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Fact Sheet

Adolescents' Need for and Use of Abortion Services In Developing Countries

• In most developing countries, stigma against sexual activity among unmarried adolescents is pervasive, unmet need for contraception among women in their teenage years is high, and abortion is highly legally restricted, constraining access to safe services for adolescents and all women.

• Accurate and complete information about sex and provision of contraceptive methods are first-line defenses against unintended pregnancy, but many adolescents in developing countries lack access to these essential services.

• In the event of an unintended pregnancy, access to safe abortion services is critical to prevent potentially fatal injury and infection from unsafe abortion. Where safe abortion is unavailable, postabortion care (PAC) services are necessary to treat the complications that result from unsafe procedures, the most severe of which can result in infertility and death.

ABORTION INCIDENCE

• Researchers estimate that in 2008 (the most recent estimate available), about 3.2 million adolescent women in developing regions underwent unsafe abortions, an annual rate of about 16 unsafe abortions per 1,000 women aged 15–19. Age-specific information on safe abortions in developing countries does not exist, so there are currently no global or regional estimates of total (safe and unsafe) abortion incidence among adolescents.

• The global rate masks substantial variation in the unsafe abortion rate between geographic regions. Africa and Latin America and the Caribbean, where most countries have very restrictive abortion laws, had very high unsafe abortion rates: 26 unsafe abortions per 1,000 adolescent women in Africa and 25 per 1,000 in Latin America and the Caribbean. In Asia*, which contains many countries with liberal abortion laws, the unsafe abortion rate in 2008 was only nine per 1,000 adolescents.

• As of this writing, reliable age-specific abortion estimates that do not rely on self-reports are available for only five developing countries (see table, page 2). There is a lot of variation in abortion rates and in the proportion of adolescent pregnancies that end in abortion. Among these five countries, Ethiopia has the lowest abortion rate and Kenya and Mexico have the highest rates. Ethiopia (with a high adolescent birthrate, 79 births per 1,000 adolescent women) also has the lowest proportion of teen pregnancies that end in abortion, while Mexico (with a lower teen birthrate of 67 births per 1,000) has by far the highest.

ABORTION SERVICE PROVISION TO ADOLESCENTS

• Very little comprehensive, nationally representative information about adolescents' use of abortion and PAC services is available. The statements below summarize findings from 21 studies in 12 developing countries (Bangladesh, Burkina Faso, Dominican Republic, Ethiopia, Ghana, Kenya, India, Malawi, Mexico, Nigeria, Tanzania and Zambia).

• Taken as a whole, these studies show that compared with older women, adolescents have a greater tendency to seek abortions from untrained providers or to self-induce. As a result, adolescents more frequently make multiple attempts to end their pregnancies, instead of having one safe, effective procedure.

• Studies from India and Ghana show that adolescents have second-trimester abortions (instead of first-trimester abortions) more often than older women. This is because adolescents typically take longer than older women to recognize their pregnancies, locate providers and find a way to pay for the procedure.

• This landscape might be changing with the increase in access to medical abortion—primarily through the use of misoprostol—in countries with highly restrictive abortion laws. Drugs such as misoprostol are less expensive than surgical procedures, and much easier to obtain and use clandestinely. Because adolescents cite cost and lack of confidentiality as the biggest barriers to obtaining safe abortion services, the context of teens' access to abortion is likely to have

*This region contains Afghanistan, Armenia, Azerbaijan, Bahrain, Bangladesh, Bhutan, Cambodia, Cyprus, Georgia, India, Indonesia, Iran, Iraq, Israel, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Malaysia, Maldives, Myanmar, Nepal, Occupied Palestinian Territory, Oman, Pakistan, Philippines, Qatar, Saudi Arabia, Singapore, Sri Lanka, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Turkey, United Arab Emirates, Uzbekistan, Vietnam and Yemen.

Adolescent Abortion in Five Developing Countries

Country (and year)	No. of abortions to women aged 15–19	Rate per 1,000 women 15–19	% of pregnancies to women 15–19 that end in abortion
Burkina Faso (2008)	23,630	30	16
Ethiopia (2008)	46,860	11	9
Kenya (2012)	76,760	38	22
Malawi (2009)	14,040	21	14
Mexico (2009)	230,180	44	34

Source: Sedgh G et al., Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends, *Journal of Adolescent Health,* 2015, 56(2):223–230.

changed significantly in places where access to medical abortion methods has expanded. Unfortunately, this development is so new that published research on adolescents' use of medication abortion in developing countries is not yet available.

ADOLESCENTS' ACCESS TO POSTABORTION CARE

• Particularly in countries where abortion is legally restricted, access to postabortion care is critical to protect women's health and to save their lives.

• In 2012, an estimated seven million women of reproductive age were treated in health facilities for complications of induced abortion; in addition, a substantial number needed this care but did not receive it.

• Adolescents account for sizeable shares of PAC patients. Data are available for only four countries, but the share of adolescent PAC patients ranged from 21% in Malawi to 34% in the Dominican Republic.

• Adolescent PAC patients start using contraceptives after their treatment less often than older women—even when they receive counseling on methods.

• In the three countries for which information was collected (India, Kenya and Malawi), rural adolescents tend to delay or forgo medical treatment for their abortion complications more often than their urban counterparts.

BARRIERS TO ABORTION AND POSTABORTION CARE

• In countries that permit abortion under broad criteria, legal restrictions, such as requiring parental notification or consent, can deter teens from seeking safe abortion services and result in their resorting to unsafe sources and methods.

• Adolescents cite cost, a desire to keep the pregnancy secret (because of stigma associated with abortion, pregnancy and sexual activity among unmarried women) and trouble locating safe providers as their main reasons for self-inducing or seeking abortions from untrained providers—even in countries where abortion is legal and widely available.

IMPLICATIONS FOR POLICY AND PROGRAMS

• Programs and policies on abortion and postabortion care provision must be sensitive to the needs of adolescents, the most prominent of which are affordability and confidentiality. Because many adolescents have no independent income, services for this population should be affordable or even free of charge. Where possible under the law, parents, guardians and spouses should be involved only at the request of the patients.

• Health care providers must be trained in the importance of behaving in a nonjudgmental manner and protecting patient confidentiality, so that fear of ill treatment or disclosure does not keep adolescent women from accessing potentially life-saving abortion and PAC services.

• Where abortion is legal, providers should be trained in adolescents' rights to abortion services under the law.

• To avert unplanned pregnancies and abortions, adolescents should be given complete, medically accurate education about sex, pregnancy and contraception.

• Contraceptive counseling and method provision should be integrated into PAC services to prevent future unintended pregnancies and unsafe abortions, and should take into account the unique needs of adolescent women, such as those relating to cost and confidentiality.

Sources

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