

DFID's policy position on safe and unsafe abortion

Summary

DFID supports safe abortion on two grounds. First, it is a right. Women have the right to reproductive health choices. Second, it is necessary. 20% of pregnancies globally end in induced abortion; unsafe abortion accounts for 13% of all maternal deaths and the hospitalisation of a further five million women every year due to serious health complications. This preventable mortality and ill-health due to unsafe abortion is seriously undermining countries' ability to achieve MDG 5 (to improve maternal health) and places a high burden on already over-stretched health systems. But DFID does not support abortion as a method of family planning. In countries where it is legal, DFID will support programmes that make safe abortion more accessible. In countries where it is illegal and mortality and morbidity is high, DFID will make the consequences of unsafe abortion more widely understood, and will consider supporting processes of legal and policy reform.

Background

Sexual and reproductive health and rights (SRHR) are core elements of good health and human development – essential to achievement of the Millennium Development Goals (MDGs). DFID's approach to SRHR and to improving maternal health is set out in ['Sexual and reproductive health and rights: a position paper'](#) and ['Reducing maternal deaths: evidence and action, a strategy for DFID'](#). Commitment to improving access to safe abortion is re-iterated in the 2009 White Paper [Eliminating World Poverty: Building our Common Future](#).

A central aim of DFID policy is to empower and enable women and adolescent girls^a 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

^a All references to women in this document also include reference to adolescents and young women.

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 (MDG 5) given that nearly all deaths from unsafe abortion are preventable. On top of this there is strong evidence of the high cost that unsafe abortion imposes upon health services, women and their families. This note expands on DFID's position regarding safe and unsafe abortion.

Level of Induced Abortion

Every year, throughout the world, about 210 million women become pregnant; and about 42 million or 20% of these end in induced abortion¹. Nearly half (20 million) of these abortions are unsafe² – equivalent to one unsafe abortion for every seven live births. Where effective contraception is available and widely used the rate of abortion declines but nowhere has it reached zero³. There are a number of reasons for this. First, 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. Even if all people using contraception were to use methods perfectly all of the time, there would still be six million unintended pregnancies globally, each year⁴. Third, high rates of violence against women, including in the home and during armed conflicts, lead to unwanted pregnancies. Fourth, changing circumstances such as divorce or other crises can result in a wanted pregnancy becoming unwanted.

In 2003 there were 6.3 million unsafe abortions in South-Central Asia, the highest number of unsafe abortions in any sub-region, reflecting the very large population and lower rates of usage of modern contraception⁵. However, women in Eastern, Western and Central Africa face the highest risk of unsafe abortion-related death; double that of women in Asia and five times that of Latin American women⁶.

Consequences of Unsafe Abortion

Complications arising from these unsafe abortions contribute to 13% of all maternal deaths⁷. Each year 67,000⁸ women die following unsafe abortion and an estimated five million are hospitalised for the treatment of serious complications such as

bleeding or infection⁹. The high volume of abortion complications exacts a heavy toll on already overburdened health systems. For example post-abortion care admissions represent more than 55% of all obstetric complications treated in Mozambique¹⁰. These complications can lead to ongoing health problems 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 girls¹¹ and about half of the 20,000 Nigerian women who die from unsafe abortions each year are adolescents where abortion complications are responsible for 72% of all deaths among teenagers below the age of 19¹². Globally, almost half of all abortion deaths are in this age group¹³.

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. They also felt that poor women were being denied access to safe abortion services because they could not pay the high prices in private clinics where safe abortions were being performed despite the legal restrictions'¹⁴

Ill health following unsafe abortion also adds a high cost to both health systems and individual families. It is estimated that 60% of the expenditure in the Nairobi Kenyatta National Hospital maternity section goes towards treatment of incomplete abortions¹⁵. There is little data available to estimate the costs of unsafe abortion, but recent cost estimates suggest that the annual cost to developing country health systems is between \$375 and \$838 million; out of pocket expenses may amount to a further \$600 million¹⁶.

Abortion: gender inequality and poverty

There are many reasons why the decision to terminate a pregnancy may be reached. Women may be unable to avoid unwanted pregnancy. Many women feel they are too young or too poor to raise a child. The social stigma of raising a child outside

marriage may be too great to bear. Sometimes contraception fails. In many countries contraception is simply unavailable, 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. All too often, sexual intercourse takes place in circumstances 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 diseases. 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. 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 to provide sex to older, socially dominant men. 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.

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. 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 rape¹⁷. Worldwide, one in five women becomes the victim of rape or attempted rape at some point in their lifetime¹⁸. Almost 50% of sexual assaults worldwide are against girls of 15 years or below¹⁹.

The consequences of gender inequality, cultural norms, some religious beliefs 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 destitution from isolation and extreme poverty.

What is DFID's policy position on abortion?

Millions of women around the world each year decide to seek an abortion, whether or not it is legal and available. Notwithstanding national legislation or local interpretation of that legislation, DFID's position is that safe abortion reduces recourse to unsafe abortion and thus saves lives, and that in a humane and just society women and adolescent girls must have the right to make their own decisions about their sexual and reproductive well being.

DFID does not promote abortion as a method of family planning and neither condones nor supports 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 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 unwanted pregnancy and sexually transmitted infections. But DFID recognises that, for many, this is not the reality. Better access to family planning is vital; but it won't always be enough.

DFID's position is that women should not face death, disability or prosecution when they decide to have an abortion. To reduce deaths from the complications of unsafe abortions DFID will continue to support the prevention of unsafe abortion as part of broader public health efforts to improve sexual and reproductive health. DFID supports programmes that make safe abortion more accessible in countries where it is legal, and make the consequences of unsafe abortion more widely understood in countries where not legal. DFID will also consider supporting processes that enable legal and policy reform.

Improving access to Safe Abortion in Nepal

Prior to legalisation of abortion in 2002, women could be jailed for up to 20 years for having an abortion. It was estimated that over half of emergency obstetric admissions and 20% of hospital obstetric deaths were due to abortion complications.

Following legal reform, the Government of Nepal, supported by DFID, 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.

Significant progress has been made with service sites established in all 75 districts. Nearly a quarter of a million women have received safe services, and medical abortion is being successfully piloted. DFID continues to work to address key issues including reducing cost barriers and improving quality and availability of services in remote areas.

What is DFID prepared to support?

DFID will consider support for activities to improve the quality, safety and accessibility of abortion services – to the extent allowed by the law of the country in which we are working. 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, DFID will consider support to strengthen mechanisms to improve its quality and affordability for poor women and girls. At all times DFID 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 unwanted pregnancy and repeat abortion. DFID 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 legal within limited or highly restricted grounds. DFID will consider support to increase awareness - among policy-makers, legislators, national health authorities and health personnel - of the circumstances under which abortion is allowed and of the consequences arising from the complications of unsafe abortion, such as the burden of maternal ill-health and high health service costs. DFID will also consider support 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 undertaking catalytic work to prevent unsafe abortion.

DFID's 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 and political disagreement.

DFID's position is consistent with the Cairo Programme of Action, agreed at the 1994 United Nations International Conference on Population and Development²⁰ (ICPD), which affirmed that in no case should abortion be promoted as a method of family planning. The ICPD agreed that prevention of unwanted 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, and that in all cases women should have access to quality services for the management of complications following abortion. It also emphasised the importance of post-abortion counselling and family planning to help women avoid unwanted pregnancy and repeat abortion.

A Special Session of the UN General Assembly in 1999 to review 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 measure to ensure that such abortion is safe and accessible'²¹.

References:

-
- ¹ WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth Edition. 2007. pp 1.
- ² Ibid p.14
- ³ WHO. Safe Abortion: technical and policy guidance for health systems. 2003 p 12
- ⁴ Ibid p 12
- ⁵ WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth Edition. 2007. p 16
- ⁶ Ibid p 15
- ⁷ Ibid p 17
- ⁸ Ibid p 17
- ⁹ Singh S, Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries, *Lancet*, 2006, 368(955):1887–1892. Accessed on line 14th July 2009.
- ¹⁰ 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 (accessed 26th June 2009)
- ¹¹ Grimes et al. Unsafe abortion: the preventable pandemic. *The Lancet*, Special Issue on Sexual and Reproductive Health October 2006, 65 – 76.
- ¹² Raufu A. 2 November 2002. Unsafe abortions cause 20 000 deaths a year in Nigeria. *British Medical Journal*, 325:988. <http://bmj.bmjournals.com/cgi/content/full/325/7371/988/> Accessed 16th July 2009.
- ¹³ WHO. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth Edition. 2007 p 19
- ¹⁴ 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.
- ¹⁵ Death and Denial: unsafe abortion and poverty. IPPF 2006 p.9
- ¹⁶ 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.
- ¹⁷ 'Gender Equality – At the heart of development'. DFID publication 2007
- ¹⁸ State of World Population report 2005. *The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*. UNFPA. 2005. 65.
- ¹⁹ Multi-country study on Women's health and Domestic Violence against Women, WHO. 2005
- ²⁰ United Nations. Programme of Action adopted at the International Conference on Population and Development, Cairo, 5 – 13 September 1994. United Nations 1995.
- ²¹ 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.