

An Overview of Clandestine Abortion in Latin America

Each year, more than four million women in Latin America undergo an induced abortion. Because most abortions are illegal, these procedures are performed under clandestine and often dangerous conditions. As a result, the region faces a serious public health problem that threatens women's lives, endangers their reproductive health and imposes a severe strain on already overextended health and hospital systems.

The practice of induced abortion in Latin America is shrouded in secrecy, a direct result of the stringent legal limitations on abortion throughout most of the region. Induced abortion is punishable by law in almost every country except Cuba and a few other Caribbean nations. In most of the region, doctors may legally terminate a pregnancy that threatens the life of the woman, that results from rape or incest, or that is characterized by fetal deformity,¹ but these options are rarely used.

Concern over the high level of clandestine abortion in Latin America is not new. Policymakers and health professionals have been aware for the past 20–30 years that unsafe procedures were being performed in most countries of the region, and at a level with serious consequences for women's health and for the cost of national health care services.

Community surveys conducted in Chile in the early 1960s were the first attempt to measure the extent of the problem. These surveys found that

women were likely to have two or three abortions over the course of their childbearing years.² And studies in the 1970s in countries as diverse as Brazil, Colombia, the Dominican Republic, Mexico, Peru and Venezuela indicated that women averaged 0.5–1.5 induced abortions over their reproductive lifetime in these countries, and 2.0 or more induced abortions in Chile and Cuba.³

Although most Latin American health experts were aware of the general scale of clandestine abortion and related problems, until recently they had little reliable information with which to answer many questions. What methods are used to induce abortion? Who are the major practitioners? How many women are hospitalized for the treatment of complications, and what proportion is this of the actual numbers of women experiencing induced abortion? Which women are most likely to have induced abortions, and for what reasons?

This report presents an overview of the practice of induced abortion in Latin America. It draws upon a number of sources: a collaborative study on clandestine abortion in six countries; a large-scale study in urban Colombia; an in-depth study of trends in abortion and contraception in three countries; and a number of smaller studies. Findings from many of these studies were presented at the first regional meeting on induced abortion in Latin America, held in Colombia in 1994.⁴

Current Level of Abortion

Estimated rates of abortion are highest in Peru and Chile (each year, almost one woman in every 20 aged 15–49 has an induced abortion), intermediate in Brazil, Colombia and the Dominican Republic (about one woman in 30), and lowest in Mexico (approximately one in 40). If these rates continue to prevail throughout the 35 years of a woman's reproductive lifetime, the average woman in Mexico is likely to have had at least one abortion by the time she is 50, compared with about 1.6 abortions among women in Chile and about 1.8 among women in Peru.

If the annual number of abortions estimated to occur in these six countries (2.8 million in the early 1990s) is extrapolated to the entire region, then about four million induced abortions are being carried out each year in Latin America (Table 1).

Most Abortion Seekers Are Married and Have Children

Profiles of women obtaining abortions based on national data are useful. Knowledge about the women most likely to terminate an unwanted pregnancy is important because it helps identify subgroups in the population most in need of contraceptive protection. In addition, the information indicates that clandestine abortion is common at many levels of society and that unsafe procedures have consequences for the health of a broad cross-section of women.

table 1
Abortion Incidence

| Country/year | Annual no. of abortions | Rate per 1,000 women | Average per woman |
|-----------------------|-------------------------|----------------------|-------------------|
| Total | 2,768,150 | 33.9 | 1.2 |
| Brazil, 1991 | 1,433,350 | 36.5 | 1.3 |
| Chile, 1990 | 159,650 | 45.4 | 1.6 |
| Colombia, 1989 | 288,400 | 33.7 | 1.2 |
| Dom. Republic | 82,500 | 43.7 | 1.5 |
| Mexico, 1990 | 533,100 | 23.2 | 0.8 |
| Peru, 1989 | 271,150 | 51.8 | 1.8 |
| Latin America* | 4,000,000 | 33.9 | 1.2 |

*Estimated on the assumption that these six countries account for 70% of the population of Latin America and that all countries in the region have similar hospitalization levels; rounded to the nearest 100,000.

One way to obtain information about women having abortions is to examine data on women hospitalized as a result of complications of clandestine procedures. However, few national systems provide data on the background characteristics of hospitalized women, and hospitalized women are not necessarily representative of all women having induced abortions.

Nonetheless, these and other data show that most Latin American women having induced abortions are in their 20s or older; married and already mothers. In most developed countries, by contrast, women having induced abortions are often very young, the vast majority are single and about half are childless.⁵

In Colombia, for example, national statistics from the 1980s show that about 87% of all hospitalized abortion inducements were older than 20.⁶ A 1992 Colombian survey representative of urban households, 23% of all women between the ages of 15 and 55 reported that they had had an induced abortion at some point in their lives;

the proportion was somewhat higher than this among women who had not completed primary school (29%, see Table 2), among women with some university education (28%) and among those in the labor market (27%).⁷

A 1990 study carried out by the Latin American Federation of Obstetricians and Gynecologists in four countries (Bolivia, Colombia, Peru and Venezuela, see Table 3) found that the vast majority of hospitalized abortion patients (79%) were married women, half (51%) had two or more children, and half had also had seven or more years of schooling. Some 86% were aged 20 or older.⁸

Another 1990 study of Chilean women hospitalized for abortion complications in nine hospitals in Santiago also found that few were young women (only 11% were younger than 20), that the vast majority (78%) were married or in a consensual union, that 76% already had children, and that more than 80% had had seven or more years of schooling.⁹

A 1992-1993 study of abortion patients in two large

maternity hospitals in the poor northeast state of Fortaleza, Brazil, found that 77% were older than 20 and that 68% had had five or more years of schooling. But in this study, 53% of women had never been married or in a stable union, and 9% were separated, divorced or widowed.¹⁰

In the Dominican Republic, in-depth interviews in 1992 with women hospitalized for abortion complications in two large hospitals in Santo Domingo (Table 4) revealed that 84% were in their 20s or older, 88% were in a union, and 73% had had five or more years of schooling.¹¹

Abortion Techniques Used

A 1993 study in Brazil, Colombia, Chile, the Dominican Republic, Mexico and Peru showed that women everywhere are familiar with teas and infusions made from herbs and other vegetable products that are believed to induce abortion (Table 5).¹²

If these products do not have the desired effect (and nobody knows whether they are genuine abortifacients), women are then likely to resort to riskier methods: the insertion of a rubber tube, caustic liquids or other foreign objects into the uterus; or the oral or vaginal application of powerful pharmaceuti-

cal and hormonal products. In Brazil, a pharmaceutical product usually prescribed for the treatment of gastric and duodenal ulcers, misoprostol (Cytotec), is widely used to terminate pregnancy.¹³

In the urban areas of some countries, women with financial resources can attend private clinics that perform safe medical abortions using dilatation and curettage (D&C) or vacuum aspiration techniques. And throughout Latin America, middle- or upper-class women are generally acknowledged to obtain safe medical abortions in doctors' offices.

Three broad types of providers perform clandestine abortion in Latin America: doctors; nurses; and untrained persons, such as traditional practitioners or pregnant women themselves. As might be expected, higher income women and urban women are most likely to go to doctors, low-income urban women might avail themselves of any of the three types of providers, and poor rural women commonly depend on untrained practitioners or use traditional methods that they themselves can use to induce abortion.¹⁴

The procedures on which poor rural women depend often occur under dangerously unsanitary conditions.

table 2
In Colombia

| Educational level of urban women | % who had an abortion |
|----------------------------------|-----------------------|
| All levels | 23 |
| Incomplete primary | 29 |
| Complete primary | 22 |
| Incomplete secondary | 21 |
| Complete secondary | 18 |
| Incomplete university | 28 |
| Complete university | 24 |

Source: See reference 7.

table 3
In Four Countries

| Characteristics of abortion patients | Percent distribution |
|---------------------------------------|----------------------|
| Marital status | |
| Single | 21 |
| Married or in a consensual union..... | 79 |
| No. of children | |
| 0 | 26 |
| 1 | 23 |
| 2-4 | 40 |
| ≥5 | 11 |
| Years of schooling | |
| 0-4 | 21 |
| 5-6 | 27 |
| 7-9 | 28 |
| ≥10 | 24 |

Note: Hospital data from Bolivia, Colombia, Peru and Venezuela.

These women frequently experience complications as serious as hemorrhage and infection that require hospital treatment.

Researchers estimate that in the six countries in question, more than half a million women are hospitalized each year to obtain treatment for abortion complications. If this number is extrapolated to all of Latin America (assuming similar conditions in other countries and given that the six study countries account for 70% of the total population of Latin America), almost 800,000 women each year are likely to obtain hospital treatment for the complications of induced abortion (Table 6). These data highlight the need to improve the treatment of abortion complications and to reduce the unhealthy consequences.

Complication Rate Declines

Obviously, the safer the abortion procedures used in any setting, the fewer the women

who will require hospitalization. However, the numbers hospitalized also depend on the availability of hospital services. Women living in rural areas are probably less likely than those living in urban areas to have access to hospital treatment, even though they are precisely the women most likely to be exposed to unsafe techniques, untrained practitioners and unhygienic settings.

Most health professionals believe that the risks of complications from induced abortion are lower in Latin America today than they were in the past. Reasons for the reduced risk are that more women have access to safe medical procedures, more women are aware of the need to seek medical treatment quickly when a complication arises and more practitioners—even those without medical training—routinely prescribe antibiotics for their patients.

The number of hospitalized women with a severe infec-

tion is believed to have declined dramatically as a result of these trends. On the other hand, the growing use of hormonal methods and of techniques like misoprostol, which induce heavy bleeding, has probably increased the numbers of women seeking treatment for hemorrhage.

Community surveys carried out in Chile in the 1960s, when the conditions for pregnancy termination were much less safe than they are now, found that one in three women undergoing induced abortion were hospitalized. Today, researchers and health professionals estimate that one in five abortion patients require hospitalization for the treatment of complications.¹⁵

What Leads Women To Seek an Abortion?

Most studies of women hospitalized for abortion-related complications conclude that the major reasons women choose not to give birth are that they are unable for economic, personal or family reasons to have or support the child. Many women are not married or are in unsta-

ble relationships. If they are single or very young, they are likely to decide that they cannot take care of a child alone and without financial support.

But the majority of the patients appear to be married women who already have all the children they feel able to care for. The difficult social and economic conditions facing many millions of families in Latin America's poor rural areas and vast city slums spur the desire of couples to have fewer children. So do increases in women's level of education and women's increased participation in the labor market.

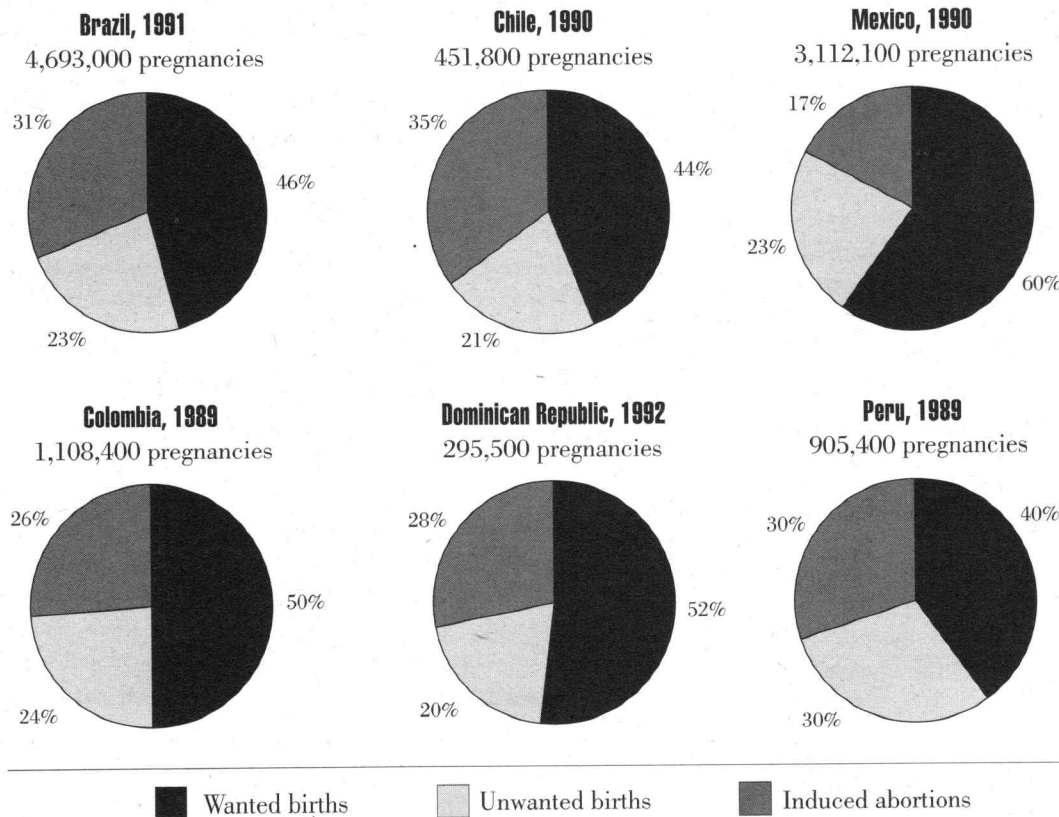
Yet, despite the desire for smaller families and for better timing of births, women are not always able to attain control over their childbearing. Surveys of women in Latin America find substantial proportions who do not want to become pregnant but are not using a contraceptive method or are relying on traditional methods, such as periodic abstinence or withdrawal, which have high failure rates. These women, often charac-

table 4
In Santo Domingo

| Characteristics of abortion patients | Percent distribution |
|--------------------------------------|----------------------|
| Age | |
| <20 | 16 |
| 20-24 | 33 |
| 25-29 | 25 |
| 30-34 | 11 |
| ≥35 | 11 |
| Marital Status | |
| Not in a union | 12 |
| In visiting union | 9 |
| In consensual union | 66 |
| Married | 13 |

Source: See reference 11.

figure 1
Outcome of Pregnancies



and as having an "unmet need for contraception, rep- anywhere from 17% of women aged 15-44 in Colombia to 43% in Bolivia.¹⁶

In addition, some women are having unplanned pregnancies because of ignorance about when they are most likely to conceive,¹⁷ and because even women who use effective contraceptive methods may do so irregularly or incorrectly.¹⁸

Natveys in 10 countries in Latin America show that as a result of all these factors, 24-65% of women who had had a child in the previous five years said they had not wanted their most recent birth at the time it occurred or that they had not wanted another child ever.¹⁹

Combining estimates of the

number of induced abortions with survey information from six countries on the proportion of births that are unplanned indicates that 60% of pregnancies in Mexico end as wanted births—the highest proportion in any of the countries—and 17% end as induced abortions. In contrast, approximately 30% of all pregnancies in the other five countries end in induced abortions (Figure 1).

These levels of abortion are not unique to Latin America: In the United States, for example, almost 30% of all pregnancies are resolved by abortions, and in China and Japan, the proportions are 30% and 25%, respectively.²⁰ Most developing regions of the world have lower levels, however.

Women Use Both Abortion And Contraceptive Methods

Although very little information exists on historical trends in abortion in Latin America, the level of abortion was probably quite low prior to the 1960s, when there was little attempt to control family size and the average woman had six or more children. It is only in the context of rapidly changing socioeconomic conditions and a rise in families' motivation to achieve a better standard of living that women increasingly have turned to both abortion and contraception to help them achieve a small family.

In the late 1960s and in the 1970s, researchers theorized that if the practice of abortion is widespread before the use of contraceptive methods

becomes extensive, then the incidence of abortion will remain high as the motivation to limit family size intensifies, even while contraceptive practice rises.²¹ According to this theory, recourse to abortion will not decrease until enough years have passed for the widespread, habitual and effective use of contraceptives to become well established at all levels of society.

Research now exists that compares national and regional levels of abortion and of contraceptive use in Brazil, Colombia and Mexico at three points in time: the late 1970s, the mid-1980s and the early 1990s.²² The comparison shows that as levels of contraceptive use increased in the late 1970s, abortion had reached a moderate level (20-30 abortions per 1,000 women per year) in all three countries. Abortion peaked in Colombia and Mexico in the mid-1980s, and there were indications of a slight drop in some urban areas by the early 1990s. During the same period, abortion levels in Brazil were still rising.

The more organized national family planning programs in Colombia and Mexico may have begun to create a permanent "culture of contraception." In Brazil, on the other hand, actual and desired family size are both small, but no national family planning program exists, many rural women lack access to high-quality contraceptive services and many women who obtain methods from commercial sources use them incorrectly or only sporadically. Reductions in levels of abortion are likely to be slower in coming to Brazil than to the other two countries.

table 5
Abortion Methods

| |
|--|
| Voluntary trauma |
| Falls, punches, excessive physical activity, etc. |
| Natural products taken orally or vaginally |
| Seaweed, vegetables, seeds |
| Teas and infusions prepared from herbs and vegetables |
| Manufactured products taken orally or vaginally |
| Beer, wine, vinegar |
| Soapy substances |
| Caustic substances, including bleach, dye, potassium salts |
| Physical objects inserted in uterus |
| Catheter (rubber tubing) alone |
| Catheter used to flush toxic fluids |
| Sharp objects such as wire, knitting needles and sticks |
| Pharmaceutical products administered orally or vaginally |
| Misoprostol, prostaglandins, estrogen, laxatives, quinine, oxytocins, etc. |
| Medical techniques |
| Dilatation and curettage |
| Vacuum aspiration |

Source: 1992 AGI Survey of Opinions on Abortion Practice in Brazil, Colombia, Chile, Dominican Republic, Mexico and Peru (see reference 12).

Abortion Will Not Disappear

Induced abortion remains a widespread practice in Latin America, primarily because women's use of contraceptives and their ability to use methods consistently and correctly have not kept pace with the growing intensity of the desire for smaller families, a desire probably fueled by rising aspirations and, often, unstable family situations.

While the true level of abortion is unknown, it is evident that at least 800,000 of the estimated four million women who have induced abortions each year require hospitalization for the treatment of abortion complications. Although abortion rates are lower in some countries than in others, the practice of abortion is not disappearing and levels may still be going up in some countries.

Despite this pessimistic scenario, abortion is probably a safer procedure for women now than it was in the past. Because of the wider use of medical techniques and the more common use of antibiotics, fewer women in the region are likely to die from abortion complications or to suffer grave health consequences, although both outcomes are still far too frequent.

Improved contraceptive services and improved contraceptive use can go a long way toward reducing levels of unplanned pregnancy in Latin America. There is evidence, for example, that abortion rates may be leveling off or declining in parts of Colombia and Mexico, two countries in which contraceptive use is widespread. Nevertheless, studies indicate that even where family planning services are available and accessible, many

women have difficulty using methods consistently and effectively, and contraceptive discontinuation and failure rates can be high.

Moreover, many circumstances conspire to make effective contraceptive decision-making and practice difficult, especially for women lacking social and family support. In this rapidly developing region of the world, the roles and responsibilities of women continue to change; life in large cities and declining agricultural areas is often precarious and economic stability elusive; migration is seen as a necessity for survival and family dissolution is commonplace.

Many of these conditions and constraints on women can be improved only by fundamental social and economic change. However, policymakers and program managers could usefully focus on services that might have a more immediate impact on women's ability to plan their families better and to have fewer unplanned pregnancies and abortions. Improvements in the availability, delivery and quality of contraceptive services and the establishment of postabortion contra-

ceptive counseling services in large public hospitals are direct steps that could be taken immediately.

Over the longer term, governments should consider reviewing laws that contain punitive measures against women who have undergone illegal abortions and improving services for the management of complications arising from abortion. Both these initiatives were among recommendations approved at the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 and agreed to by almost all nations of the world.

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table 6
Unsafe Abortions

| Country/year | Number of hospitalizations |
|-----------------------------|----------------------------|
| Total | 555,630 |
| Brazil, 1991 | 288,110 |
| Colombia, 1989..... | 57,680 |
| Chile, 1990..... | 31,930 |
| Dom. Republic, 1992..... | 1 |
| Mexico, 1990..... | 10 |
| Peru, 1989 | 54,200 |
| Latin America* | 800,000 |

*Estimated on the assumption that these six countries account for 70% of the population of Latin America and that all countries in the region have similar hospitalization levels; rounded to the nearest 100,000.

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