

Confronting the Reality of Abortion in Latin America

By Lisa C. Remez

The Spanish- and Portuguese-speaking nations of Latin America share a broad cultural heritage; they also share an epidemic of clandestine abortion. Although in none of these countries, except Cuba, are women given wide legal access to abortion, an estimated four million procedures are performed in Latin America each year.¹ Clandestine abortions are not necessarily unsafe ones, but the high levels of abortion-related morbidity and mortality in the region stem from the dangerous conditions that still surround a high proportion of clandestine procedures.² Often the only way to determine the incidence of induced abortion is indirectly, through the hospital records of women who receive substandard care and then need treatment for complications; hospitals, however, are believed to seriously misclassify such cases, and on a lesser scale, to underreport them.

Efforts to reduce the deleterious effects on women's health caused by clandestine abortion have to start somewhere—perhaps just by identifying and quantifying the problem. But even this is a daunting task. How does one accurately measure and describe something that is not registered and that officially does not occur because it is prohibited by law and condemned by prevailing cultural values? Participants in the Research Conference on Induced Abortion in Latin America and the Caribbean gathered in Bogotá, Colombia, from November 15–18, 1994, to grapple with this enormously complex issue. The conference, organized by the Universidad Externado de Colombia with the collaboration of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) of the World Health Organization (WHO) and the Alan Guttmacher Institute (AGI), brought together some 130 re-

searchers, health professionals, policymakers and legislators from 20 countries.* WHO and the Ford Foundation provided funding for the event. The conference was the first of its kind in Latin America, and the very fact that it took place marks a turning point in the way in which the region's reproductive health and population field has confronted the issue.

The impetus for the conference grew from the sense that the epidemic is so vast and that enough research has been conducted by individuals, universities and organizations—much of it under the auspices of the WHO programme and through AGI's multicountry research project on abortion—to call a meeting to assess the findings and the state of abortion research in Latin America. According to Axel Mundigo, head of social science research at HRP, the purpose of the conference was, more than anything else, to exchange knowledge on clandestine abortion in the region—its incidence, determinants, consequences, and social and economic costs. In doing so, Mundigo affirmed, the conference would “synthesize the experience [of induced abortion] and communicate it to senators, deputies and others who can exert their influence to change very outdated laws.”³

In addition to researchers, the organizers invited elected officials from national and regional parliaments and representatives from women's groups and activist organizations to help develop joint strategies of how best to use data on abortion to effect change. The sheer volume of papers the conference attracted and the range of subjects they encompassed—not only the expected studies of incidence, determinants, consequences, service provision and treatment of complications, but new research on the role of men in the abortion decision, the attitudes of the general public and the opinions of Catholic priests—indicate that the organizers knew that the time for such a gathering had come.

Presentations and Discussions Incidence

A first step toward analyzing the problem of clandestine abortion is quantifying it. The conference opened with a session devoted to the incidence of abortion, with two presentations that employed different strategies for collecting hidden and sensitive data. In the AGI study conducted in six Latin American countries, data on hospitalized abortion cases were adjusted for incomplete and inaccurate reporting and for misclassification of induced abortion as spontaneous abortion (since women rarely report that an abortion has been illegally induced, and many of the clinical symptoms are the same).

Depending on the proportion of all induced abortions that were thought to result in complications serious enough to warrant hospitalization,⁴ the data were then multiplied by the appropriate factor to get the total number of induced abortions. These multiplication factors reflect the degree to which safe abortions are available in individual countries and may range from three, in countries where the majority of procedures are performed in unhygienic conditions by nonprofessionals to seven, in countries where relatively safe, although clandestine, abortion services are available. Table 1 presents the estimated annual abortion rates from this indirect technique in six countries using a uniform multiplier of five, on the assumption that about one in five women who obtain clandestine abortions are hospitalized.

A second methodology, a direct household survey of 22 major cities in Colombia conducted by the Center of Social Dynamics Research at the Universidad Externado in Bogotá, solicited abortion history

*Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, the United States (and Puerto Rico), Switzerland, Uruguay and Venezuela.

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data from 33,275 women aged 15–55 through a short, confidential self-administered questionnaire.⁵ (While only women who could read and write were included in the survey, the vast majority of urban women in Colombia are literate.) Almost one-quarter of these women (23%) admitted to having had at least one induced abortion; among women who had ever been pregnant, the proportion was 30%. The study produced an annual abortion rate among urban 15–55-year-old women of 25 per 1,000 for the period 1988–1991 (which is somewhat lower than the national rate of 34 per 1,000 15–49-year-olds estimated by the AGI study⁶). Furthermore, the results indicated that adolescent women were most likely to have reported an abortion—nearly 45% of 15–19-year-old respondents who had ever been pregnant had had an induced abortion.

There are drawbacks to both broad types of approaches. With the indirect method of studying hospital discharge data, researchers not only have to develop a wide array of multipliers, assumptions and adjustment factors, but they also have to continually revise them as conditions affecting hospitalization rates evolve (i.e., as safe abortions become increasingly available in urban areas, or as use of certain abortifacient agents or techniques surges, as was the case of misoprostol in Brazil⁷). Similarly, with direct population-based studies of abortion, the problem of underreporting an illegal and censured activity (which varies among subgroups) is ever-present, even when women fill out forms in private or are willing to be interviewed.

Most of the other conference presentations were based on small-scale surveys from particular countries or parts of countries, or analyses of hospital-based data from a single facility. José Barzelatto, director of the Ford Foundation's Reproductive Health and Population Program, called for more research efforts that would use the direct survey approach to measuring abortion levels, saying that indirect hospitalization data are inherently weaker. Barzelatto appealed to researchers for their data collection methods to be so solid and irreproachable that the findings can withstand any challenges made in the highly charged abortion debate.

The Cuban Exception

Cuba, the one country without any of these data collection problems, was an anomaly among the countries represented, and the conference participants debated about how much of Cuba's example to follow. The island shares none of the legal, political,

health infrastructure and religious constraints that define the reality of abortion elsewhere in the region. According to Oscar Mateo de Acosta of the country's Instituto Nacional de Endocrinología, Cuban law stipulates four circumstances under which first trimester abortion is illegal—when it is performed without the woman's consent; when it is performed by untrained personnel who cannot assure the safety of the procedure; when it is done for profit; and when the procedure is not performed in an official health institution.⁸ Cuban researchers reminded conference participants that one result of their country's unusual legal recognition of abortion is a corresponding anomaly in maternal mortality ratios: In 1988, Cuba's ratio was 39 maternal deaths per 100,000 live births, compared with averages of 160 per 100,000 for Central America and 220 per 100,000 for South America.⁹

Although Cuba's system, in which all hospital gynecologic departments offer the procedure, stood out in stark contrast to the clandestine circumstances surrounding abortion in the rest of region, the Cuban researchers acknowledged that annual abortion rates are unacceptably high, at 50–60 abortions per 1,000 women. Moreover, they revealed serious shortcomings in the contraceptive delivery system, which contribute to the high abortion rates, and called for needed improvements in contraceptive promotion and education. According to a Chilean physician who has worked in Cuba on HRP projects, the problem is compounded by a shortage of contraceptive supplies attributed to the U.S. economic blockade of Cuba. As a result, women are using outdated or inappropriate methods and condoms are scarce. The availability and frequent use of "menstrual regulation" in Cuba, which costs about one-fourth as much as a standard induced abortion¹⁰ and is performed without a pregnancy test, add another dimension to the Cuban example.

The Cuban situation is so different that many of the standard determinants of induced abortion—such as age, social status and education—do not apply in Cuba to the same degree they do elsewhere. According to one Cuban study funded by HRP and presented at the conference, results of a multivariate logistic regression analysis indicate that the single most important deter-

Table 1. Estimated numbers, ratios and rates of abortion in six Latin American countries

Country and year	Estimated total no. of induced abortions	Ratio per 100 live births	Annual rate per 100 women aged 15–49
Brazil, 1991	1,443,350	44	3.65
Chile, 1990	159,650	55	4.54
Colombia, 1989	288,400	35	3.37
Dom. Rep., 1992	82,500	39	4.37
Mexico, 1990	533,100	21	2.33
Peru, 1989	271,150	43	5.19

Note: Estimates are based on hospital data adjusted for misreporting, underreporting and misclassification of spontaneous abortion, using a multiplier of five (i.e., one in five induced abortions results in hospitalization) *Source:* *Clandestine Abortion: A Latin American Reality*, AGI, New York, 1994, p. 21.

minant of abortion among Cuban women is not being in a stable union.¹¹

The peculiarity of the Cuban situation also provides the opportunity to test new medical methods in a developing country in Latin America. Evelio Cabezas, chief physician of Obstetrics and Gynecology of the Cuban Ministry of Public Health presented data from an acceptability study that examined adolescents' experience with RU 486, administered with misoprostol.¹² Results of the study—in which 15–19-year-olds had the highest proportion of successful induced abortion (98% vs. 90–93% among older women) and tolerated the drug well—led Cabezas to conclude that RU 486 might be suitable for adolescents. His presentation, however, raised questions from participants on the increased bleeding the drug causes and potential risks if women are not under appropriate medical surveillance.

Religious Attitudes

Cuba is also an anomaly in that it does not feel the full force of the Catholic Church. For the rest of Latin America, however, the Church's antiabortion position permeates the cultural context in which women consider abortion and are treated (or are sometimes even denied treatment) for its complications. When results were presented of a Colombian study on religious attitudes toward abortion, including a small-scale survey of clergy members,¹³ the conference participants reacted with keen interest, and even mild shock. In the first part of a three-part survey funded by the Ford Foundation, 151 priests in 13 of Colombia's largest cities filled out questionnaires (with a notable response rate of 76%, given the difficult subject matter for a priest). Psychologists also administered questionnaires to 1,239 patients aged 13–47 at clandestine clinics; a third survey was

*These circumstances also apply to later abortions which have more stringent authorization requirements.

conducted among 56 health professionals who provided services in the two clandestine clinics where the women were surveyed. The questionnaires contained items on abortion and the confession of sins, the Church's teachings on abortion, and private perceptions of abortion as sin.

More than two-fifths (43%) of the priests said that they thought women who confessed having had an abortion had not committed a grave mortal sin; curiously, a smaller proportion of abortion patients—36%—said they had not committed a mortal sin. Almost all the women (91%) designated their abortion as the lesser wrong compared with not having the abortion. Further, 84% of priests affirmed they would grant absolution in such cases. The responses of the clinic personnel were quite uniform. The vast majority (96%) believed that providing abortion was not a mortal

general consensus of the need for an alternative terminology, because "family planning" is a vague, ambiguous term. Many participants emphasized that an abortion is never planned, but is something that women resort to only when they have no other choice; in this sense abortion is certainly a method of fertility regulation, but not one of family planning.

Even though some argued that this prickly issue is only one of semantics, how abortion is classified has definite political ramifications. As one Guatemalan participant pointed out, equating abortion with family planning would be disastrous in a country like Guatemala, where family planning is not totally accepted by the government or by the population as it is. She mentioned that her country, like the Vatican, had expressed reservations about specific items in the approved Programme of Action that grew out of the 1994 International Conference on Population and Development in Cairo.

The controversy surrounding abortion at the Cairo conference surfaced again and again—with the Cairo document being cited, among other instances, as the impetus for opening the

debate about abortion's legal status in individual countries, as evidence of the enormity of the problem in an official document prepared by elected officials, and as a reference for the definition of unsafe abortion. In his presentation on the Cairo conference, Barzelatto related personal impressions of the conference and asserted that its landmark achievements were the conceptual change from concern about population size to recognition of reproductive and sexual rights and health, and to making governments accountable for guaranteeing those rights.¹⁴

Crime and Punishment

The common thread throughout the duration of the conference that touched on every aspect—from the difficulty of eliciting true responses on abortion to calculating hospital costs and designing new research methodologies to uncover unreported abortion deaths—was the procedure's illegality in the region. The even more substantive effect of this penalization is the added emotional weight it brings to an already difficult event and the increased morbidity and mortality that can result when abortions are performed in clandestine and often unsafe conditions. As Mundigo

stressed in the opening session of the conference, "the objective of depenalization is to reduce the danger to women and the needless human suffering" associated with clandestine abortion.¹⁵

Participants were repeatedly reminded through presentations and comments that women are punished not just by the law, but often by health personnel and authorities. One Nicaraguan physician related an anecdote of how a hospitalized abortion patient was denigrated and ignored while the patient in the next room, a wounded man who had committed murder, was constantly attended by awed medical personnel. On several occasions, physicians faulted fellow medical professionals for refusing to perform even those abortions that are legal. One medical doctor, for example, cited an incident in Bolivia where even though a judge had ruled that an abortion was legally indicated, no physician would agree to perform it; another mentioned that an abortion performed for the requisite legal circumstances in Brazil had elicited a huge public protest.*

Women's reluctance to seek treatment for abortion complications out of fear of reprisals—which contributes to morbidity and mortality by delaying or effectively preventing treatment—was also repeatedly mentioned. Mirta Kennedy, a Honduran researcher with Centro de Estudios de la Mujer, presented evidence that these fears are well grounded, at least in Honduras.¹⁶ According to her presentation of results of a small study of health providers, 26% of the sample said they would collaborate with authorities in turning over a woman who had had an abortion, and a further 31% said they were undecided about whether they would do so. Another researcher, Elena Prada, however, in her presentation on hospital data in Colombia, attributed at least part of the vast misclassification and underreporting of induced abortion complications in hospital records to physicians' reluctance to report women who had come to them for help.¹⁷

While concrete legal reform has yet to occur, there have nonetheless been signs that the slow and arduous process has begun in pockets of the region. María Isabel Plata, director of Profamilia, mentioned the recent minority opinion in Colombia's constitutional court which, for the first time, used language referring to women's reproductive rights and to their right to dignity.¹⁸ She warned against partial liberalizations of the law that do not acknowledge women's procreative autonomy and reiterated that society cannot keep asking

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sin; the identical high proportion said they did not feel rejected by God (96%), and had not considered leaving their work because of religious conflicts (96%).

These data were followed with a sampling of theological arguments for a relativist, progressive interpretation of the Church's position on abortion. As the presentation was clearly out of the norm for many of the participants, several jumped at the chance to ask questions; in the ensuing discussion, the political necessity of bringing forward the range of positions held by Catholic laypersons and clergy was a constant theme.

Contraception and Abortion

In their discussions of the link between contraception and abortion, and indeed throughout the conference, participants could not avoid arguing about how abortion should be classified in the context of family planning methods. There was a

*In Bolivia (as well as Argentina, Costa Rica, Ecuador, El Salvador and Peru) the law permits induced abortion in the following circumstances—to save the life or health of the mother, when the pregnancy results from rape or incest, or when there is a fetal malformation; in Brazil (and Mexico) abortion is permitted for the first two reasons but not for the third (see reference 18).

women to break the law; if abortion is going to be safe, it has to be legal.

Many of the legislators in attendance acknowledged the difficulties ahead; a Chilean senator, for example, mentioned how a reform-minded candidate had not been reelected and said that liberalization loses votes. The fact that some speakers lamented a reactionary climate in their countries while others spoke of seizing an opening in the debate attests to the diversity in the current political reality across the region. The brief presentation by the president of the Colombian senate, Juan Guillermo Angel, who spoke of acknowledging the common reality of abortion, and the ample coverage of the conference by the Colombian press provide evidence of a willingness to debate the issue publicly, at least in Colombia. But no matter where their very different countries are in the process toward reform, the legislators concurred that collaboration with researchers was essential; the assertion of one legislator—that “facts are what validate our proposals”—was widely affirmed.

Recommendations

In the final day of the conference, participants broke into working groups to develop recommendations in predetermined aspects relating to induced abortion—incidence, legislation, adolescents, hospitalization and costs for treatment of complications, contraception and maternal mortality. There was considerable overlap in the groups’ subsequent presentations to the entire reassembled conference, because, clearly, many of the problems associated with induced abortion are interrelated. The recurrent complaint that women who seek treatment for abortion complications are humiliated and mistreated led several groups to recommend that medical personnel—and the public in general—be educated and sensitized about this issue. In fact, the unifying theme in the six sets of recommendations was a request for knowledge—for improved contraceptive knowledge among women, especially adolescents, and for education and training of providers in abortion techniques, reporting procedures and nonjudgmental care by medical personnel and administrators.

More specifically, the researchers in the incidence group insisted that the com-

plexity of the problem warranted more sophisticated methodologies; that the methodologies currently used needed to be compared and shared through a Spanish information network that could ease the Latin researchers’ sense of isolation; that results needed to be simplified for the media and policymakers to have maximum utility; and that the time had come for researchers to meet with religious groups and other groups opposed to abortion to open a more meaningful debate.

Both the hospitalization and mortality groups recommended that hospital maternal mortality committees be strengthened to monitor mortality and sensitize personnel to its occurrence. (Both groups, however, were reminded in the subsequent plenary discussions that such committees have had a patchy record and that their effectiveness depends entirely on the individuals who run them.) Both groups also cited the inexcusable use of outdated, less safe techniques, and thus recommended that abortion treatment techniques be simplified and standardized and that the procedure be taught in medical school.

The working group on mortality called for improving use of the diagnostic codes of the International Classification of Diseases (ICD); although there is a separate category for complications of induced abortion, deaths from ectopic and molar pregnancy are nonetheless lumped together with deaths caused by induced abortion. (In the working group session, Cabezas used a chart to demonstrate that as much as 50% of the annual mortality in Cuba grouped under the same ICD code resulted from deaths following ectopic pregnancy.) The group also recommended that physicians be reminded that they are obligated to treat women for abortion complications by the medical code of ethics. (However, a Bolivian participant disagreed, saying the medical ethics code in her country strictly forbids providing any abortion-related care.)

The working group on legislation insisted that the authorities allow those abortions currently permitted by law to be carried out without delay. A topic of much discussion and suspense throughout the conference was whether the working group on legislation would recommend depenalization of abortion. It did, calling for removal of induced abortion from the penal code and its placement in the health code. Only unsafe abortion—as defined by the Cairo document*—and abortion without a woman’s consent would remain a crime. This was undoubtedly one of the

most significant recommendations that emerged from the conference.

The group also recommended that family planning and family planning education be stressed to reduce the need for abortion, that discrimination preventing women from freely choosing motherhood be eliminated, and that the documents produced by the conference be widely distributed throughout the region. They reiterated that the problem needed to be addressed on two fronts—through depenalization on the one hand, to lessen the discriminatory effects of illegal abortion on mostly the poor and young women, and through prevention on the other hand, to limit its occurrence as much as possible.

The legislators issued a separate document directed to the Health Commission of the Latin American parliament, which was meeting the following week in Havana, Cuba, urging it to take up the issue of induced abortion and its consequences on women’s health. This document, signed by the seven legislators who attended the conference (from Argentina, Brazil, Chile, Colombia, El Salvador and Panama), called for reducing the demand for abortion, improving and expanding family planning services, and giving the highest priority to the elimination of high-risk, unsafe abortion.

As the conference was closing, there was a spontaneous movement to continue its work through technical coordination teams from each country that would conserve resources by meeting regularly to exchange data and experiences. The need to end the isolation researchers in the area felt came up again and again, with more than one individual claiming they would never have known others were using the same methodology if it weren’t for the conference that had brought them together.

Thus, the conference clearly achieved its first objective—exchanging knowledge on induced abortion and research techniques among the various countries that make up the region; as many participants acknowledged, this was the first opportunity they had had to do so. It was also the first time that researchers as a group had sat down with politicians to deal with the issue of abortion. The conference gave substance to what was always apparent—how much both groups needed each other; as the conference organizers had stressed, research fuels the political debate.

But how likely is it that the conference recommendations, especially the ones requesting depenalization, will be fulfilled? As Barzelatto confided at the end of the conference, “If there is one thing I have

*A footnote to the Cairo Programme of Action defines unsafe abortions as either those performed by untrained personnel or those done in a substandard medical environment, or both. (See: United Nations International Conference on Population and Development, “Programme of Action of the Conference,” Cairo, Sept. 12, 1994.)

learned, it is that you cannot predict history; the fact that any one group recommends something does not mean it will happen. Some countries are further along in the process, and each will have to proceed at its own pace. But I'm optimistic; one can sense these things, and my sense is that change is not far away."¹⁹

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