

Safe Abortion: A Public Health Imperative

According to the World Health Organization (WHO), unsafe abortion is “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.”¹

The international community has recognized that unsafe abortion is a major threat to women’s health. By liberalizing restrictive abortion laws and investing in abortion safety, governments can save the lives of tens of thousands of women every year.

History has shown that women worldwide, when faced with unwanted pregnancy, seek abortions regardless of the legality of the procedure. Many have no choice but to undergo abortions performed by unqualified practitioners in unhygienic settings. About one-third of the women who have abortions performed under these circumstances experience complications that pose major risks to their lives and health.⁶ The stigma associated with illegal abortion and the disapproval often expressed by hospital providers discourage many women from seeking care for these complications,⁷ which include:

- sepsis, hemorrhage, and uterine perforation—all of which may be fatal if left untreated;
- acute renal failure, which contributes to abortion deaths as a secondary complication;
- chronic pelvic pain, pelvic inflammatory disease, as well as a high risk of ectopic pregnancy, premature delivery, and future spontaneous abortions; and
- reproductive tract infections, of which 20-40% lead to pelvic inflammatory disease and consequent infertility.⁸

At the International Conference on Population and Development (ICPD) in 1994, governments agreed to “deal with the health impact of unsafe abortion as a major public health concern.”⁹ At the ICPD’s 5-year review in 1999, these governments agreed to take steps to ensure that, where legal, abortion is safe and accessible. These steps include such measures as training and

An estimated 68,000 women in low-income countries die each year from complications of unsafe abortion.² Over 40% of those deaths occurred in Africa.³ Unsafe abortion is responsible for 13% of all maternal deaths globally.⁴

Each year, an estimated 19 million unsafe abortions are performed worldwide, 95% of which are performed in low-income countries.⁵

equipping health-service providers.¹⁰ The United Nations human rights system has also recognized governments' duty to address unsafe abortion. Several UN bodies charged with overseeing governments' implementation of the principal human rights treaties have addressed the rights implications of illegal and unsafe abortion. The Human Rights Committee, the CEDAW Committee, and the Committee on the Rights of the Child, for example, have characterized high rates of maternal mortality caused by unsafe abortion as a violation of women's rights to health and life.¹¹ In 2003, WHO released *Safe Abortion: Technical and Policy Guidelines for Health Systems* to help governments fulfill their commitment to ending unsafe abortion.¹²

Where legal restrictions on abortion force women to undergo unsafe procedures, governments should take legislative action to remove those restrictions. Where abortion is legal under limited circumstances, governments should ensure that safe procedures are in place for women entitled to them under the law. In addition, governments must allocate resources toward improving the quality of abortion care, taking guidance from WHO.

REMOVING LEGAL RESTRICTIONS AND SETTING PROTOCOLS FOR ABORTION SERVICES MAKE THE PROCEDURE SAFER

When abortion is legally restricted, women are often forced to obtain unsafe abortions in non-medical facilities, frequently performed by untrained practitioners. Even where legislation decriminalizes abortion in some circumstances, a failure to set guidelines and protocols for the provision of services may prevent access to abortion in public facilities.

- Where access to abortion is restricted by law, qualified medical practitioners are usually reluctant to provide the service. In addition, abortion services are rarely available in public hospitals, which are often the only source of safe medical care for low-income women. Services offered in private clinics are likely to be out of reach for these women.¹³
- In countries in which abortion is generally illegal, physicians do not routinely receive training in abortion procedures. As a result, providers may employ out-moded abortion practices.¹⁴
- Fear of criminal prosecution may affect a physician's willingness to treat women with complications arising from spontaneous or unsafe, clandestine abortion. Similarly, women who fear prosecution for having undergone an illegal abortion are more likely to delay seeking care, thereby putting themselves at greater risk.¹⁵
- Legalizing abortion decreases the rate of abortion-related deaths. Under Romania's highly restrictive abortion law, the abortion-related death rate

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peaked at 142 deaths per 100,000 live births in 1989. That year, the government legalized abortion and by the end of 1990, deaths caused by abortion dropped to below 50 per 100,000 live births.¹⁶ When abortion was made legal in Guyana in 1995, admissions to a capital city hospital for septic and incomplete abortion declined by 41% within six months of enacting the law. Before passage of the law, septic abortion was the third largest cause of admissions to public hospitals and incomplete abortion was the eighth largest.¹⁷

- WHO has recommended that health providers work with their national ministries of health and justice to help develop “regulations, policies and protocols to ensure access to quality services” where abortion is not against the law.¹⁸ In Nepal, though abortion was made legal under broad circumstances in September 2002, the service did not become available in a government clinic until March 2004, some two months after the government adopted a procedural order setting parameters for the delivery of abortion services in public facilities.¹⁹

GOVERNMENTS SHOULD INVEST IN SAFE ABORTION SERVICES

The benefits of ensuring access to safe abortion—to women, children, and society—far outweigh the minimal costs.

- In some low- and middle-income countries, up to 50% of hospital budgets are used to treat complications of unsafe abortion.²⁰ The treatment of abortion complications uses a disproportionate share of resources, including hospital beds, blood supply, antibiotics, medication, operation rooms and services, anesthesia, and medical specialists.²¹
- Making abortion more accessible does not increase demand for the procedure.²² For example, Barbados, Canada, Tunisia, and Turkey all liberalized their laws to increase access to legal abortion, but they did not experience an increase in abortion rates.²³ The Netherlands, with a non-restrictive abortion law, widely accessible contraceptives, and free abortion services, has one of the lowest annual abortion rates in the world.²⁴
- Investing in abortion safety brings long-term benefits for the next generation. Most women who seek abortions already have children.²⁵ Young children who lose their mothers to unsafe abortion are likely to have serious health problems of their own. When a mother dies, surviving children tend to receive less health care and education than children with both parents and are much more likely to die than children who live with both parents.²⁶

ENDNOTES

- 1 WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 13 (2003), *available at* http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf [hereinafter WHO, TECHNICAL AND POLICY GUIDANCE].
- 2 WHO, UNSAFE ABORTION 14 (2004), *available at* http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf [hereinafter WHO, UNSAFE ABORTION].
- 3 *Id.* at 15.
- 4 *Id.*
- 5 *Id.* at 13.
- 6 ALAN GUTTMACHER INSTITUTE, FACTS IN BRIEF: INDUCED ABORTION WORLDWIDE (1999), *available at* http://www.guttmacher.org/pubs/fb_0599.pdf.
- 7 UNITED NATIONS POPULATION FUND (UNFPA), STATE OF THE WORLD POPULATION 2004, at 59 (2004), *available at* http://www.unfpa.org/swp/2004/pdf/en_swp04.pdf.
- 8 WHO, UNSAFE ABORTION, *supra* note 2, at 4.
- 9 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 8.25, U.N. Doc. A/CONF.171/13/Rev.1 (1995).
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- 11 CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO INTERNATIONAL PROGRAMME ON REPRODUCTIVE AND SEXUAL HEALTH LAW, BRINGING RIGHTS TO BEAR 156 (2002).
- 12 WHO, TECHNICAL AND POLICY GUIDANCE, *supra* note 1, at 8.
- 13 Anika Rahman et al., *A Global Review of Laws on Induced Abortion, 1985-1997*, 24 INT'L FAM. PLAN. PERSP. 56 (1998).
- 14 *Id.*
- 15 *Id.*
- 16 ALAN GUTTMACHER INSTITUTE, SHARING RESPONSIBILITY: WOMEN, SOCIETY & ABORTION WORLDWIDE 38-39 (1999).
- 17 *Id.* at 39.
- 18 WHO, TECHNICAL AND POLICY GUIDANCE, *supra* note 1, at 15.
- 19 Center for Reproductive Rights, *Fourteen Nepalese Women Freed for Abortion-related Offenses; Others Continue to Languish in Prison*, at http://www.reproductiverights.org/ww_asia_nepal.html (last updated Nov. 2004).
- 20 WHO, UNSAFE ABORTION, *supra* note 2, at 5.
- 21 *Id.*
- 22 ALAN GUTTMACHER INSTITUTE, *supra* note 16, at 46.
- 23 *Id.* at 28, chart 4.5.
- 24 *Id.* at 54, tbl.4.
- 25 WHO, UNSAFE ABORTION, *supra* note 2, at 5.
- 26 Family Care International & the Safe Motherhood Inter-Agency Group, *Maternal Health: a Vital Social and Economic Investment* (1998), *available at* http://www.safemotherhood.org/facts_and_figures/good_maternal_health.htm.

