

Envisioning Life Without *Roe*: Lessons Without Borders

By Susan A. Cohen

Abortion has been legal nationwide in the United States for 30 years. Statistics as well as the personal accounts of physicians and women who are now grandmothers tell the tale of hardship, injury and death due to American women's underground recourse to illegal, septic procedures in an earlier time. These provide an important context for the current debate over the future of legal abortion in the United States—but the fact remains that the country's memory of life before *Roe v. Wade* is becoming more and more remote.

Looking back in time is one way to reflect upon what women face in a world without access to safe, legal abortion; looking beyond the borders of the United States is another. Today, one in four of the world's women—and half of the women in the developing world—live in countries that severely restrict or block entirely their ability to obtain a legal abortion. Yet, as in the pre-*Roe* United States, many women determined to end an unwanted pregnancy will find a way to do so despite the law, often at great risk to their health and too often their life.

Laws and Reality

Prior to the 1973 decision in *Roe v. Wade*, illegal abortion in the United States was common; some 700,000 to 800,000 abortions were estimated to have taken place annually in the 1950s and 1960s. Poor women, mostly young and minority, suffered the health consequences, and maternal mortality rates were high. Women of means had more options. Some were able to pay a medical

professional to safely perform an illegal procedure. In those states that permitted abortion under very narrow circumstances, some were able to persuade hospital authorities that they fit the criteria. New York legalized abortion, without a residency requirement, in 1970, which immediately put New York City on the map as an option for those women who could afford to travel. Before that, it was an open secret that affluent American women would travel to London to obtain a safe, legal procedure (“Lessons from Before *Roe*: Will Past Be Prologue?” *TGR*, March 2003, page 8).

Today, London is still a primary destination for “abortion tourism,” now mainly for Irish women. Ireland's law remains uniquely restrictive in Europe, banning abortion completely except when necessary to save the woman's life. (The threat of suicide remains a life-threatening justification for an abortion in Ireland, following an unsuccessful attempt by the government and the Catholic hierarchy to close this “loophole” by national referendum in 2002.) In terms of abortion-related information available to women, nondirective pregnancy counseling is legal, but referrals and any activity that could be construed to “advocate or promote” abortion are not.

Roughly 7,000 Irish women annually manage to travel to England or Wales for the purpose of having an abortion, according to the Irish Family Planning Association. Not surprisingly, those able to make the trip are more likely to have abortions later in pregnancy than English residents because of the time

involved in making travel arrangements and gathering the necessary funds beyond just the medical costs. Abortion later in pregnancy carries increased health risks, but when the procedure is performed in an appropriate setting by a trained medical professional, those risks are still low. And they pale in comparison to the risks millions of women in developing countries take every day in having an illegal abortion.

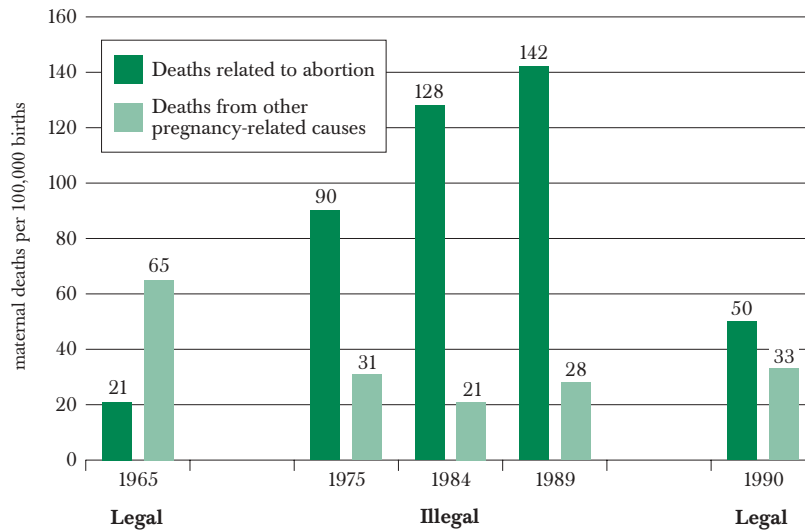
Of the 46 million abortions occurring worldwide each year, 20 million are illegal. As was the case with affluent U.S. women in the years before *Roe*, a small proportion of women living in urban areas in some developing countries may be able to afford the services of a private physician who can perform a safe, if still illegal, abortion. Not so, however, for the vast majority who live in extreme poverty, in rural areas or otherwise without access to emergency hospital care for the treatment of complications of an abortion induced by crude and often dangerous traditional methods.

According to the World Health Organization, about 13% of the 500,000 deaths worldwide from pregnancy-related causes each year are associated with unsafe abortion; in Latin America, the proportion is as high as 21%. In Egypt, abortion-related problems are responsible for about one-fifth of all obstetric and gynecologic admissions. Indeed, in some developing countries, women suffering from complications of illegal abortion account for two of every three maternity hospital beds in large urban hospitals, consuming as much as one-half of obstetrics and gynecology budgets.

In some parts of the world, lay practitioners' use of noninvasive techniques and the increasing availability of antibiotics may be having a positive impact in lowering infection rates associated with clandestine abortion procedures. (In the United States, abortion-related maternal

CLEAR IMPACT

When abortion was against the law in Romania, from 1966 to 1989, abortion-related deaths soared.



Source: The Alan Guttmacher Institute (AGI), *Sharing Responsibility: Women, Society & Abortion Worldwide*, New York: AGI, 1999, Chart 5.4, p. 38.

deaths declined sharply following the introduction of antibiotics in the 1940s.) Experience in country after country has shown, however, that reducing the need to resort to unsafe procedures and untrained practitioners—through legalization and bringing the provision of services into the open—has a direct and immediate effect on reducing abortion-related mortality and, therefore, overall maternal mortality rates.

Six months after abortion was legalized in Guyana in 1995, for example, admissions for septic and incomplete abortion dropped by 41%. Previously, septic abortion had been the third largest, and incomplete abortion the eighth largest, cause of admissions to the country's public hospitals. Another stark example is Romania, where abortion was legally available from 1957 until 1966. The Ceaucescu regime then outlawed abortion in 1966 as part of its pronatalist policy, which led to soaring maternal death rates. Maternal death rates then fell dramatically once abortion was relegalized in 1990 after Ceaucescu's ouster (see chart).

Abortion and Unplanned Pregnancy

While the consequences of having an abortion vary widely according to whether or not medically safe services are available and accessible, the reasons women have abortions transcend national boundaries, religions and cultures. The proximate cause is unplanned pregnancy, a common occurrence in the United States and abroad.

Worldwide, 38% of the 210 million pregnancies occurring each year are unplanned; 22% end in abortion. Some of these pregnancies occur to women who want to have children but not until later; others occur to women who already have all the children they want. In either case, this phenomenon reflects the apparently inexorable and nearly universal trend toward couples' wanting, and having, smaller families and trying to time the births of their children to best advantage.

Contraceptive use is central to the ability of sexually active, fertile women to have the number of children they want when they want them. But much can go wrong. Accidental pregnancies can and do result from inadequate access to effective methods of contraception, from failure of the methods themselves or, more often, from imperfect use. A woman seeking to limit her family to two children, and to do so without resorting to abortion, needs to successfully practice birth control for 20 of her roughly 25 childbearing years; a woman wanting four children must do so for 16 years. Yet, data from the United States—where contraceptive use among women at risk of unintended pregnancy is nearly universal—show how difficult it can be for many women to use contraceptive methods correctly and consistently over many years; in terms of their failure rates, many methods have a considerable gap between consistent and less consistent use (see table).

Once faced with an unintended pregnancy, women in the developed and developing world alike give broadly similar reasons for deciding to end a pregnancy. Many younger women report that they are seeking to delay childbearing until they are better prepared to be parents—when they are older, have completed their education, are married and are more financially secure. Other women say they are too poor to have another child or that they simply have had

RATES OF METHOD FAILURE DEPENDING ON CONSISTENCY OF USE

METHOD	% OF USERS WHO BECAME PREGNANT	
	CONSISTENT/ CORRECT USE	LESS CONSISTENT/ CORRECT USE
WITHDRAWAL	15	29
PERIODIC ABSTINENCE	14	57
SPERMICIDES	13	55
DIAPHRAGM	9	42
CONDOM	6	51
ORAL CONTRACEPTIVES	3	27
IUD	3	5
FEMALE STERILIZATION	0.5	0.5
DEPO-PROVERA	0.3	0.3
NORPLANT	0.1	0.1
MALE STERILIZATION	0.1	0.2

Notes: Based on U.S. women, during the first year of contraceptive use.
Source: AGI, *Sharing Responsibility*, Table 2d, p. 16.

ABORTION LAWS, RATES AND MATERNAL MORTALITY		
COUNTRY	ABORTION RATE PER 1,000 WOMEN, 15-44	MATERNAL DEATHS PER 100,000 LIVE BIRTHS
WHERE ABORTION IS BROADLY PERMITTED		
AUSTRALIA	22	6
ENGLAND/WALES	16	10
FINLAND	10	6
NETHERLANDS	7	10
UNITED STATES	21	12
WHERE ABORTION IS SEVERELY RESTRICTED		
BRAZIL	38	260
CHILE	45	33
COLOMBIA	34	120
DOMINICAN REPUBLIC	44	110
MEXICO	23	65
PERU	52	240

Note: Most recent data available. *Sources:* Abortion data—AGI, *Sharing Responsibility*, Appendix Table 4, p. 54; Finer LB and Henshaw SK, Abortion incidence and services in the United States in 2000, *Perspectives on Sexual and Reproductive Health*, 2003, 35(1):6-15. Maternal mortality rates—United Nations Statistics Division (UNSD), *The World's Women 2000: Trends and Statistics*, New York: UNSD, 2000/updated 2002.

all they children they want. In between, large numbers of women are seeking to space their births, for their child's benefit and their own. Indeed, just last year, Johns Hopkins University's *Population Reports* noted new evidence that a child born at least three years after a previous birth has a greatly increased chance of survival beyond infancy and through early childhood than one born within two years; the longer interval significantly benefits

the mother's health as well. These are the main reasons, but some women are ending a pregnancy resulting from incest or rape, because they have AIDS or another serious health problem, because they may live in a culture in which it is taboo for an unmarried woman to have a child or in which they lack the status and autonomy to use contraception or use it effectively.

Into the Future

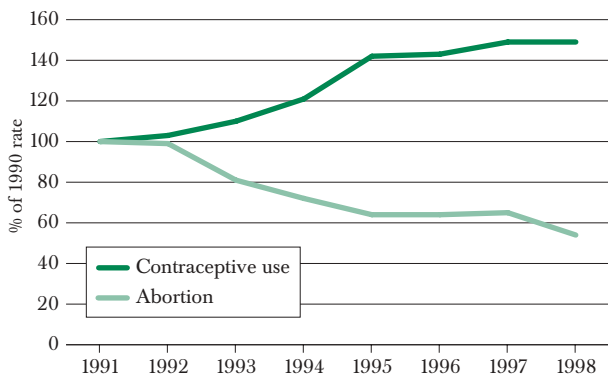
The public health rationale for open, accessible and safe abortion is as compelling today in Africa, Asia, throughout Latin America and even in Ireland as it was in the United States in the 1950s. Moreover, the American pre-Roe experience, just as that in the developing world today, demonstrates quite clearly that liberal abortion laws do not cause abortion, unintended pregnancy does. Indeed, some of the world's lowest abortion rates may be found in countries with the most liberal abortion laws, where services are easily available and even subsidized; by contrast, high abortion rates (and, generally, high maternal mortality rates as well) may be observed in countries where the procedure is severely restricted (see

table). In one sense, Eastern Europe is the aberration, in that abortion has been legal there for decades and rates remain high. In another sense, it is the aberration that proves the point, in that Eastern Europe's high abortion rates result from the almost total lack of availability until quite recently of modern contraceptive methods. Increased contraceptive use over the last decade already is having a major impact, however, in reducing the abortion rates in countries such as Kazakhstan (see chart).

Reducing unintended pregnancy through more and more effective contraceptive use can go a long way toward lowering the incidence of abortion. But as long as contraceptive technology is imperfect and so are the human beings who use it, abortion will continue to be a fact of women's lives as it has been for centuries. A major question going forward is whether women living where abortion is now illegal will see a day in their home country where even the poor may be able to have a safe abortion. Another is whether the United States has moved so far beyond the days of soaring pregnancy-related deaths and clandestine abortions that Americans have forgotten or are finding it easier to deny the main effect of a restrictive law. In that sense, women in the developing world are present-day reminders of America's past. ☹

DIRECT LINK

Kazakhstan is similar to other former Soviet republics, where abortion rates have been declining dramatically as modern contraceptive methods have become available.



Source: Westoff CF, *The Substitution of Contraception for Abortion in Kazakhstan*, Population Resource Center, 2001, <<http://www.prcdc.org/summaries/newabortion/newabortion.html>>.