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Unsafe Abortions in a Developing Country: Has Liberalisation of Laws on Abortions made a Difference?

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ABSTRACT

Unsafe abortion is still a major cause of maternal morbidity and mortality in Africa. To assess whether the introduction of legal abortions in South Africa has decreased admissions resulting from mid-trimester abortions, a prospective study of abortion cases admitted to the King Edward VIII Hospital, Durban, South Africa, over a four-month period was carried out. Two hundred and four women were admitted with incomplete abortion; 49% of which were spontaneous, 17% certainly induced, 10% probably induced, 18% possibly induced and 4.3% legally induced. A change in the laws on termination of pregnancy (TOP) has resulted in a decrease in cases of incomplete abortion being admitted to the gynaecological wards. However, illegal TOPs are still prevalent for a variety of reasons. There is need to place more emphasis on the delivery of efficient contraceptive services and reproductive health education for women. (*Afr J Reprod Health* 2003; 7[2]: 34-38)

RÉSUMÉ

Avortement dangereux dans un pays en développement: la libéralisation des lois sur l'avortement légal a-t-elle fait une différence? L'avortement dangereux demeure encore une cause principale de la morbidité et mortalité maternelle en Afrique. Pour vérifier si l'introduction de l'avortement légal en Afrique du Sud a diminué les admissions occasionnées par les avortements qui se produisent dans le deuxième trimestre, nous avons mené une étude prospective sur les cas d'avortement qui ont été admis dans le King Edward VIII Hospital à Durban en Afrique du Sud, pendant quatre mois. Deux cent quatre femmes ont été admises pour l'avortement inachevé; 49% étaient spontanées, 17% étaient sûrement déclenchés, 10% étaient probablement déclenchés, 18% étaient peut-être déclenchés alors que 4,3% étaient légalement déclenchés. Une modification sur les lois de l'interruption de grossesse (IDG) a abouti à la réduction de cas d'interruption de grossesse qu'on admet dans les salles de gynécologie à l'hôpital; néanmoins, les IDG illégales sont encore prévalentes pour diverses raisons. Il faut mettre davantage l'accent sur la prestation efficace des services de contraceptifs et l'éducation de la santé reproductive au profit de la femme. (*Rev Afr Santé Reprod* 2003; 7[2]: 34-38)

KEY WORDS: *Legal termination, pregnancy, incomplete abortion*

INTRODUCTION

In Africa, an estimated three million unsafe abortions are performed every year and studies estimate that 20-35% of maternal deaths are attributable to induced abortion.^{1,2} Other studies have shown that 40-60% of all gynaecological admissions in South Africa are due to abortions.^{3,4} This enormous burden also carries with it significant financial costs on restricted health budgets.

Although the issue of legal termination of pregnancy is fraught with religious, moral, legal and ethical debates, there is no doubt that liberalisation of the laws on legal abortion have been shown to decrease the mortality and morbidity associated with illegal abortions. In England and Wales, abortion-related mortality was reduced by 90% with the legalisation of induced abortion.⁵ Further, the laws on illegal abortion in Romania are a classic example illustrating that liberalisation of a restrictive legal process in 1990 led to a decrease in abortion-related mortality by 55% from 1986 to 1990.⁶

Liberalisation of the law on abortion on its own, however, may not lead to a decrease in the number of illegal abortions or an increase in requests for legal termination of pregnancy. Factors such as education, dissemination of information, empowerment of women, and the provision and access to facilities for TOP may all play a role. Prior to the change to the 1975 abortion and sterilisation act, TOP on legal grounds was allowed in cases that childbirth presented a serious threat to the woman's physical health, or danger of permanent damage to her mental health. It also allowed it in cases that the woman was mentally handicapped, in cases of rape or incest, or in cases that the child would be born

with a mental or physical defect. In practice, very few had access to the provisions of the law.

Matchaba et al found that only 62 legal abortions were done from 1989 to 1994 at King Edward VIII Hospital, Durban.⁷ The low prevalence was attributed to the social class and lack of awareness of the indigent population served by the hospital. The legislative changes to the South African abortion and sterilisation act occurred in 1996 and most importantly includes the fact that termination of pregnancies can be performed by midwives as well as physicians. The aim of this study was to assess whether the TOP act of 1996 in South Africa had any effect on the number of abortions admitted to the gynaecological wards of King Edward VIII Hospital, Durban.

METHODOLOGY

This was a prospective descriptive study performed over a period of four months following institutional ethical approval. All women admitted into the gynaecological wards of King Edward VIII Hospital (KEH) with a diagnosis of abortion were counselled and appropriate informed consent obtained for inclusion in the study. The interviews were discretely performed while maintaining confidentiality.

Information was elicited using a structured questionnaire that addressed the socio-demographic, clinical and other parameters of the subjects. Data obtained were entered into a computerised data sheet enabling a rapid and accurate comparison with those of Karimi 1997.⁸ Abortions were subsequently classified according to the FIGA-TALAMANCA categories.⁹ Simple statistics were utilised and all results are presented as frequencies and percentages.

RESULTS

Socio-Demographic Profile

A total of 204 patients were admitted for incomplete abortion from August to November 1999. The mean age was 26.4 years (range 13-45 years), and teenagers comprised 14.7% of cases. Ten per cent of cases were however above 35 years old. The vast majority of subjects were unmarried (88.5%) and unemployed (71.5%). Thirty four per cent had no formal education, while 54% and 12% had primary and college education respectively.

Pre-Conceptual Contraceptive Use

Fourteen per cent of the patients interviewed were on a contraceptive method three months before conception. They discontinued contraception for various reasons including abnormal vaginal bleeding, nausea, vomiting and weight gain. The remainder were not on

any contraceptive because of lack of information and motivation.

Classification of Abortion (FIGA-TALAMANCA)⁹

Spontaneous abortion accounted for 49.5%, certainly induced abortion for 17.8% (37 patients), probably induced abortion 10.1% (21 patients), possibly induced abortion 18.3% (38 patients), and legally induced abortion 4.3% (9 patients).

Persons and Materials Involved in Illegal Abortions

Health professionals were involved in the induction of abortion in 68.2% of cases. They initiated the induction in their consulting rooms, or in facilities not licensed for TOP. The non-professional persons involved included friends, relatives and consorts. The abortion process was initiated in health facilities in 39.6% of cases (hospitals and clinics), whereas in 60.5% of the cases it occurred in the patient's home or a boyfriend's house. Various methods of induction were utilised; the most common of which was the use of tablets, which by description suggests misoprostol. Others included anti-malarials, tetracycline, soap, traditional medicines and the use of metallic objects to rupture the fetal membranes.

Reasons for Termination of Pregnancy

Amongst the patients with certainly induced abortions, several reasons were given for the termination. They include young age, academic pursuits, poverty and relationship problems, unpreparedness for childbearing, etc. The reasons were often multiple.

Awareness of the TOP Act of 1996

Of the 206 responses to the awareness of the existence and implication of the new law, 135 patients (65%) claimed that they were aware of the intense debate before the bill was passed; however, very few understood the practical implications. Also, 68% were not aware of any existing facility for TOP. Among the subjects who had induced abortion, 67.6% were aware of the new act but only 24.6% were aware of a TOP facility. Fifty per cent of all subjects interviewed were aware of the possibility of offering the baby for adoption, but very few would actually do it.

DISCUSSION

It is interesting to note that the incidence of incomplete abortion has dropped from an average of 110 cases a month, representing 24.5% of all gynaecological admissions, to an average of 50 cases per month, representing 4.5% of all gynaecological admissions. This is in sharp contrast to the situation in most hospitals in the sub-Saharan Africa where abortion still represents 40-60% of all gynaecologic admissions.⁴ In previous studies

conducted at our institution, abortions formed the bulk of the gynaecologic "load", representing 46% of all admissions.¹⁰ The present findings are probably due to the fact that a greater proportion of the population has access to safe and legal abortion. It is also possible that illegal abortions are being performed safely and effectively. Our results contrast with those of Shweni et al, which reports that 27% of patients who had septic abortion required ICU admission in the same institution. We found that only 1.9% required ICU admission.¹⁰

The circumstances surrounding the termination of unwanted pregnancy are complex. The women are mostly single as shown by our study (83.5%), unemployed (71.5%) and not in any stable relationship. The prospects of a young woman going through pregnancy alone and delivering an unwanted child looks gloomy. The financial and psychological burden of raising the child is of monumental proportions, the order of which a young woman is not geared to sustain. Furthermore, an unmarried status is usually associated with unwanted pregnancy. Studies in Kenya¹¹ and Zimbabwe¹² indicate that being single increases the risk of maternal morbidity and mortality from abortions. The level of education also affects the accessibility of women to contraception and facilities for legal abortion. Thirty three per cent of subjects interviewed in our study had no formal education. This is in sharp contrast to the situation in affluent societies. Education certainly affects access to quality information and appropriate facilities for termination of pregnancy.

The outcome of abortion, once embarked upon, depends on the circumstances surrounding the TOP and materials involved. While abortions carried out in any place by any person other than a designated facility and in accordance with established protocols have a potential for disaster. It is possible that TOP initiated by health workers may be relatively safe. From an unpublished study done by Karimi⁸, complications from induced abortion were far less than that found by Shweni et al¹⁰ in the same institution. This is possibly because illegal abortions are probably being performed more safely, there is an increase in awareness of aseptic techniques and early recourse to hospital when symptoms arise.

From our study, 59.1% of induced abortions were initiated by doctors, mostly general practitioners, 31.8% by nurses, and others by lay consultants. While abortions initiated by doctors and nurses may be safer than those by lay persons, it is important to note that in order to achieve the aims and objectives of the South African termination of pregnancy act of 1996, the procedures should be initiated and completed by appropriately trained personnel in designated facilities.

Efforts at promoting responsible and healthy reproductive and sexual behaviour among adolescents and youths through the provision of life skills, sexuality and gender sensitive education, user friendly health services should be renewed. The role of health workers is critical to the success of any governmental policy to reduce unwanted pregnancy, dealing

with problems associated with them and ensuring post-abortion contraception. Results from our study show that 61.1% of women who had evacuation accepted to use a method of contraception, while 24.1% would not use contraception. The reasons given include non-tolerable side effects and spouse related problems. However, 5.4% were not counselled about post-abortion contraception before enrolment into this study.

Empowerment of women by uplifting their socio-economic status, exercising their right to education, information, and gender equality is very crucial to the enhancement of their reproductive health. This will ultimately affect their uptake of contraceptive methods and the use of TOP services if necessary. A review of contraceptive use in Bangladesh revealed that a rural uneducated and ill-informed woman could be expected to have 3.4 births. A relatively educated and informed urban woman can be expected to have 2.1 births. The total fertility rate rose from 2.1 in women with secondary education to 3.9 in women without formal education.¹³

In Africa, studies have shown that a large proportion of adolescents in Nigeria are exposed to the risk of unwanted pregnancies, receive poor sexuality and contraceptive education and, therefore, have a high incidence of adolescent childbirth.¹⁴ Research conducted in South Africa indicates that the situation resembles that found in most African societies.¹⁵

In conclusion, our study has shown that the change in termination of pregnancy laws has resulted in a decrease in the number of incomplete abortions being admitted to the gynaecological wards. Furthermore, the number of women with abortions being admitted to intensive care has declined. Our findings, however, strongly suggest that more emphasis needs to be placed on the delivery of efficient contraceptive services and the education of women.

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REFERENCES

1. World Health Organisation/UNICEF. Revised 1990 estimates of maternal mortality. April 1996.
2. Ladipo OA. Preventing and managing complications of induced abortions in Third World countries. *Int J Gynecol Obstet* 1989; 3(s): 21-28.
3. Rees H, Katzenellobogen J, Shabodien R, Jewkes R, Fawcus S, McIntyre J, Lombard C and Truter H. The epidemiology of incomplete abortions in South Africa. *S Afr Med J* 1994; 87(4): 432-437.
4. Mati JKG. A strategy for Reduction of the impact of Unsafe Abortion. Keynote

- address given at the 1st Conference on reproductive health priorities for the New South Africa. *Obstet Gynaecol Forum* 1995; 1: 17-21.
5. World Health Organisation. Complications of abortions. Technical and managerial guidelines for prevention and treatment. Geneva, WHO, 1995.
 6. International Planned Parenthood Federation. *Unsafe Abortion. Clarifying the Issue*. London: IPPF, 1991.
 7. Matchaba P and Moodley J. Legal abortion: a five-year retrospective analysis at King Edward VIII Hospital, Durban, KwaZulu/Natal. *Obstet Gynaecol Forum* 1995; 2: 29B33.
 8. Karimi PO. Epidemiology and management of abortions at King Edward VIII Hospital, Durban South Africa. Unpublished data, 1997.
 9. Figa-Talamanca I, Sinnathuray TA, Yusof K, Fong CK, Palan VT, et al. Illegal abortion: an attempt to assess its cost to the health services and its incidence in the community. *Int J Health Services* 1986; 16: 375-389.
 10. Shweni P, Margolis J and Monokwane T. Abortions, the King Edward VIII Hospital experience. *Obstet Gynaecol Forum* 1992; 2: 22-26.
 11. Aggarwal V and Mati JK. Review of abortions at Kenya National Hospital, Nairobi. *E Afr Med J* 1980; 57(2): 138-143.
 12. Mbizvo M, Fawcus S, Lindmark G and Nystrom L. Maternal morality in rural and urban Zimbabwe: social and reproductive factors in an incident case-reference study. *Soc Sci Med* 1993; 36(9): 1197-205.
 13. Mitra SN, et al. Bangladesh Demographic and Health Survey 1996-1997, Dhaka, Bangladesh.
 14. Makinwa-Adebusoye P. Sexual behaviours, reproductive knowledge and contraceptive use among urban Nigerians. *Int Fam Plan Persp* 1992; 18(2): 66-70.
 15. Rees H. An overview of abortion practice in sub-Saharan Africa. *Obstet Gynaecol Forum* 1994; 3: 17-22.

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