for women and oral contraceptives became available. Still, however, the right to abortion was restricted, contraceptives were expensive and services were difficult to find, at least for

young and unmarried women. However, lobbying from women's organizations and a lively public debate on women's issues and women's emancipation smoothed the way to the legislation on abortion on request in 1974. It was also a demand from female health workers and activists that the Abortion Act should be combined was preventive efforts and appropriate contraceptive services.

The reproductive freedom, women achieved in the 1970s, through the access to safe and reliable contraceptives and legal and safe abortions, was used not so much for limiting the number of children as for timing the childbearing, to postpone the first child. From then on the attitudes in society changed to more acceptance of premarital sexuality and single mothers.

Today, young people often start a sexual relationship at an early age and live together for several years without the intention to form a family. Usually they want to complete their education and launch a working career before they have their first child. To become pregnant is often the result of a deliberate decision and for many women it is a more important step than the decision to live together with a man. Women want to choose the appropriate time and, above all, the right father for the child.

The postponement of the first child is the most characteristic trend in the contemporary demographic development. The fertility decline which started in late 60s, lasted in 1984. The reasons for the low birthrate in the Seventies was a predominant norm of two children per family together with an increasing tendency to postpone the first child. The median age for the first child went from 23 year in 1965 to 26 in 1985. In addition, less and less women gave birth to a third child.

Since 1985 the fertility rate has shown an upward trend often to refered as a baby-boom. In 1989 the number of children per woman reached just over 2.0 for the first time in 20 years. As reasons for the high birth rate in Sweden, not seen in other European countries, are suggested partly larger age cohorts in childbearing ages, partly a statistical effect of the previous postponement of the first child, and partly an increasing inclination to have more than two children (Hoem, 1992). This in turn may reflect improvement in the social welfare system regarding child allowances and parental leave (Hoem, 1993).

East Europe—Abortion as a Birth Control Measure

In the early 1950s, the Soviet Union and several of its Eastern European satellites experienced a decline in fertility. Since no modern contraceptives were available at the time and since most of the countries had adopted liberal abortion laws, abortion became the main method for birth control. The widespread use of abortion contributed to the fertility transition, especially evident in the USSR.

In Hungary as in other East European countries, the majority of women and men who wanted to limit the family size accepted abortion as a safe method of fertility regulation. Two children per family, rather early in life, used to be a common pattern. Unlike in Sweden, the birth rate fell in the late 1980s to a total fertility rate of 1.8. To day it is even lower. The abortion rate, that used to be very high, has declined in the 1980s to an estimate of

1.2 abortions in a woman's lifetime (Henshaw, 1990). Abortion services are available in public health institutions at reasonable cost. First trimester abortions dominate and the complication rate is low. Access to contraceptive services has improved and the use of modern contraceptives is increasing, but still it is at a fairly low level.

A study of the use of contraceptives versus abortion in Hungary and in the city of Moscow in the 1980s reveals significant disparities in birth control practices in Russian and Hungarian societies. More than 60 per cent adolescents in Hungary used contraceptives compared to less than 40 per cent in Moscow, while few in either area relied on abortion. After the first or second child, women in both countries practised some type of family planning. In Hungary the majority used contraceptives, while the women in Moscow chose abortion as often as contraceptives. After the age of 35 the use of abortion increased to about 30 per cent in Hungary and 60 per cent in Moscow. The differences reflect the insufficient access to family planning services and supply of contraceptives in Russian society (Popov, 1991).

In the USSR, in the late 1980s a woman had, on average, 2.4 children in her lifetime and 5.4 abortions. This abortion rate includes both officially registered abortions and those performed outside the public health service. In 1988,6.5 million legal abortions were reported, which represented 10% of the world's total of induced abortions. In addition, about 4 million so-called 'illegal' abortions occurred, including out-patient menstrual regulation, abortions in private or industrial clinics, and also botched and unsafe procedures (Popov, 1991).

Since the services and supply of contraceptives in many republics of the former Soviet Union are severely insufficient, reliance on induced abortion is not a matter of choice, but a pressing necessity created by the lack of any viable alternative (David, 1992). Though abortion services consume a large proportion of resources, they are far from sufficient and adequate. In recent years, due to lack of disposables, drugs and anaiesthetics, the complications in relation to hospital abortions have increased. In 1988, the previous practice of extra pay for better quality was 'legalized' by the system of commercialized and private medical care. These services are safer, but out of reach for most women (Popov, 1994).

Women in the republics of the former USSR, with no other options for limiting the family size than induced abortion face a grim situation. They are afraid of the risks related to hospital-performed abortions and can not afford either abortion or contraceptive services from private sources. The maternal mortality in the USSR has increased since the 1980s and about 30% of the mortality and morbidity is related to abortion. There are wide variations between and within the republics and in many areas the abortion-related morbidity is higher than what the official figures indicate (Popov, 1994).

Latin Ameria—Hypocrisy and Macho Culture

Historically Brazil, like other Catholic countries in Latin America, has had a very high rate of illegal abortions. In recent decades the fertility in Brazil has decreased and a woman will have on an average three children and 2.3 abortions. Contraceptive services are not available in public health care, but oral contraceptives are sold over the counter. They are widely used but the discontinuation rate is high due to high costs and inadequate supply (Singh and Wulf, 1991).

In Brazil, a young woman is trapped in the double standards of the macho culture. Young women are expected to refrain from sex before marriage, while young men are excused for their strong sexual needs. A girl who takes precautions by using contraceptives is looked upon as a 'bad' woman. Premarital sexual relations are common, while virginity is still important on the marriage market. Although abortion is strictly forbidden, safe abortion services are widely marketed. In all big cities there is a network of clinics advertising 'early pregnancy diagnosis' or 'all types of reproductive health services', which stands for high quality abortion services. The majority of women, among them an increasing number of teenagers, have to resort to less expensive and unsafe procedures. The result is a high rate of abortion-related maternal mortality, 25% of a mortality ratio of 200 (Barbosa and Arilha, 1993).

Population Policy and Abortion in Vietnam

In Vietnam, abortion services are part of the national family planning policy to control population growth. In the late 1980s, in connection with a rapid social transition and the shift from the centrally planned economy towards a free market, a national 'one-or-two-child' policy was introduced. Family planning services are provided in the public health system but, since the IUD is virtually the only option for contraception, abortion becomes a common choice.

The number of annual abortions increased from 1.1 million in 1991 to 1.4 in 1993. In 1992, the total abortion rate was 2.5 while the fertility rate reached just under four children per woman (Goodkind, 1994).

The average pattern for a married woman living in a stable union is to have two or three children in her 20s and a first abortion after the age of 30. In case of another pregnancy she will choose an abortion provided at least one of her children is a boy.

The majority of abortions are performed in early pregnancy, in many areas, 70-80 percent of them are menstrual regulations by manual vacuum aspiration before the eight week of pregnancy. The mortality related to abortion is fairly low, but many women suffer from symptoms such as fatigue, headache, back-pain, and ureo-genital infections. Even IUD-use is combined with similar complaints and psychosomatic side effects, reflecting the ambivalence towards fertility regulation. The reproductive choices are determined by several conflicting factors in women's life, including socio-economic circumstances and a wish to make a better living for the family, limited contraceptive options, son-preference, and strong political pressure to limit the number of children (Johansson *et al.*, 1996).

Bangladesh—High Maternal Mortality

On average a woman in Bangladesh gives birth to four children and may have one abortion. Many women have to limit their child bearing because of poverty and concern for the children they already have, but access to family planning is limited. If a woman comes early enough to the health centre, a delayed menstruation can be induced by a simple procedure, so-called menstrual regulation. But most women do not know about this or come too late and have to resort to unsafe procedures.

Abortion is illegal in Bangladesh and the official statistics do not reflect the real situation. The estimate of 800,000 abortions/year includes menstrual regulations and a considerable number of illegal abortions. The relatively small proportion of pregnancies—one out of six—terminated by illegal abortion nevertheless contributes a very large part of the high maternal mortality (Dixon-Muller, 1988).

Sub-Saharan Africa—Strict Legislation and Poor Health Services

In Sub Saharah Africa abortions were traditionally practised by women who already had given birth to many children. In recent years, however, with loosening of traditional rules for family life and marriage, a growing number of young women are resorting to abortion. Abortion among teenagers is mainly performed under unsafe conditions with serious consequences for the young woman's health and fertility.

In spite of the low number of abortions relative to births in this region, complications from unsafe abortions contribute substantially to both maternal mortality and morbidity. Between 30 and 40 per cent of the maternal mortality in Sub Saharan Africa are due to unsafe abortions.

In Kenya the total fertility rate is 6.4 children per woman, yet only one woman out of three will ever experience an induced abortion. Abortion is permitted for strict medical reasons only. Services, including treatment of complications to self-induced abortions, are badly insufficient. Sex education in school or access to contraceptive services is limited or not existing, especially for young and unmarried women.

In Ethiopia abortion is forbidden by law and reproductive health services are severely inadequate. The fertility rate is high, with seven children and 0.9 abortion per woman. The social control of young girls used to be strict, but social change, migration, civil war, and sexual exploitation have resulted in a growing number of unplanned pregnancies among teenagers. At a gynaecological ward in Addis Ababa, 60 per cent of the emergency admissions are due to complications from incomplete abortion, and 80 per cent of these women are under the age of 20. As much as 50 per cent of the maternal mortality in Ethiopia is related to abortion (Kwast *et* a/., 1986).

A young pregnant women who resorts to a botched, unsafely induced abortion to avoid being expelled from school or bringing shame over her family may risk her life, and can ruin her future health and social life. Infertility after termination of the first pregnancy will cause lifelong suffering in a culture where a woman's status depends on her ability to give birth to many children.

Abortion on the International Agenda

While family planning has been a concern for many international and national health agencies and donor organizations, the health consequences of unsafe abortion have not, until recently, attracted the same attention. Gradually the international health community has begun to pay attention to women's reproductive health, including abortion. In September 1994 at

the UN Conference on Population and Development (ICPD) in Cairo, abortion was put on the table by the Norwegian Prime Minister, Mrs Gro Harlem Brundtland, in her opening speech: "Decriminalizing abortions is a necessary means of protecting the life and health of women". After intense discussions and revisions of the one and only paragraph in the document dealing with abortion, most countries agreed on a compromise. The statements in the final 'abortion' paragraph were of special importance:

1. It was spelled out that "unsafe abortion is a major public health concern".
2. Extensive negotiations resulted in the statement: "In circumstances in which abortion is not against the law, such abortion should be safe" which means that appropriate abortion care should be provided at least iri countries where abortion is legal.
3. It was clearly stated that "in all cases, women should have access to quality services for complications . . . arising from abortion"—an obligation for the health services to provide emergency obstetric care for women with symptoms from incomplete, botched abortions.

Thus, the Cairo Conference became a breakthrough for the international recognition of abortion as a health issue (United Nations, 1994).

A year later, in September 1995, the UN Conference on Women in Beijing repeated the ICPD declaration on abortion and went a little further by touching upon the legal aspect. A recommendation was directed to Governments: "Consider reviewing laws containing punitive measures against women who have undergone illegal abortions."

Although rather weak—'consider reviewing' is not the same as 'change'—this sentence is an opening for efforts to make abortion legal. Apart from this suggestion, however, it is difficult to find an explicit opinion, in the Beijing document, on legalization of abortion either for promotion of women's health or as a reproductive right for women (United Nations, 1995).

Nevertheless, two UN conferences have placed abortion on the international agenda by recognizing as a major public health concern. To follow up these declarations in the coming years and put the recommendations into practice is a major challenge for health authorities at all levels.

In Conclusion

Abortion is one of the most serious and neglected health issue in the world today. It is also an area where the inequity in health is most obvious. The abortion-related morbidity and mortality are the highest in countries where women do not enjoy equal rights and control over sexuality and reproduction, where abortion is legally restricted, and where reproductive health services are insufficient.

Experiences from many countries confirm that legalization of abortion does not increase the abortion rate, it only determines whether the abortions are performed under safe or unsafe conditions. However, in order to reduce the number of unsafe abortions and the abortion-related mortality, legalization needs to be accompanied by appropriate abortion services. And last but not the least, women must achieve equal rights and opportunities in family and society.

The disparities in the world today are immense but at the same time, the differences between countries indicate that the situation can be changed. Women can be empowered, laws can be revisesd, and mortality and morbidity from abortion prevented.

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