

# Safe and unsafe abortion

Practice Paper

DFID Policy July 2011



# **DFID Policy 2011**

UK's policy position on safe and unsafe abortion in developing countries

Practice Paper

# Contents

## Executive Summary

	Page No
<b>Chapter 1 Background</b>	
1.1 Background	5
1.2 The Extent of Induced abortion	5
1.3 The consequences of unsafe abortion	6
1.4 Abortion: gender inequality and poverty	6
<b>Chapter 2 Our position</b>	
1.1 Our position and the international consensus on abortion	8
1.2 What is our policy position on abortion in developing countries	8
1.3 Abortion and the law	9
1.4 What are we prepared to support	10

## Endnotes

# Executive Summary

## Our Position

Women and adolescent girls must have the right to make their own decisions about their sexual and reproductive health and well being, and be able to choose whether, when and how many children to have.

We do not support abortion as a method of family planning – indeed we are working to increase access to modern methods of family planning (which would ultimately reduce demand for abortion).

Safe abortion reduces recourse to unsafe abortion and saves maternal lives.

We do not enter the ring on the rights and wrongs of abortion, but in countries where abortion is permitted, we can support programmes that make safe abortion more accessible.

In countries where it is highly restricted and maternal mortality and morbidity are high, we can help make the consequences of unsafe abortion more widely understood, and can consider supporting processes of legal and policy reform.

## Key Facts

- 215 million women who want to delay or avoid a pregnancy are not using an effective method of family planning.
- Worldwide, there were an estimated 21.6 million unsafe abortions in 2008. Nearly all were in developing countries<sup>1</sup>.
- Unsafe abortion accounts for 13% of all maternal deaths<sup>2</sup>;
- Where effective contraception is available and widely used the rate of abortion declines, but nowhere has it reached zero.
- Unsafe abortion is most common in countries where abortion is prohibited or permitted only in highly restricted circumstances.
- Death from unsafe abortion is rare in countries where abortion is permitted and quality, affordable services are available.

# Chapter 1

## Background



Complications arising from unsafe abortions contribute to 13% of all maternal deaths. Young women are particularly at risk of unsafe abortion. Globally, women and adolescent girls under the age of 25 account for almost half of all abortion deaths.

# Background

## 1.1 Background

A central aim of the UK Government's policy is to empower and enable women and adolescent girls<sup>a</sup> to have sexual and reproductive choices; to avoid unwanted sexual contact, injury and infection; to make informed decisions about childbearing; and to face fewer risks in the course of pregnancy and childbirth. But millions of women still do not have access to good quality contraceptives, or have no control over the circumstances in which they become pregnant. Many die as a result of unsafe abortion; many more are permanently injured. Lowering abortion-related maternal death is a key way to reduce overall maternal mortality as nearly all deaths from unsafe abortion are preventable. There is strong evidence of the high cost that unsafe abortion imposes upon health services, women and their families. This note expands on our position regarding safe and unsafe abortion.

## 1.2 The extent of induced abortion

Every year, worldwide, about 210 million women become pregnant; and about 21.6 million or 10% of these ended in unsafe abortion<sup>3</sup>. Nearly all (98%) of unsafe abortions take place in developing countries with restrictive abortion laws<sup>4</sup>. Where effective contraception is available and widely used the rate of abortion declines but nowhere has it reached zero<sup>5</sup> - there are a number of reasons for this. First, and most importantly, millions of people either do not have access to modern contraceptives or do not have adequate support to use them. Second, no method of contraception is 100% effective. Third, high rates of violence against women, including in the home and during armed conflicts, lead to unwanted pregnancies. Fourth, many women feel they are too young or too poor, for example, to raise a child.

In 2008 there were 6.8 million unsafe abortions in South-Central Asia, the highest number of unsafe abortions in any sub-region; reflecting the very large population and low rates of usage of modern contraception<sup>6</sup>. However, women in Sub-Saharan Africa face the highest risk of unsafe abortion-related death; three times that of women in Asia and nine times that of Latin American women<sup>7</sup>. In 2007 only around 15% of women in sub-Saharan Africa were using any form of modern contraception, but the numbers were as low as 6% in Sierra Leone (2008) and 5% in Niger (2006)<sup>8</sup>.

---

<sup>a</sup> All references to women in this document also include reference to adolescents and young women.

### 1.3 The consequences of unsafe abortion

Complications arising from these unsafe abortions contribute to 13% of all maternal deaths<sup>9</sup>. Each year 47,000<sup>10</sup> women die following unsafe abortion and an estimated five million are hospitalised for the treatment of serious complications such as bleeding or infection<sup>11</sup>. These complications can lead to ongoing health problems for women, including among others infertility, anaemia and depression.

Young women are particularly at risk. For example in Africa a quarter of all those who have an unsafe abortion are adolescent girls<sup>12</sup> and about half of the 20,000 Nigerian women who die from unsafe abortions each year are adolescents. Globally, women and adolescent girls under the age of 25 account for almost half of all abortion deaths<sup>13</sup>.

#### Box 1: Poor women are least able to access safe abortion

*'The women we interviewed [in Dar es Salaam, Tanzania] thought that existing laws were discriminatory, because they denied women the right to choose in the case of unwanted pregnancy, while the men who got them pregnant did not have to bear the hardships involved.'*<sup>a</sup>

From: Abortion in the Developing World, WHO 1999

<sup>a</sup>Mpangile GS, Lesharbari MT and Kihwele DJ. Induced abortion in Dar es Salaam. In Abortion in the Developing World eds Mundigo AI and Indriso C. WHO 1999.

Ill health following unsafe abortion also adds a high cost to both health systems and individual families. The high volume of abortion complications is a heavy burden on already overstretched health systems. For example post-abortion care admissions represent more than 55% of all obstetric complications treated in Mozambique<sup>14</sup>. It is estimated that 60% of the expenditure in the maternity section of the Nairobi Kenyatta National Hospital goes towards treatment of incomplete abortions<sup>15</sup>. Recent cost estimates suggest that the annual cost of unsafe abortion to developing country health systems is between \$375 million and \$838 million; out of pocket expenses may amount to a further \$600 million<sup>16</sup>.

### 1.4 Abortion: gender inequality and poverty

In many countries contraception is simply unavailable or not available consistently enough, or women may not be properly informed about contraceptive choices or able to access contraception themselves.

But the reality is that the youngest and the poorest women are least able to fulfil their basic sexual and reproductive rights and are more likely than better off and urban women to have an unintended pregnancy and unsafe abortion<sup>17</sup>. All too often, sexual intercourse takes place in circumstances which are not freely chosen or consenting. Some beliefs and practices place women and girls directly at risk, not only of pregnancy but also of HIV and other sexually

transmitted infections. For example the tradition of widow ‘cleansing’ practiced in some African cultures where a widow is required to have sexual relations with either a designated ‘village cleanser’ or a relative of her late husband<sup>18</sup>. Poverty also places girls at risk for example through the custom of having a ‘sugar daddy’ to assist with payments such as for education. Many societies require the sexual submission of women to men – and women (married or unmarried) are unable to refuse sex with older, socially dominant men<sup>19</sup>. This may be the teacher, healer or local priest. When a girl at school becomes pregnant it is likely that she will have to drop out – significantly lessening her opportunities for a productive and healthy life<sup>20</sup>.

Rape and forced pregnancy as a tool of war and retaliation have been documented in a number of countries and regions including Sierra Leone, Somalia and Darfur<sup>21</sup>. It is estimated that between 2,000 to 5,000 children were born in Rwanda as a result of rape during the genocide. Many thousands of women were also infected with HIV as a result of rape<sup>22</sup>. Worldwide, one in five women becomes the victim of rape or attempted rape at some point in their lifetime<sup>23</sup>. Almost 50% of sexual assaults worldwide are against girls of 15 years or below<sup>24</sup>.

The consequences of gender inequality, cultural norms and poverty on unwanted pregnancy for the most vulnerable are dire. For many it equates to social exclusion, expulsion from the family, abandonment and deepening poverty. For most the choices are limited – risk death from an unsafe abortion, or face social exclusion and destitution from isolation and extreme poverty.

## Chapter 2

# Our position



Brenda is a Community Based Educator who exposes the dangerous practice of unsafe abortions, that lead to thousands of young girls dying unnecessarily each year.

# Our position

## 2.1 Our position and the international consensus on abortion

Abortion is an emotive and complex subject that encompasses the status of women, human rights, power, politics and religion. It continues to generate social, cultural and political disagreement.

Our position is consistent with the Cairo Programme of Action, agreed at the 1994 United Nations International Conference on Population and Development<sup>25</sup> (ICPD), which affirmed that in no case should abortion be promoted as a method of family planning. The ICPD agreed that prevention of unintended pregnancies should be given priority - through expanded family planning services. But ICPD recognised the health impact of abortion complications, and agreed that where permitted by national law, abortion should be safe. It also noted that in all cases (whether or not abortion is permitted) women should have access to quality services for the management of complications following abortion. It particularly emphasised the importance of post-abortion counselling and family planning to help women avoid unintended pregnancy and repeat abortion.

A Special Session of the UN General Assembly in 1999 to review the implementation of the Cairo Programme of Action further agreed that 'in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that abortion services are safe and accessible'<sup>26</sup>.

## 2.2 What is our policy position on abortion in developing countries?

Millions of women around the world each year decide to seek an abortion, whether or not it is legal and available. Our position is that safe abortion reduces recourse to unsafe abortion and thus saves lives, and that women and adolescent girls must have the right to make their own decisions about their sexual and reproductive health and well being.

We do not promote abortion as a method of family planning and neither condone nor support any organisation that promotes abortion as a means of family planning. We believe the best way to eliminate unsafe abortion is to improve access to comprehensive family planning information, services and supplies and to ensure that women have more control over the circumstances in which they have sex. All women and men should be able to access and choose quality contraceptives including male and female condoms that help prevent unintended pregnancy and sexually transmitted infections. But we recognise that, for many, this is not the reality. Better access to family planning, so that women and couples can decide whether, when and how many children to have, is vital; but it won't always be enough.

Women should not face death or disability when they decide to have an abortion. To reduce deaths to women from the complications of unsafe abortion we support the prevention of unsafe abortion as part of broader public health efforts to improve sexual and reproductive health. We support programmes that make safe abortion more accessible in countries where it is permitted. We can help make the consequences of unsafe abortion more widely understood in countries where it is highly restricted. We can also consider supporting civil society-led processes that enable legal and policy reform.

### 2.3 Abortion and the law

Unsafe abortion is most common in countries where abortion is highly restricted. Death from unsafe abortion is rare in countries where abortion is permitted and quality affordable services are available. The worldwide trend in abortion law is towards liberalization. Since 1997, 22 countries or administrative areas have liberalised their laws, including Colombia, Ethiopia, Iran, Mexico City, Nepal, and Thailand. Globally, 40% of women of child bearing age live in countries with highly restrictive laws, especially in sub Saharan Africa and Latin America<sup>27</sup>.

As more developing countries have reformed their abortion laws, new evidence is accumulating that legal abortion saves women's lives. By 2002 in South Africa, for example, six years after liberalising its abortion law, deaths due to unsafe abortion dropped by at least 50% and the number and severity of post abortion complications fell dramatically as well<sup>28</sup>.

#### Box 2: Improving access to safe abortion in Nepal

*Prior to safe abortion legislation in Nepal, women were given prison sentences of 3 years or more for having an abortion. For infanticide, the sentence could be up to 20 years. It was estimated that 20% of the women in Nepali jails had been convicted of abortion or infanticide. The costs of managing abortion complications ranged from US \$20-\$133 per case depending on the severity and the treatment.<sup>a</sup> It was estimated that 20% of deaths in health facilities were caused by unsafe abortion.<sup>b</sup>*

*Following legal reform, the Government of Nepal initiated a National Safe Abortion Programme establishing services across the country and training public and private service providers. A partnership approach for expansion of the programme was adopted, working closely with national NGOs, the private sector and international agencies. Safe abortion services are now available across the country with private providers playing a key role. Marie Stopes International provided 89% of abortion services in 2008-9 and have been providing services since 2004. It is estimated that this has resulted in 1,622 maternal deaths being averted and 153,292 unsafe abortions avoided.<sup>c</sup>*

<sup>a</sup> Thapa S, Thapa PJ, Shrestha N. 'Abortion in Nepal: Emerging Insights' Journal of Nepal Medical Association, 1994, Vol 32 pages 175-190.

<sup>b</sup> Government of Nepal, UNICEF 'Needs Assessment on the Availability of Emergency Obstetric Care Services, 2000.

<sup>c</sup> MSI Nepal: calculated using service coverage data and the MSI impact calculator. 2009.

## 2.4 What are we prepared to support?

Where countries have decided that abortion is permitted, we can consider support for activities to improve the quality, safety and accessibility of abortion services. These might include, for example:

- the training of health personnel in safe abortion techniques, including medical abortion and counselling, for comprehensive abortion care;
- life saving post-abortion care;
- the provision of drugs and equipment for health facilities;
- improving the conditions under which services are provided;
- the provision of information to health personnel and women;
- the development of plans and protocols to improve service quality; and
- research to monitor progress in improving health outcomes.

Where the private sector is an important source of service provision, we can consider support to strengthen mechanisms to improve its quality and affordability for poor women and girls. At all times we will seek to ensure that abortion was available only as a matter of un-coerced individual choice and within a broader package of sexual and reproductive health services, including post-abortion family planning counselling and services, to help women avoid unintended pregnancy and repeat abortion. We would also seek to ensure that safe abortion services, to the extent allowed by national laws, are included as a core part of national health plans and budget processes.

In many countries abortion may be permitted only on limited or highly restricted grounds. In these circumstances, we can consider support to increase awareness among policy-makers, legislators, national health authorities and health personnel of the circumstances under which abortion is allowed. We can also work to highlight the consequences arising from the complications of unsafe abortion, such as the burden of maternal ill-health and high health service costs. We can also consider support to locally-led efforts to enable legal and policy reform in circumstances where the existing law and policy are contributing to high maternal mortality and morbidity; and to regional or international initiatives that are working to prevent unsafe abortion.

# End Notes

- <sup>1</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 1.
- <sup>2</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 1.
- <sup>3</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003 Fifth Edition. 2008. Abstract.
- <sup>4</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 1.
- <sup>5</sup> WHO. Safe Abortion: technical and policy guidance for health systems. 2003. p 12.
- <sup>6</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 22.
- <sup>7</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. Calculated from table 6 p 28.
- <sup>8</sup> UN Dept Economic and Social Affairs Population Division. World Contraceptive Use. 2009.
- <sup>9</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 27.
- <sup>10</sup> WHO WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. 2011. p 27.
- <sup>11</sup> Singh S, Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries, *Lancet*, 2006, 368(955):1887–1892. Accessed on line 14<sup>th</sup> July 2009.
- <sup>12</sup> Grimes et al. Unsafe abortion: the preventable pandemic. *The Lancet*, Special Issue on Sexual and Reproductive Health October 2006, 65 – 76.
- <sup>13</sup> WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth Edition. 2007. p 19.
- <sup>14</sup> From Jamisse et al 2004 referenced in Dgedge et al. 2005. Confronting maternal mortality: The status of abortion care in public health facilities in Mozambique. Chapel Hill, NC, Ipas. [http://www.ipas.org/Publications/asset\\_upload\\_file744\\_2417.pdf](http://www.ipas.org/Publications/asset_upload_file744_2417.pdf) (accessed 26th June 2009).
- <sup>15</sup> Death and Denial: unsafe abortion and poverty. IPPF 2006. p 9.
- <sup>16</sup> Vlassoff M, Shearer J, Walker D and Lucas H. Economic Impact of Unsafe Abortion Related Morbidity and Mortality: evidence and estimation challenges. Institute of Development Studies Research report 59. December 2008.
- <sup>17</sup> Singh S et al. Abortion Worldwide: a decade of uneven progress. Guttmacher Institute 2009.
- <sup>18</sup> UNFPA/UNAIDS/UNIFEM. Women and HIV/AIDS: Confronting the Crisis. [www.unfpa.org/hiv/women/report/chapter7.html](http://www.unfpa.org/hiv/women/report/chapter7.html) Accessed 1 July 2010.
- <sup>19</sup> Leclerc-Madlala. S. Intergenerational/Age Disparate Sex – a Policy and Programme Action Brief. UNAIDS, RHRU/University of the Witwatersrand. Undated. [www.unaidsrstea.org/userfiles/file/womenGirls\\_AgeDisparate.pdf](http://www.unaidsrstea.org/userfiles/file/womenGirls_AgeDisparate.pdf) Accessed: 1 July 2010.
- <sup>20</sup> Lloyd C. Girls' schooling in developing countries, Highlights from Population Council Research, Brief 24, Sept 2007
- <sup>21</sup> Ben-Ari, N & Harsch, E. Sexual violence, an 'invisible war crime' *Africa Renewal*, Vol.18 #4 (January 2005), page 12005.
- <sup>22</sup> Newbury C. & Baldwin. H. Aftermath: women in postgenocide Rwanda. Working Paper No. 303, Centre for development Education and Information, USAID July 2000.
- <sup>23</sup> State of World Population report 2005. The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals. UNFPA. 2005. 65.
- <sup>24</sup> Multi-country study on Women's health and Domestic Violence against Women, WHO. 2005.
- <sup>25</sup> United Nations. Programme of Action adopted at the International Conference on Population and Development, Cairo, 5 – 13 September 1994. United Nations 1995.
- <sup>26</sup> United Nations General Assembly. Key actions for the further implementation of the programme of Action of the International Conference on Population and Development. United Nations 1999.
- <sup>27</sup> Singh S et al., Abortion Worldwide: a decade of uneven progress. Guttmacher Institute 2009.
- <sup>28</sup> Cohen S A. Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide, Guttmacher Policy Review, 2009 Vol 12, No 4.

Front cover: Image of woman in Nepal. Person depicted is model. Material is being used for illustrative purposes only © Mikkel Ostergaard / Panos Pictures.  
Chapter 1: Image of woman in Ethiopia. Person depicted is model. Material is being used for illustrative purposes only © Federic Courbet / Panos Pictures.  
Chapter 2: Image of Brenda © Marie Stopes International.

<http://www.dfid.gov.uk/abortion>

# What is international development?

International development is about helping people fight poverty. Thanks to the efforts of governments and people around the world, there are 500 million fewer people living in poverty today than there were 25 years ago. But there is still much more to do.

1.4 billion people still live on less than \$1.25 a day. More needs to happen to increase incomes, settle conflicts, increase opportunities for trade, tackle climate change, improve people's health and their chances to get an education.

## Why is the UK government involved?

Each year the UK government helps three million people to lift themselves out of poverty. Ridding the world of poverty is not just morally right, it will make the world a better place for everyone. Problems faced by poor countries affect all of us, including the UK. Britain's fastest growing export markets are in poor countries. Weak government and social exclusion can cause conflict, threatening peace and security around the world. All countries of the world face dangerous climate change together.

## What is the Department for International Development?

The Department for International Development (DFID) leads the UK government's fight against world poverty. DFID has helped more than 250 million people lift themselves from poverty and helped 40 million more children to go to primary school. But there is still much to do to help make a fair, safe and sustainable world for all. Through its network of offices throughout the world, DFID works with governments of developing countries, charities, nongovernment organisations, businesses and international organisations, like the United Nations, European Commission and the World Bank, to eliminate global poverty and its causes. DFID also responds to overseas emergencies. DFID's work forms part of a global promise, the eight UN Millennium Development Goals, for tackling elements of global poverty by 2015.

## What is UKaid?

UKaid is the logo DFID uses to demonstrate how the UK government's development work is improving the lives of the world's poorest people.

## Department for International Development

1 Palace Street  
London SW1E 5HE  
UK

and at:

Abercrombie House  
Eaglesham Road  
East Kilbride  
Glasgow G75 8EA  
UK

Tel: +44 (0)20 7023 0000

Fax: +44 (0)20 7023 0016

Website: [www.dfid.gov.uk](http://www.dfid.gov.uk)

Email: [enquiry@dfid.gov.uk](mailto:enquiry@dfid.gov.uk)

Public enquiry point: 0845 3004100

or +44 1355 84 3132 (if you are calling from abroad)