International Seminar on

The Health, Social and Economic Consequences of Unsafe Abortion

San Juan del Rio, Mexico, 10-12 November 2010

Organized by the IUSSP Scientific Panel on Abortion and Population Council – Mexico Office

IUSSP Scientific Panel on Abortion:
Chair: Susheela Singh;
Panel members: Agnes Guillaume, Sandra G. Garcia, Hailemichael Gebreselassie, Ali Mohammad Mir, Friday Okonofua and Ndola Prata.

REPORT

The IUSSP Scientific Panel on Abortion, in collaboration with the Population Council's Mexico office, held a seminar on "The Health, Social and Economic Consequences of Unsafe Abortion" in San Juan del Rio, Mexico, 10-12 November 2010. The seminar was supported by funds provided by the IUSSP, and with additional external support from the Population Council, Mexico Office, Venture Strategies Innovations (VSI), the Bixby Center for Population Health and Sustainability, University of California, Berkeley and Venture Strategies for Health and Development (VSHD).

This seminar provided a forum for discussing current research on a wide range of consequences of unsafe abortion. The 24 papers presented covered: health consequences – mortality and morbidity – and access to health services; economic costs of treating unsafe abortion to the health system and to households, as well as the cost-effectiveness of providing safe abortion services as compared to postabortion care; social consequences – with a focus on stigma among women, in the broader community and public, and among stakeholders. In addition, a couple of papers covered specific interventions to reduce unsafe abortion. This is a relatively underdeveloped area of research, and the seminar offered the opportunity to review and critique some very new methodologies, and some innovative advances on more established approaches and measures.

Health consequences

Two papers addressed the global burden of mortality and morbidity that results from unsafe abortion. The first paper presented new WHO 2008 estimates of abortion-related mortality and also provided a trend analysis and historical perspective: it showed that percent of maternal deaths due to unsafe abortion has not changed over the past decade, but the absolute level of abortion-related mortality has fallen as overall maternal mortality declined (and there are now 47,000 abortion-related deaths annually, compared to an estimated 69,000 in 1990). The second paper, presented preliminary results from a systematic review of published studies, aimed at assessing the global burden of various complications associated with unsafe abortion. In addition to presenting substantive results on the incidence and types of complications associated with induced abortion, this paper also discussed methodological strengths and weaknesses of the available evidence. Two papers covered the topic of abortion-related mortality in Mexico. The first of these two assessed trends in abortion mortality between 2000-2008 using government data for the public sector: This paper

calculated a special rate – the number of abortion-related deaths per 100,000 hospitalizations for treatment related to all types of abortion (including spontaneous pregnancy losses). The results show a decline over time, from a rate of 54.3 in 2000 to 38.9 in 2008 (all health systems combined), and very wide variation across states from rates as low as about 10 to as high as almost 150 deaths per 100,000 hospitalized abortion patients. A limitation of this new indicator is that it is affected not only by the conditions under which abortion is provided (that is the extent to which abortion is unsafe) but also by differences in access to care and the quality of care. The second paper described case studies of women who died due to unsafe abortion, and provided an in-depth portrait of conditions of unsafe abortion experience by these women, as well as revealing the poor quality of postabortion services in facilities, as well as stigma among providers.

Other papers presented new findings on trends in the morbidity due to unsafe abortion in Colombia and Brazil, approximately over the past two decades, using different types of data sources. Because of the conditions under which women obtain abortions is changing over time (usually in the positive direction overall, but with large inequities in access to safe abortion services continuing to exist), it is especially important to know whether morbidity is changing, and where possible, how such changes affect different areas of the country and groups of women. The information presented for these two countries suggests that hospitalization for treatment of unsafe abortion has declined in Brazil over the past two decades, but has not changed very much in Colombia. A likely reason is the longer-term use of misoprostol in Brazil, compared to the relatively more recent increases in use of this medication to induce abortion in Colombia, where ineffective use of the method appears to still be common. A paper on Iran provided both quantitative and qualitative findings on abortion, providing insights into the reasons and process by which women seek unsafe abortion, and its consequences. A paper on a pilot project in one province in Ethiopia assessed the characteristics of postabortion patients who experienced more severe morbidity, using an established measure of level of severity of abortion-related morbidity, and found that some characteristics (rural residents, lower education, being married, and being older) were associated with having more severe morbidity.

Three papers on India focused on measurement of abortion-related morbidity using different types of data and measures and also examine access to postabortion treatment. A 2007 study in 10 hospitals documented types and severity of postabortion complications, pathways to attaining medical care, and the difference in health and economic consequences depending on these pathways. Women who obtained unsafe induced abortion generally took a longer and more complicated pathway before finally obtaining medical care at a facility, compared to women identified as having had spontaneous pregnancy losses. As a result, the first group had more severe complications and experience greater social and economic consequences. The other two papers conducted secondary analyses of existing large-scale survey data to examine the nature of health consequences resulting from unsafe abortion and factors associated with access to postabortion care. The first used the 2002-04 District Level Household Survey and Reproductive and Child Health survey (DLHS-RCH), with a large nationally representative sample of currently married women ages 15-44, and found that about one-third of women who reported having had an abortion (either induced or spontaneous) said they had experienced post-abortion complications within six weeks after the abortion; slightly over one-fifth of these women did not receive medical care for the complication. The second paper analyzed survey data for 2001-2003, on ever-married women in two states, Maharashtra and Tamil Nadu. Much higher proportions of women who reported having had an abortion reported having complications, compared to the first study; while some of the difference may

be real (the data are for an earlier time period, 1996-2002, five years before interview), it does highlight the need to seek ways to standardize measures based on self-reported morbidity.

A common and expected finding from this cluster of papers that measured gestation is that higher gestation at the time of the abortion is associated with more severe morbidity. High levels of use of D&C procedures to treat complications, rather than WHO –recommended procedures (MVA and medication abortion), were also often reported, indicating an important gap in quality of care.

Economic costs of unsafe abortion

Economic costs are the second major category of consequences covered by the seminar. This is a relatively new area of research, and the papers are therefore more exploratory in nature. One 2008 study in Ethiopia applied a new study design and questionnaires in 14 facilities selected to represent the three main categories of health facilities and both the public and private sectors. The study's methodology is based on existing approaches to estimating health-care costs developed by WHO for maternal and newborn health in general. The Ethiopia study built on a 2007 pilot study that adapted the WHO approach to specifically measure costs of providing postabortion care (that took place in three countries, Ethiopia, Mexico and Pakistan). The study collected detailed cost information on drugs, supplies, material, personnel time inputs, and out-of-pocket expenses. The paper presented national cost estimates by complication, region and level of facility. National estimates of costs were estimated for those women who did receive postabortion care (US $7.6 million), as well as the hypothetical costs should all women who need such care obtain it (US $31.6 million). A second paper described the design and current status of an ongoing full-scale study of economic costs in Uganda. This study is broader than the Ethiopia study and is addressing three questions: (1) how unsafe abortion affects individual and household economic well being, including its relationship to poverty; (2) what is the cost to the Ugandan health care system of treating complications from unsafe abortions; and (3) what would the costs and benefits be of increasing contraceptive services to reduce the level of unintended pregnancy and consequently the abortion rate. The paper described the methodological and data-collection aspects of this study, which is the first full-scale study of this type. It also discussed the experience of the survey field work and methodological issues involved in carrying out follow-up interviews with post-abortion patients on this sensitive and stigmatized issue.

Two additional papers on the theme of economic costs also documented the cost of postabortion care, but in addition they estimate the cost of safe abortion procedures under different scenarios, in order to demonstrate the potential savings to the facilities if cases of abortion complications were converted to safe, legal procedures. Both of these studies used a costing spreadsheet *"Savings"* specially developed for estimating the costs of safe and unsafe abortion care. One paper on Nigeria reported on preliminary findings of a study that estimated the per-case and total costs of postabortion care (PAC) in 14 secondary-level health facilities in four states in Nigeria, and that also estimated the costs of 60% of these women obtaining a safe abortion procedure. This study found that under current treatment approaches, the annual total cost for PAC to the study facilities was approximately $190,000; assuming that 60% of these PAC cases were to have a safe abortion using outpatient MVA, and 40% still needed PAC also with MVA, it was estimated that the cost to the facilities would drop to just over $100,000 per year, a decline of 48%. Cost savings would result from eliminating supplies and medications needed for treatment of complications of unsafe abortion; shifting clinical care primarily from physicians to trained midwives; use of lower levels of pain medications; and providing services on an outpatient rather than inpatient basis.

The second paper on Bangladesh conducted in 2008, collected data on costs of providing menstrual regulation (MR) and PAC, surveying 165 providers of these procedures at 21 public sector facilities. Using *Savings,* the study estimated that on a per case basis, MR with manual vacuum aspiration (MVA) is 8% of the costs of treating severe abortion complications at secondary and tertiary care levels. This study also shows that costs of postabortion care varies depending on severity, procedure and place of treatment: The cost for treatment of severe complications is over US$80 per case on average; however the cost of treatment of moderate complications is under US$30 per case, dropping to US$13 per case when the care is provided at primary care facilities and MVA is used.

Social consequences of abortion

This seminar provided substantial coverage of stigma, an important type of social consequence of abortion. Stigma may appear at the individual, community or institutional level. Stigma can increase the risk of morbidity and mortality due to unsafe abortion because it can cause a delay in seeking treatment; in addition, the negative attitude of health workers leads to poor quality of care, including further delays in attending to women seeking postabortion care.

Three papers documented the theme of stigma in Africa. It is associated with abortion but also with unwanted pregnancies especially among adolescent or unmarried women (including widows, divorced women and women whose husbands live away from home). Stigma is linked to norms that expect all sexual activity by women to take place inside of unions and to be solely for procreation. The first study was conducted in Zambia, a country which has one of the most liberal laws of sub-Saharan Africa and the question addressed was why do women continue to have unsafe abortion. This study used both qualitative and quantitative data from community leaders and 668 men and women ages 18-49 years. It found a striking lack of knowledge of the abortion law in Zambia, and that pregnancy-related deaths are perceived as a big problem in the country. Nearly half of people interviewed thought that abortion is obtained from traditional healers because of abortion related stigma in formal abortion services and because of greater privacy and the absence of negative attitudes among traditional providers. The study found broad support for family planning among married couples but not for unmarried women, and reported strong community norms sanctioning premarital sex. Most respondents said that abortion is immoral (88%); yet, about half thought that women should have access to abortion services and more that 1/3 said that women should have the right to decide about abortion. The second study on this theme was conducted in Malawi with interviews with 485 Malawian stakeholders including policymakers, health care providers, religious leaders, and community members. This study also found that the impact of unwanted pregnancy and unsafe abortion was perceived to be greatest in regard to young women, and stigma was mainly focused on premarital and extramarital pregnancies. This study highlighted the fact that young women are expelled from school if they are pregnant or have had an abortion, that women may lose their job if they cannot prove the legitimacy of their pregnancy and that poverty leads women to unsafe but low-cost services. The third paper on Africa used qualitative data (focus group discussions among women receiving post abortion care (PAC) services in a teaching hospital) and reinforces findings from the other papers of a high level of stigma attached to pregnant unmarried women, leading to fear, shame, and embarrassment among women who had abortions, as well as to indifference and poor quality of care among medical providers.

One paper discussed stigma around abortion in Mexico through a quantitative survey: A nationally representative face to face household probability survey was conducted among

3000 self-identified Catholics in Mexico. A stigma indicator was developed based on the results of questions on hypothetical situations about women who aborted, to measure respondents' reactions. Abortion stigma appears to be very common in Mexico whatever the characteristics of people interviewed: this situation could have important repercussions on the possibility of improved access to legal abortion and on provision of treatment for abortion complications, as well as on the support that women can obtain from family members

Two other papers focused on the United States, providing information on new methodologies for studying abortion stigma that would be useful in the developing world as well. One paper analyzed data from a nationally representative survey of 4,613 abortion patients to explore perceived and internalized stigma among abortion patients. Two-thirds of women perceived abortion stigma, mainly from their family or friends but also from healthcare providers. Stigma is internalized by the majority of respondents and women mentioned the need to keep their abortion a secret from friends and family. Perceived and internalized stigma varies significantly according to race and ethnicity. The second US paper provided a summary of an ongoing prospective longitudinal study (the Global Turn-away project), which aims to investigate the consequences for women of being denied access to abortion, in a particular type of situation - where the woman are denied an abortion because they are beyond the permitted gestational age. The objective is to compare consequences in terms of mental and physical health and also socio-economic consequences between women who obtained an abortion just under the gestational limit and those who did not and were just over the limit. The project plans to expand into comparative studies and to include developing countries where the risk associated with unsafe abortion is high.

Policies and programs

Three papers were presented as part of the session on policy and programs of the seminar. The first paper presented findings on unsafe abortion from a community-based intervention program in Bangladesh. Data collected from five rural districts in Bangladesh were used to assess knowledge and practices on Menstrual Regulation (MR), as well as consequences of unsafe abortion. MR services have been implemented in Bangladesh since 1974 as part of the national family planning program. From a stratified two-stage sample of 300 married women of reproductive age and 100 adolescents in school, researchers found that knowledge of MR was universal. Around 38% of women in the sample had ever used MR services. In addition, women knew about unsafe abortion, with the majority (67%) acknowledging that unskilled providers contribute to unsafe abortion. Even though with the program has existed for many decades, the study showed that access to MR services remain challenging, especially for poor women and adolescents.

The second paper looked at the expansion and implementation of a harm reduction model to prevent unsafe abortion in Latin America. This harm reduction model has been implemented in 31 clinics in 7 countries in Latin America. The Harm reduction model employs principles from human rights, woman's right to health, autonomy, complete information about health practices and patient—provider confidentiality. Results showed that under this model, women receive comprehensive counseling and support, as well as information about the safety of available methods to terminate a pregnancy. Service data in Uruguay, Argentina, Ecuador, Mexico, Peru and Venezuela demonstrated that when implemented, this model can result in reduction of post-abortion complications. The vast majority of women who were counseled interrupted their pregnancy medically with misoprostol before ten weeks gestation, and of those who returned for follow-up less than 4% had any complications. The paper argues that under the harm reduction model, providers can offer a timely response to women facing

unwanted pregnancy, thus contributing to the reduction of unsafe abortion and maternal morbidity and mortality.

The third paper looked at evidence from a community-based intervention project that aimed at increasing the quality of post-abortion care in Nigeria. Over a period of 10 years, a total of 1397 private providers (including doctors, and nurse/midwives) in eight states in Nigeria were trained to provide high quality services in the areas of treatment of incomplete abortion, post-abortion family planning and integrated STD/HIV care. Service provider data showed that more than 17,000 women were treated by these trained providers. Client exit interviews were available for 2559 women, of which less than 2% reported mild to moderate complications. The assessment concludes that provider training in post abortion care can help reduce mortality and morbidity due to unsafe abortion, especially where abortion is highly restricted.

Concluding notes

As part of the final session of the seminar, the panel led an interactive discussion to recap broad themes that had emerged over the three days; invite feedback and discussion on these themes and generally; answer questions about the panel, the seminar series and next steps for papers; and to hear participants' preferences regarding publication plans.

We provide here a summary of the ten key themes that were identified:

1) There is need for greater precision in measurement in abortion consequences research in all three areas (health, economic and social);
2) In times of increasing constraints for funding, the field needs "cost-effective" approaches in data collection, especially when planning large-scale population-based studies;
3) An appreciation was expressed for the growing body of evidence documenting and describing abortion stigma and related contributions from the psycho-social sciences;
4) There was support for more ethnographic studies to put a "human face" on the most tragic cases of negative consequences due to unsafe abortion, particularly for increasing awareness;
5) Regarding evidence-based advocacy stemming from studies such as those discussed here, the group recommended cautious messaging in contexts where the topic of abortion is still taboo, so as to avoid risking backlash e.g. policies that further restrict women's reproductive rights;
6) There was applause for studies that made concerted efforts to "gave back" to study participants and/or communities through follow-up activities with beneficiaries and stakeholders;
7) The group acknowledged the tangible recent progress achieved in the study of economic costs of unsafe abortion, including improved study designs, protocols and analysis tools;
8) Evidence from various studies supports recommendation of continued training of mid-level health providers in abortion care in developing country settings, particularly in the use of MVA and medical abortion;
9) There was a call for increased research on women's use of misoprostol for abortion in legally restricted settings to fill this large gap in the international literature;
10) The group noted the benefits and importance of small-group meetings such as this IUSSP seminar, to encourage academic exchange in a friendly, constructive environment.

International Union for the Scientific Study of Population
Union Internationale pour l'Étude Scientifique de la Population
Unión Internacional para el Estudio Científico de la Población
国际人口科学研究联盟
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Population Council

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Programme

Wednesday, November 10

9:00-9:45 **Welcome (Population Council, Panel, IUSSP)**
Introductions – Participants and special guests

9:45-10:15 *Coffee Break*

10:15-12:30 Session 1: Maternal mortality due to unsafe abortion

Chair: Sandy Garcia *Discussant: Ndola Prata*

- Unsafe abortion mortality: New estimates and trends.
  Elisabeth Aahman and Iqbal Shah
- Estimating the global burden of near-miss due to unsafe abortion.
  Adler A, Filippi V, Thomas S, Wagner K and Ronsmans, C
- Analysis of abortion-related mortality in Mexico (1990-2008).
  Raffaela Schiavon, Gerardo Polo, and Erika Troncoso
- Maternal mortality due to abortions in México City from 2005-2007: An assessment of specific abortion related deaths and the factors that caused them.
  Marieke G. Van Dijk, Patricio Sanhueza Smith, Kristina Granger Beall and Sandra G. Garcia

11:30-11:50 Discussant: *Ndola Prata*

11:50-12:30 Open discussion

12:30-2:00 ***Lunch***

2:00-5:00 Session 2: Abortion morbidity and post abortion care: Part I

Chair: Ali Mohammad Mir *Discussant: Fatima Juárez*

- Health consequences of unsafe abortion in Colombia 1989-2008.
  Elena Prada, Susheela Singh, Cristina Villarreal

- Trends in hospitalization for abortion complications and the potential impact of misoprostol use: The case of Brazil.
  Susheela Singh, Mario Monteiro and Jacques Levin

- Interpreting social aspects and health consequences of abortion in Iran.
  Meimanat Hossein Chavoshi

- An unequal burden: Health outcomes, socio economic status, and unsafe abortion in Tigray Province, Ethiopia.
  Caitlin Gerdts

3:40-4:00 *Coffee Break*

4:00-4:20 Discussant: *Fatima Juárez*

4:20-5:00 Open Discussion

7:00 Welcome Dinner – <u>All Participants Invited</u>

Thursday, November 11

8:30-10:30 Session 3: Abortion morbidity and post abortion care: Part II -The case of India

Chair: Susheela Singh *Discussant: Ali Mohammad Mir*

- Pathways and consequences of unsafe abortion: A prospective study amongst women with post-abortion complications in Madhya Pradesh, India.
  Sushanta Banerjee

- Post-abortion complications and treatment seeking behaviour in India: Socio-economic and medical services provider correlates.
  Ramesh Chellan

- Abortion morbidity and post abortion care in India: Evidence from two community-based studies.
  Shelley Saha-Sinha

9:30-9:50 Discussant: *Ali Mohammad Mir*

9:50-10:30 Open Discussion

10:30-11:00 *Coffee Break*

11:00-1:30: Session 4: Economic costs of unsafe abortion

Chair: Agnès Guillaume *Discussant: Friday Okonofua*

- Documenting the economic cost of unsafe abortion in Uganda.
  Michael Vlassoff, Charles Kiggundu, Fred Mugisha, Aparna Sundaram, and Akin Bankole
- The health systems cost of post-abortion care in Ethiopia.
  Michael Vlassoff, Tam Fetters, Solomon Kumbi, Mamo Girma, and Susheela Singh
- Health system costs of treatment of abortion complications in Nigeria and Malawi.
  Janie Benson
- Assessing the cost-efficiency of menstrual regulation and postabortion care service delivery in Bangladesh: A comparison of multiple service delivery strategies.
  Heidi Johnston

12:30-12:50 Discussant: *Friday Okonofua*

12:50-1:30 Open Discussion

1:30-2:30 Lunch

2:30 - Group excursion

Friday, November 12

9:00-11:00: Session 5: Social consequences of abortion: Part I

Chair: Ndola Prata *Discussant: Sandy Garcia*

- Abortion stigma in Zambia.
  Cynthia Geary
- Abortion stigma in the United States: quantitative and qualitative perspectives from women seeking an abortion.
  Kristen Shellenberg
- Brief summary of on-going longitudinal project in the US.
  Diana Green Foster

9:45-10:00 Discussant: *Sandy Garcia*

10:00-10:30 Open discussion

10:30-11:00 *Coffee Break*

11:00-1:00: Session 5: Social consequences of abortion: Part II

Chair: Friday Okonofua *Discussant: Agnès Guillaume*

- Public opinion about abortion-related stigma among Mexican Catholics and implications for unsafe abortion

  Kate Wilson, Stephanie McMurtrie, Claudia Diaz Olavarrieta, Gillian F. Garcia, Evelyn Aldaz, Maria Consuelo Mejia, and Sandra G. Garcia

- "Fear, Shame and Embarrassment" The Stigma Factor in Post Abortion Care at KATH, Kumasi. Ghana

  Eva Tagoe-darko

- Social and economic consequences of unwanted pregnancy and unsafe abortion in Malawi.

  Brooke Levandowski, Linda Kalilani-Phiri, Yirgu Gebrehiwot, Paschal Awah, Godfrey Kangaude, and Hailemichael Gebreselassie

12:00-12:20 Discussant: *Agnès Guillaume*

12:20-1:00 Open discussion

1:00-2:30: **Lunch**

2:30-4:30: Session 6: Policies and programmes

Chair: Claudia Diaz Olavarrieta *Discussant: Janie Benson*

- Unsafe abortion in rural Bangladesh: findings from a community based survey.
  M. Sheikh Giashuddin

- Expansion and implementation of the harm reduction model for unsafe abortion in Latin America
  Giselle Carino

- Training private abortion providers improves abortion access and safety in Northern Nigeria: evidence from a community-based intervention study
  Rosemary Ogu

3:30-3:50 Discussant: *Janie Benson*

3:50-4:30 Open discussion

4:30-4:45 *Coffee break*

4:45-5:30 Session 7: Next steps and closing

Panel: Sandy Garcia (Chair), Susheela Singh and Fatima Juarez

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