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SAFE ABORTION: THE PUBLIC HEALTH RATIONALE

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ABSTRACT It is now more than 50 years since the World Health Assembly recognized abortion as a serious public health problem. The challenge still stands. Addressing the problem of unsafe abortion is a national and global public health imperative, dictated by the magnitude of the problem and its impact on individuals and society, inequity of the burden of disease, and an international consensus of the global health community. Almost every abortion death and disability could be prevented through cost-effective public health interventions including sexuality education, use of effective contraception, provision of safe, legal induced abortion, and quality humane postabortion care.

Safe abortion continues to be a challenge to public health because of diverse national restrictive legal regulations, prevailing stigma, and lack of political commitment. Health professionals have a social responsibility to educate policymakers, legislators, and the public at large about adverse impacts of restrictive abortion regulations, laws, and policies on women's health.

KEYWORDS :

INTRODUCTION:

The abortion issue is debated by proponents and opponents in divisive abstract terms of fetal rights, women's rights, religious beliefs, legal principles, and political positions. The intense debate overwhelms rationality and often generates heat not light. Public health, on the other hand, being founded on scientific evidence and guided by health values, can objectively enlighten the debate and highlight the reality of what ultimately happens to women.

Back in 1967, the World Health Organization (WHO) recognized abortion as a serious public health problem, in an Assembly resolution [1]. More than 50 years later, although progress has been made, the abortion public health challenge still stands. Public health is concerned with promoting health, preventing disease, and prolonging life through the organized efforts of society [2]. The rationale for the need of public health action to address a health problem is based on the magnitude of the problem, its impact on individuals and on the society at large, and whether the problem is preventable, and costeffective public health interventions are available. Safe abortion: a definition In terms of safety, abortions are defined by the WHO as safe, less safe, and least safe or dangerous [3,4].

Abortions are defined as safe when "done with a method recommended by the WHO that is appropriate to the pregnancy duration and if the person providing or supporting the abortion is trained," The WHO definition recognizes that "the people, skills, and medical standards considered safe in the provision of induced abortions are different for medical abortion (which is performed with drugs alone) and surgical abortion (which is performed with a manual or electric aspirator)" and that "skills and medical standards required for safe abortion also vary depending upon the duration of the pregnancy and evolving scientific advances." Abortions are defined as less safe when they meet either method or provider criterion but not both. Thus, abortion is considered less safe when performed using outdated methods such as sharp curettage even if the provider is trained, or if women using tablets do not have access to proper information or to a trained person if they need help.

Abortions are least safe when they meet neither method nor provider criterion, such as when they involve ingestion of caustic substances or when untrained persons use dangerous methods such as insertion of foreign bodies, or use of traditional concoctions. As of 2010e2014, an estimated 55% of abortions in the world are considered safe, 31% as less safe, and 14% as least safe [5]. The more restrictive the legal setting, the higher the proportion of abortions that are least safedranging from less than 1% in the least-restrictive countries to 31% in the mostrestrictive countries. In developing regions, 49% of abortions are unsafe (less and least safe) compared with 12% in the developed world (largely concentrated in Eastern Europe where dilation and curettage procedures, not recommended by the WHO, are still used) [5]. The magnitude of the problem of unsafe abortion provides an impelling rationale for the need for public health action.

Prevalence:

Regardless of whether abortion is required or not by the society, abortion has been needed by women throughout human history, and they have often risked their health or life in the process. Women are not passive reproducers. When they are faced with an unwanted pregnancy, they may resort to whatever means at hand to attempt to terminate it. Based on an exhaustive review of materials from 350 ancient and preindustrial societies, an anthropological study concluded that "(T)here is every indication that abortion is an absolutely universal phenomenon, and that it is impossible even to construct an imaginary social system in which no woman would ever feel at least compelled to abort." [6].

Hippocrates, writing in 400 BCE, could not ignore the reality that women resort to abortion, often with serious consequences to their health, noting that "when the woman is afflicted with a large wound as a consequence of abortion, or the womb is damaged by strong suppositories, as many women are always doing, doctoring themselves, or when the fetus is aborted and the woman is not purged of the afterbirth, and the wound inflames, closes and is not purged, if she is treated promptly she will be cured but will remain sterile" [7].

Before legalization in the USA, abortion was an open secret; widely practiced; and neither legal statutes nor the words of priests, ministers, or rabbis represented the views of citizenry or congregations [8]. The global abortion rate fell between 1990-1994 and 2010-2014, but the drop was relatively small in absolute terms (from 40 to 35 abortions per 1000 women) [5]. A large and statistically significant decline in the rate occurred in developed regions (from 46 to 27 per 1000 women), while the rate in developing regions remained unchanged (36e39 per 1000 women). It is estimated that between 2010 and 2014, approximately 56 million induced safe and unsafe abortions occurred worldwide each year [9]. Of these cases, approximately 25 million were estimated as unsafe, almost all in developing countries, and among these, 8 million were carried out under least safe or dangerous conditions [9].

MORTALITY AND MORBIDITY:

The toll of mortality and morbidity of unsafe abortion is imperative for public health action. At the global level, between 4.7% and 13.2% of all maternal deaths can be attributed to complications due to unsafe abortion [10]. In human terms, this translates to approximately 47,000 lives of young women in the prime of their lives unnecessarily lost each year. Yet, these numbers reflect sustained improvements in avoidable deaths. Globally, the estimated abortion-related case fatality rate (i.e., the number of deaths per 100,000 induced abortions) dropped by 42% between 1990e1994 and 2010e2014, from 108 to 63 [9]. In highly restrictive contexts, clandestine abortions are currently less dangerous because women increasingly use medication abortion methods primarily the more available drug misoprostol.

In developing countries, approximately 7 million women were estimated to be admitted every year to hospital as a result of complications resulting from unsafe pregnancy termination [11]. A systematic review of data on the type and severity of complications of abortions, based on 70 studies from 28 countries where access to abortion is limited, estimated that at least 9% of abortion-related

hospital admissions had near miss events (defined as "a woman who nearly died but survived a complication") and approximately 1.5% ended in a death [12]. Mortality and disability related to unsafe abortion are probably underestimated. Facility-based data on abortion, especially in legally restrictive settings, do not reflect the true toll of abortion-related morbidity and mortality in a population [13].

Stigma and fear of punishment following illegal procedures may deter reliable reporting. Many women may avoid seeking care for complication, impeding timely recognition and treatment and also hindering accurate data collection. Healthcare providers may also be reluctant to report abortion related morbidity and mortality because of fear of stigma and legal retaliation against their patients and themselves.

Economic Costs To Patients, Families, Health System, And Society At Large :

The economic cost of abortion-related maternal mortality and morbidity is enormous, burdening public health systems, the households in which these women live, and also the economies of the countries. The total cost to the developing world has been estimated to lie between $375 and $838 million, with a central estimate of approximately $500 million (US$2006) [14]. Considering purchasing power, abortion complications are considerably more expensive to treat in sub-Saharan Africa than in Latin America. Furthermore, if millions of other women with serious complications who receive no treatment from the health system were able to do so, an additional $375 million or so would probably be expended. The cost of long-term morbidities, mainly infertility and chronic reproductive tract infections, may cost many additional billions of dollars annually. The losses to the economies of developing countries from lower productivity caused by abortion-related maternal mortality and morbidity may be more than $400 million. Out-of-pocket expenses to the women and their families may amount to a further $600 million and can be catastrophic for poor individuals and families.

Inequity Of The Burden And Social Injustice:

Equity and social justice in population health are important concerns for public health. At the global level, unsafe abortion is a glaring case of inequity and social injustice. Unsafe abortions occur overwhelmingly in developing regions, where countries that highly restrict abortion are concentrated. Even where abortion is broadly legal, inadequate provision of affordable services can limit access to safe services. The proportion of least-safe abortions increases from 1% in high-income countries to 5% in upper-middle-income countries, 20% in lower-middle-income countries, and 54% in low-income countries [9].

In the United States, first-trimester abortions are safer than many other common healthcare procedures and carry an extremely low risk of death (0.3e0.5/100,000 abortions) [15]. In developed regions, because of availability of health services, it is estimated that only 30 women may die for every 100,000 unsafe abortions; this number increases to 220 in developing regions and 520 in sub-Saharan Africa [3]. Mortality from unsafe abortion disproportionately affects women in Africa. While the continent accounts for 29% of all unsafe abortions, it sees 62% of unsafe abortion-related deaths. In countries where abortion is legally highly restricted, poor women have little choice but to resort to unsafe abortions, while abortions that meet safety requirements can become the privilege of the rich who can afford the cost of private services.

International Calls For Public Health Action :

The public health rationale to address unsafe abortion as a serious public health problem is supported by several international calls. In 1994, the Programme of Action of the United Nations International Conference on Population and Development stated, "All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services" [16]. The Report of the Fourth World Conference on Women, held in Beijing in 1995, noted that "unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk" [17]. At a Special Session of the UN General Assembly in June 1999, governments agreed that "in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible" [18]. The WHO Global reproductive health strategy, adopted by the World Health Assembly in 2004 calls, in one of its key components, for programmatic, legal, and policy aspects of the provision of safe abortion to be adequately addressed [19].

Feasibility For Prevention Through Public Health Action:

Unsafe abortion is a global health challenge, but it is a challenge that can be met with current knowledge, available resources, and commitment [20]. Unsafe abortion has been described as a preventable pandemic [21]. Countries face competing demands for the limited resources their health systems can afford. The cost of providing safe abortion services has to take into consideration that treating complications of unsafe abortion is costly and can overwhelm health systems in low-income countries [14,22]. Healthcare system costs of unsafe abortion in Africa and Latin America divert scarce health resources, compared with the much less costly alternatives for preventing unintended pregnancy and unsafe abortion namely, the provision of contraceptive services and access to safe abortion where it is legal [23]. It was estimated that with access to safe legal abortion, the healthcare system in Mexico could potentially save $1.7 million annually, by shifting abortion management from emergency in-patient procedures to routine outpatient procedures, as well as use of medical abortion [24]. The WHO states that almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and timely care for complications [3].

Sexuality Education And Prevention Of Unsafe Abortion Among Adolescents:

Adolescent girls suffer a significant and disproportionate share of deaths and disability from unsafe abortion practices compared to women above 20 years of age [25]. Every year, an estimated 3.9 million girls aged 15e19 years undergo unsafe abortions [26]. Adolescent girls are more likely than older women to self-induce an abortion or seek abortion services from untrained providers and are generally less knowledgeable about their rights concerning abortion and postabortion care. They typically longer than adult women to realize they are pregnant and those who want to end their pregnancy consequently have abortions later in the gestational period, which carry more risk.

Evidence has been accumulating about the effectiveness of sexuality education,in or out of schools [27]. Programs that promote abstinence-only have been found to be ineffective in delaying sexual initiation, while programs that combine a focus on delaying sexual activity with content about condom or contraceptive use and which address both pregnancy prevention and STI/HIV prevention were more effective.

Reducing The Need For Abortion:

Public health experience has demonstrated that women's need for abortion can be reduced by making contraceptive information and services available, accessible, and affordable [28]. Introduction and use of modern contraceptive methods lowered the incidence of abortion in countries in Eastern Europe and Central Asia, where induced abortion used to be the main method for regulating fertility [29]. Rates of induced abortion are the lowest in Western Europe, where modern contraceptive use is high and abortion is generally legally available on request. Women will continue to face unintended pregnancies and resort to abortion for unwanted pregnancy as long as their family planning needs are not met. An unmet need for family planning continues to persist in spite of impressive gains in contraceptive use worldwide. As of 2017, it is estimated that approximately half of the 1.6 billion women of reproductive age (15e49 years old) living in developing regions want to avoid a pregnancy; of this subset of women, approximately 214 million women are not using a modern contraceptive method [30]. This includes 155 million who use no method of contraception and 59 million who rely on traditional methods. Women with an unmet need for modern contraception account for 84% of all unintended pregnancies in developing regions.

Women's diverse contraceptive needs are not adequately met by currently available methods, dictating the need for development of additional methods for which science is ripe [31]. Investing more resources in family planning programs to prevent unwanted and mistimed pregnancies would help reduce health systems costs, particularly in African countries where post-abortion care consumes a substantial portion of the total expenditure in reproductive health

[32,33]. Although contraceptive use reduces the number of unintended pregnancies, it will not eliminate the need for access to safe abortion. Unintended pregnancies are still a problem in Europe after 50 years of effective contraception [34]. Using 2007 data on contraceptive prevalence and the typical failure rates of contraceptive methods, it was estimated that approximately 33 million women worldwide annually may experience an accidental pregnancy while using a method of contraception [22]. Some of these accidental pregnancies are terminated by induced abortions, and some end up as unplanned births.

When women are exposed to unprotected sexual intercourse, back-up methods for emergency contraception will reduce the need for abortion. This "retroactive contraception" would be particularly needed by adolescents where the decision to contracept is often made post-coitally, in refugee situations and cases of sexual assault [35,36]. Methods of emergency contraception are not a substitute for regular contraception, but they should be accessible and information about them should be made known to those who may need them. Access should not be denied for misguided ideological reasons, ignoring the scientific evidence and the public health rationale [37].

Safe legal abortion services:

Making safe abortion accessible is a public health imperative [38]. The world government community at the Cairo United Nations International Conference on Population and Development agreed that "In circumstances where abortion is not against the law, such abortion should be safe" [16]. Country legal environments surrounding abortion provision are very diverse. With the exception of the Dominican Republic, El Salvador, the Holy See, Malta, and Nicaragua, which did not permit abortion under any circumstances, there are always circumstances where abortion is not against the law, ranging from very restrictive, to restrictive, to least restrictive [39].

In 2013, 97% of governments permitted abortion to save a woman's life. In approximately two-thirds of countries, abortion was permitted in addition when the physical or mental health of the mother was endangered and in half of the countries when the pregnancy resulted from rape or incest or in cases of fetal impairment. Approximately one-third of countries permitted abortion for economic or social reasons or on request. Patients and health care providers should be well informed about conditions where abortion is not against the law. A Joint WHO interactive online Global Abortion Policies Database containing comprehensive information on the abortion laws, policies, health standards, and guidelines for all countries is available [40]. Unsafe abortion and illegal abortion are not synonyms.

Although illegal abortion is commonly unsafe, this is not always the case. In many countries where abortion is illegal, abortion may be performed safely by private physicians for high medical fees for the wealthy who can afford it. Even when abortion is not against the law, women may still experience barriers to accessing safe abortion, including availability of services, high cost, conscientious objection of healthcare providers, and unnecessary requirements [41]. A country may have wonderful laws but may not have people to implement those laws [42]. Stigma is also still attached to abortion in high-income and low-income countries and in countries with liberal and restrictive abortion laws [43,44].

Because of prevailing stigma, women may prefer secrecy over safety and go to medically unqualified abortionists. In some settings, the number of providers willing to do the procedure is limited by the stigma associated with abortion, thereby obstructing women's access to a safe abortion [45]. The WHO provides and updates technical and policy guidance to help countries to provide safe abortion services [22,46]. A clinical practice handbook for safe abortion is also provided for use by a range of providers in different settings and varying legal and health service contexts [47]. A recent WHO international comparative study reviewed lessons learnt from geographically and developmentally diverse countries that have implemented new abortion laws, or changed interpretations of existing laws or policies, within the past 15 years (Colombia, Ethiopia, Ghana, Portugal, South Africa, and Uruguay) [48]. Countries about to undertake similar efforts can learn from these experiences.

Political commitment emerged as a key factor, common to all six countries, in establishing or expanding access to safe abortion services. Other components that proved useful included framing the need for safe services in public health terms, conceptualization of abortion as one component of a comprehensive reproductive health package, task sharing, and the use of low-technology techniques of abortion such as manual vacuum aspiration and medical abortion particularly in low-resource and rural settings, providing free or low-cost public sector services, informing women about the legal landscape and care options, implementing WHO guidelines for comprehensive monitoring and evaluation of safe abortion services, and drawing on the expertise of a broad range of stakeholders including country-based women's rights organizations, and the health profession.

Post Abortion Care:

As emphasized in the Programme of Action of the International Conference on Population and Development, "In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will help to avoid repeat abortions." [16]. There is strong evidence of the public health rationale of emergency treatment, family planning, and other programming components in postabortion care [49]. Healthcare providers have the obligation to provide life-saving medical care and medical treatment to any woman who suffers abortion-related complications, regardless of the legal grounds for abortion. A restrictive legal atmosphere is not an acceptable excuse for not providing postabortion care [50]. Women who request hospital care for abortion-related complications should not be mistreated [51]. They should not be discriminated against in the priority for timely treatment compared with other obstetric emergencies [52].

Reporting of patients who had unlawful abortions is unethical [53]. The WHO states that the practice of extracting confessions from women seeking emergency medical care as a result of illegal abortion, as well as any legal requirement for doctors and other healthcare personnel to report cases of women who have undergone abortion, delay care, put women's health and lives at risk, and violate UN human rights standards, which call on countries to provide immediate and unconditional treatment to anyone seeking emergency medical care [3]. Healthcare providers should not be conscribed as police informants. Confidentiality is a central principle of medical ethics and professionalism The WHO provides technical and policy guidance for postabortion care [54]. Postabortion care has, as a basic preventive component, the provision of contraceptive information, counseling, and services, including emergency contraception, before leaving the healthcare facility.

A review of 20 years of strong evidence concluded that postabortion family planning uptake generally increases rapidly and unintended pregnancies and repeat abortions can decline as a result [49]. Although postabortion care is an essential emergency service, the capacity of primary-level and referral-level health facilities to provide basic and comprehensive postabortion care, respectively, is low. Analysis of data from 10 developing countries with divergent abortion legal, morbidity, and mortality contexts showed that less than 10% of primary-level facilities in seven countries had the capability to provide basic postabortion care and less than 40% of referral-level facilities in eight countries could provide comprehensive postabortion care [55].

Impact Of Criminalization And Decriminalization Of Abortion On Public Health:

There is already an accumulated international experience about the impact of criminalization and decriminalization of abortion. The case of Romania was a hard lesson to learn. Few countries in history have made such dramatic shifts in abortion policy that would allow the study of causal links to public health outcomes [56]. In October 1966, one year after coming to power, Romania's communist leader Nicolae Ceausescu made abortion broadly illegal, permitting the procedure legally only under a narrow range of circumstances: for women with four or more children, those above the age of 45 years, in circumstances where the pregnancy was the result of rape or incest or threatened the life of the women, or in the case of fetal congenital defect. Just months after abortion was restricted, the number of safe, registered abortions had fallen by 20-fold.

At the same time, deaths from unsafe abortion increased rapidly. Between 1966 and 1989, although abortion was illegal in Romania, overall maternal mortality increased dramatically, from 85 per 100,000 live births in 1965 to a peak of 169 per 100,000 live births in 1989. During the same period, maternal mortality from unsafe abortion skyrocketed to an incredible 147 per 100,000 live births, while maternal deaths from other obstetric causes continued to decline. Within days of the fall of Ceausescu's regime in December 1989, the

anti-abortion law was abolished and abortion made available on request. Within the span of one year, the maternal mortality rate fell by half to 84 per 100,000 live births.

When modern contraceptive methods became available and widely used, abortion-related maternal mortality rate fell to 5.2 per 100,000 live births in 2010. In Ethiopia, abortion law was liberalized in 2005. It was estimated that in 2014 alone, 961 maternal deaths and nearly 180,000 unsafe abortions were averted as a result of services provided by public and private healthcare providers [57]. This translated into more than US$4 million in direct health costs saved by families and the healthcare system on pregnancy-related care. Abortion rates are reported to be similar in countries where abortion is highly restricted and where it is broadly legal (37 per 1000 women in countries where abortion is prohibited or permitted only to save the life of the pregnant woman, and 34 per 1000 women in countries where abortion is not restricted as to reason) [5]. Legal restrictions do not eliminate abortion. Rather, they increase the likelihood that abortions will be performed unsafely, as they compel women to seek clandestine procedures.

The lowest abortion rates are observed in countries where access to legal abortion is easy such as in western European countries. Decriminalization would facilitate the opportunities for prevention of abortion through postabortion counseling including provision of contraceptives. The sudden and dramatic reduction in abortion rates in Eastern Europe between 1995 and 2008, coinciding with improved access to safe and effective modern contraceptives, is a good demonstration that women prefer to prevent a pregnancy than to abort it, even if termination of pregnancy services are legal and accessible [58].

Expanding The Evidence Base:

There is a need to expand the evidence base for the public health rationale to address the abortion problem, both in countries with restrictive laws and high rates of unsafe abortion and in countries that have liberalized or are considering to liberalize their abortion laws [59]. National-level studies of incidence, morbidity, and health system costs of unsafe abortion, where such studies have not been conducted, are needed to inform policies and programs in countries with restrictive laws. In countries with liberalized abortion laws, there is a need to better understand the root causes of abortion stigma and the social and economic barriers women face in accessing safe abortion [41e45]. There is also the need to build the evidence for increasing the availability of safe abortion to all women who need it, particularly in low-resource and rural settings, through the use of low-technology techniques of abortion, such as manual vacuum aspiration and medical abortion. There is a need to assess the potential of task shifting and provision of abortion by diverse providers such as midwives and community health workers and, where appropriate, the potential of self-managed medication abortion [60e62].

Groups with special needs to be addressed include adolescents, refugees, and survivors of sexual violence. The voices of women should be incorporated in the design of the research and the results of the research should be properly communicated to policymakers, service providers, and other stakeholders. There is also the need to share and learn from other country experiences.

Call To Action:

It is now more than 50 years since the World Health Assembly recognized abortion as a serious public health problem. Progress has been made, but it has been uneven. The challenge to public health still stands and calls for action. The public health message, loud and clear, is that almost every abortion death and disability could be prevented through cost-effective public health interventions. Ideological views opposed to abortion are entitled to full respect but should not be imposed on those who do not share them, nor should they be enforced to adversely impact on women's health. Health professionals and their organizations have a social responsibility to educate policymakers, legislators, and the public at large about adverse impacts of abortion regulations, laws, and policies on women's health. When women put their trust in the health profession, they expect more than fixing diseased organs and delivering babies. They expect a profession that stands beside them and behind them, as they claim their human rights, including their right to health.

Summary:

Addressing the problem of unsafe abortion is a national and global public health imperative. Almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and postabortion care. Sexuality education programs that combine a focus on delaying sexual activity with content about contraceptive use and STI/HIV prevention are more effective. Contraceptive use reduces the number of unintended pregnancies, but it will not eliminate the need for access to safe abortion. Where abortion is not against the law, women may still experience barriers to accessing safe abortion, including availability of services, high cost, conscientious objection of healthcare providers, and unnecessary requirements. International experience demonstrates that legal restrictions do not eliminate abortion. Rather, they increase the likelihood that abortions will be done unsafely, as they compel women to seek clandestine procedures.

Postabortion counseling, education, and family planning services will help to avoid repeat abortions. There is a need to expand the evidence base for the public health rationale, both in countries with restrictive laws and high rates of unsafe abortion to inform policies and programs and in countries with liberal abortion laws to address barriers women face in accessing safe abortion, Public health has a social responsibility to educate policymakers, legislators, and the public at large about adverse impacts of abortion regulations, laws, and policies on women's health.

Practice points

- In almost all countries, there are circumstances where abortion is not against the law, and such abortion should be accessible and safe.
- Healthcare providers have the obligation to provide life-saving medical care and medical treatment to any woman who suffers abortion-related complications, regardless of the legal grounds for abortion.
- Postabortion care has, as a basic preventive component, the provision of contraceptive information, counseling, and services, including emergency contraception, before the patient leaves the healthcare facility.

Research agenda

- National-level studies of incidence, morbidity, and health system costs of unsafe abortion, where such studies have not been done, to inform policies and programs in countries with restrictive laws.
- Better understanding of the root causes of abortion stigma and the social and economic barriers women face in accessing safe abortion
- Building the evidence for increasing the availability of safe abortion to all women who need it through the use of low-technology techniques, task shifting, and provision of abortion by diverse providers such as midwives and community health workers and, where appropriate, to assess the potential of self-managed medication abortion

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