Induced Abortion in Latin America: Social, Cultural, and Technical Aspects

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Latin America encompasses both Central and South America. It is an area that has been marked by frequent social unrest and economic instability. Its population is predominantly Catholic and induced abortion is, for the most part, illegal in the region. Observers of the region have concluded that abortion laws are not likely to be liberalized soon, and that policy makers, social commentators, church officials, and many women oppose legal change. Despite the illegality of abortion, an unknown number of illegal abortions take place in the region. Because abortion is mostly illegal, there are few published studies available. Many of the few available studies are written by those in favor of legalizing abortion and/or reducing the population in the region.

Section I of this article briefly discusses certain cultural aspects of the region which would increase the likelihood of illegal abortion. Section II discusses induced abortion as a violation of beliefs, conscience, or religion of the women. Section III summarizes published studies which discuss characteristics of those who obtain induced abortions, and why women obtain them, as well as some of the abortion techniques used and resulting physical and psychological complications.

I. Related Cultural Aspects

Emphasis on Contraception

The region has been subjected to a vast array of contraceptive programs for purposes of population control. These birth control efforts have resulted in a considerable reduction in the number of children born per woman living in Latin America. For example, the number of births per woman in Brazil in 1980 was 4.5. By 1986 this figure had fallen to 3.8, and by 1991 had fallen to 3.0. In Colombia, the number of births per woman in 1976 was 4.9. By 1986 it had fallen to 3.9, and by 1990 was 3.4. In Mexico, the number of births per woman in 1977 was 6.7. By 1987 it had fallen to 4.6 and by 1992 was only 3.61. However, the development of a contraceptive mentality tends to separate sexual relations from a reasonable possibility of procreation. Thus, induced abortion is increasingly looked upon as a form of birth control providing a necessary secondary back-up for contraceptive failure, or as a primary form of birth control if contraceptives are not used.

Male Violence

Male violence is a social problem in certain Latin American countries. One such country is **Colombia** where it was reported that 36.8% of all male deaths were due to external causes in 1994 . Females, in contrast, were

much more likely to die of degenerative diseases. Nonfatal injuries in Colombia increased 15% between 1995 and 1995 and sexual offenses increased 7.6% during the same period. Men in **Peru** have been found to be much more likely to die from homicide and intentional injury, injuries due to legal interventions and operations of war, or motor vehicle accidents compared to women. In **Ecuador**, during 1995 the leading cause of death in men from 45-59 years of age was accidents and violence (23.2% of the total)2. Male violence or abusive behavior, particularly if directed against females, is a potential risk factor for induced abortion. A 1996 U.S. study of urban women who were undergoing abortions at a single facility found that approximately 40% reported prior abuse3.

Weakened Family Structures

The WHO has reported that in **Paraguay**, more than one-fifth of all households were headed by women in 1995. In Colombia, one-third of all households are headed by women. In Ecuador, the WHO reported that families have undergone a major transition in recent decades, characterized by shrinking size, less community participation, less bonding with the extended family, and rising rates of separation and divorce, which have created a high proportion of single parent families. Multiple marriages and tacit separations, even though no divorce is involved, result in many families living in inadequate economic and social conditions4. As the following studies will demonstrate, lack of financial and emotional support from fathers increases the likelihood of abortion if pregnancy occurs.

Male Promiscuity

Various researchers have found that males in Latin America are more likely to engage in premarital sex than females. One study found that 36% of the women living in Guatemala City, and 49% of the women in **Paraguay**, who were between the ages of 20-24 years, had premarital sexual intercourse. For men between the ages of 20-24, 86% of those living in Mexico City and 87% of those living in Guatemala City had premarital sexual intercourse5. Men also tend to initiate sexual activity at an earlier age than women. In one study among Mexican university students, the average age was 16 years for men and 19 years for women6.

A study was conducted in Lima, **Peru** between September 1991 and January 1992 of 300 men and 300 women obtaining preemployment or annual health screenings from municipal health centers situated in low income communities. It found that males were much more likely than females to be sexually promiscuous. The mean age of the sample was 25 for men and 26 for women. Overall, 75% of the sample was single and 83% were Catholic although only one-third of the females and one-quarter of the males attended church weekly. Some 53% of the males but only 3% of the females had had at least five (5) sexual partners in their lifetime. Women were more than three times more likely than men to have their first sexual experience with their spouse or with a "beloved or exclusive partner." In contrast, men were more likely to have their first sexual experience with a friend or with a prostitute7. Casual sexual relationships are more likely to result in abortions if pregnancy results compared to married relationships or consensual unions8.

Male Attitudes toward Pregnancy

The degree of commitment of the male toward the female is an important factor as to whether a pregnancy results in childbirth or abortion. A study was undertaken in 1974-1975 of women in Cali, **Colombia** with a total number of 123 pregnancies who had had at least one pregnancy they had described as unwanted. No attempt was made by the women to intervene in the pregnancy outcome in 28 cases, one minor intervention was made in 31 cases, multiple major interventions were made in 22 cases, and induced abortion took place in 42 cases. The women reported that it was the response of the male partner that had a direct bearing on the

decision, and that his response was the single most important factor influencing the outcome. In nearly 80% of the cases, where the male partner accepted the pregnancy or was indifferent to its outcome, the woman made no attempt or only one minor attempt toward abortion. If the male partner advised an abortion, in 70% of the cases the woman took major steps or several minor steps toward abortion. Husbands were most likely to suggest an abortion if they were thinking of leaving or had already established other households. Women not in stable relationships tended to seek abortion unless they secured a promise of regular assistance from the father. The authors concluded that, "a sizable proportion of abortion decisions may be understood in terms of the woman's relationship to the economic system. When the relationship's viability was threatened, she sought to obtain an abortion. It was the perception of a threat, rather than the threat per se that was the key to understanding a woman's evaluation of her situation and her timing of the abortion."9

Other Latin American studies have found that whether or not the father of the unborn child offers or provides support is also an important factor as to whether the woman carries a pregnancy to term or has an abortion. For example, a study of women in **Argentina** found that the key factor in women's decisions for abortion was whether they had emotional and economic support from their partners10. A 1988 study of 357 **Chilean** women reported that 25% of the women stated as a reason for abortion that she had a relationship problem or that her partner did not want the pregnancy. Some 30% of the Chilean women in this study also stated as a reason for abortion that she could not afford a baby. This may not have been a problem if the partner had provided financial support. Only 5% of the women in this study said they wanted no more children11. A small study of 19 women who had abortions in **Honduras** during 1992-93 found that 42% of the women stated as a reason for abortion that she had a relationship problem or her partner did not want the pregnancy12.

A study of 156 **Mexican** women who had abortions in 1980-1988 found that 33% of the women said they were pressured into the abortion by their partner. Other reasons for abortion included women not wishing to marry the partner (21%), and economic reasons (18%). Only 15% of the women said they did not want a baby at this time as a reason for abortion13. In another study of 602 women in Bogota, Colombia who were treated for incomplete abortion in area clinics and hospital in 1990-91, 16.1% of the women reported a relationship problem with her partner or partner does not want the baby as a reason for seeking abortion. In addition, 35.2% of the women said they could not afford the baby. Again, the lack of emotional or financial support appeared to be important reasons for the abortion in up to almost one-half of the cases. Only 6.3% of the women in this study said they had an abortion because they wanted to postpone childbearing14. (See Table 1)

Table 1

Primary reasons stated by Latin American women for seeking abortion

Country	Mexico 1988	Chile 1988	Colombia 1990-1991	Honduras 1992-1993
Number of Women	156	357	602	19
Reasons Stated:				

Has relationship problem or partner does not want pregnancy	33%	25%	16%	42%
Cannot afford baby	16%	30%	35%	5.3%
Too young or parents or others object to pregnancy	31.8%	25%	13.5%	36.8%
Having a child will disrupt education or job	---	15%	15.3%	15.8%
Risk to maternal health	---	---	8.8%	---
Wants to postpone childbearing	---	---	6.3%	---
Wants no more children or has too many	10%	5%	4.3%	---
Source: Reasons Why Women Have Induced Abortions: Evidence from 27 Countries, A Bankole et al, Int'l Planned Perspectives 24(3):117, Sept 1998				

Some of the specific reasons for abortion identified by researchers in the context of the partner relationship, include a threat to abandon the woman if she gives birth, that the partner or the woman herself refuses to marry to legitimate the birth, that a breakup is imminent for reasons other than the pregnancy, that the pregnancy resulted from an extra-martial relationship, that the husband or partner mistreated the woman because of her pregnancy, or that the husband or partner simply does not want the child. Sometimes the women may combine these reasons with not being able to afford a baby, **suggesting the importance of a partner who can offer both emotional and financial support**15.

Several studies have also identified the social circumstances and reasons for **Brazilian** women admitted to the hospital with complications from induced abortion. Many of these women had taken the drug misoprostol in an attempt to induce abortion. In one study of 803 women admitted to a Rio de Janeiro hospital in 1991 with complications of induced abortion, 56% were single, and living alone with little income16. In another study of women admitted to the main obstetric hospital in Fortaleza, Brazil, during 1990-1992 with incomplete abortions induced by misoprostol, 70% were single17. In another study of 102 women in Fortaleza during 1992-1993 with a history of known misoprostol use to induce abortion, 46% were never married and 15% had been married but were not now married. The most frequent reasons stated by these women for abortion were rape, no stable partner, and poor economic conditions18.

The negative or indifferent attitude of the husband or partner toward childbirth and unwillingness to provide emotional or financial support may also be sometimes inferred from the circumstances. In some countries in Latin America and the Caribbean, husbands may not want to know their wives abortion histories although they may take responsibility as to whether or not contraception is used19. If the relationship between the woman and her partner is casual, and economic and social support is lacking for childbirth, then a woman may

perceive that the male partner desires an abortion, or simply based upon pragmatic grounds, may procure an abortion once she becomes pregnant. For example, a **Cuban** study reported that 31.5% of all abortions in that country during 1986 were among women age 15-19 years old. The risk of abortion among students was 10 times higher than that of housewives and almost 7 times higher than that of employed women of the same age. Students in co-educational boarding schools in rural areas were at the highest risk for abortion20.

II. Induced Abortion as a Violation of Moral or Religious Beliefs

The beliefs of women about the desirability of abortion frequently conflict with the actions. In-depth interviews were undertaken of 225 women with complications from abortion at two hospitals in Lima, **Peru** between February-August, 1993. Forty-five percent (45%) were age 24 and below, 27% were between 25-29, 16% were between 30-34, and 12% were age 35 and above; Twenty-six percent (26%) had a primary education, 65% had a secondary education, and 9% had higher education; Fifty-three percent (53%) were not working and 47% were working; Twenty-one percent (21%) were single, 22% were married, and 56% were in union; Twenty-nine percent (29%) never had any children and 71% had at least one child; Eight percent (8%) said they wanted a child as soon as possible, 31% said they wanted a child after two years, 43% said they did not want a child, and 18% were undecided. Forty-eight percent had never used contraceptives. Women using contraceptives had mainly used rhythm and withdrawal methods.

The women were asked under what situations they thought abortion was justified. Among the responses were: if woman is unmarried (16%), if woman is in school (26%), if woman has no money but has many children (40%), the last child is too young (31%), the timing of the pregnancy is wrong (24%), or pregnancy is the result of infidelity (22%). Apparently because of the frequent difference between the stated beliefs and the actions of the women, the authors concluded that **abortion is not an acceptable option for the women, even by those who resort to it, and that it is employed as the final option**. (emphasis added). The same conclusion was made for postabortion women from Kenya and the Philippines21.

Other research has found that preexisting beliefs about abortion are frequently inadequate to resolve the dilemma. This was confirmed in a study of women in Chile who had abortions which found that, although abortion was regarded as a grave religious sin by the women, a substantial majority of women (76%) who obtained them thought that the distress caused by the pregnancy outweighed the distress of personal conflicts and fears about abortion22.

Stresses which occur shortly before undergoing abortion appear to be very intense. In a recent study of U.S. women in the St. Louis area who were volunteering for a RU-486 (Mifepristone) induced abortion in combination with a prostaglandin (Misoprostol), high preabortion acute stress reactions dominated by high avoidance, intrusion, and anxiety were identified. The researchers stated that "what appears to be happening is that women are trying to control their response to the unwanted pregnancy/abortion situation by avoiding thinking about it23." Other studies have also demonstrated that frequently a woman may undergo a temporary personality change prior to abortion which may be an intense grief reaction, high anxiety and depression, or self-criticism. guilt and hostility similar to those of psychiatric populations24.

Other studies of Latin American postabortion women in **Venezuela** and **Colombia** have found that the abortion experience evoked a complex combination of feelings including relief, guilt, depression and confusion. It was concluded that, while women accepted the fact of abortion, the experience left emotional scars that usually heal, but may never wholly disappear25. Also, conflict about the meaning of the abortion and its relationship to deeply held values or beliefs, has been identified as a factor that may result in negative psychological reactions26. Influences of cultural and psychosocial traditions deeply ingrained in many women

in Latin America through the socialization process have been identified as a risk factor for negative psychological effects from abortion27.

Other studies have found that abortion may represent a denial or alteration of religious beliefs. A Nigerian study in 1988-89 of primarily Christian women with complications from induced abortion, determined from interviews that the women believed that abortion was immoral and was against the wish of God28. U.S. studies have also found that young women may obtain an induced abortion despite her beliefs about abortion, or that abortion may alter her previously held beliefs about God29. Induced abortion also results in frequent guilt or remorse or regret among postabortion women indicating a violation of the conscience of these women. What may be concluded from these studies is that having an induced abortion frequently will not represent the real aspirations of women. It also violates the right of conscience of many of the women who undergo abortion. This violates the basic rights and human dignity of the woman as set forth in the United Nations Declaration of Human Rights in 1948.

III. Induced Abortion Studies

One study involved 156 women who had induced abortions in **Mexico** between 1980-1988 in Mexico City, Oaxaca, and Acapulco. Women were interviewed by trained psychology students from the National University (UNAM). Out of the 156 women, 119 reported they had their abortion performed by a trained person most often in a hospital or clinic, 32 reported abortions by untrained persons who operated in the woman's home, and 5 could not recall the qualifications.

The ages of the 156 women ranged from 12-56 years, with 14% under age 20, 40% between 20-25, 26% between 26-30, and 20% over age 30. Some 49% were single, 42% were married or living in consensual union, and 8% were separated, divorced or widowed and 61% of the women were nulliparous. Out of the remaining 61 women with children, 31% had one child, 31% had two children,l6% had three children, and 21% had four or more children. The occupations of the women were skilled labor (37%), student (36%), homemaker (19%) and manual worker (8%). Some 32% of the women reported they had previously tried unsuccessfully to self-induce an abortion by resorting to injections (35%), herbs (29%), pills (14%), injections and pills (12%), wires or needles (4%), strenuous exercise (4%), or heavy massage (2%).

Women having abortions by trained persons were more likely to have attended college (39% v 25%), have a professional occupation (19% v 4%), have received contraceptive information (43% v 3%), affirmatively stated they would recommend the abortionist to other women (75% v 25%), and have paid more for their abortion ($88 v $33). Women who had abortions by a trained person were less likely to have had two or more abortions (13% v 22%).

The reported incidence of complications or "troubles" was 22%. Among the women reporting complications (troubles), 44% experienced hemorrhages, 21% reported hemorrhages with infections, 21% reported pain, l2% reported emotional difficulties, and 3% (1 woman) needed a hysterectomy.

Women reporting abortions by trained persons compared to untrained persons were more likely to have undergone a curettage procedure (50% v 13%) or had a suction abortion (20% v 0%), and less likely to have had the abortionist utilize a catheter (3% v 19%) or injection (3% v 25%) or use wire, needles or herbs (0% v 29%) to procure the abortion.

When women were asked the reason for abortion, women reporting abortions by trained persons were much more likely to state partner pressure (39% v 13%) but were less likely to say they had too many children (8% v

16%) or had abortions for economic reasons (15% v 19%). Other reasons stated for having the abortion included not wishing to marry the partner (21%), not wanting a baby at this time (15%), or being too young (9%)30.

Another study evaluated 4371 women admitted to 11 major **Bolivian** hospitals during a one year period beginning July 1, 1983 with complications associated with pregnancy losses. At admission, medical personnel classified each case as definitely or probably spontaneous or alternatively definitely or probably induced. If the woman said it was induced, then it was considered to be induced. If she said it was spontaneous, and there was clinical evidence to the contrary, such as cervical lacerations, then it was considered to be induced.

Table 2

Pregnancy Losses Classified as Induced Abortions Compared to Type of Partner Relationship-4371 Bolivian Women

Type of Relationship	**Percent Classified as Induced Abortion**
Married Women	18%
Women in Consensual Union	23.6%
Single Women never in union	46.3%
Separated, divorced or windowed Women	54.8%

Source: PE Bailey et al, A Hospital Study of Illegal Abortion in Bolivia, PAHO Bulletin 22(1):27, 1988

Overall, 22.7% of the pregnancy losses were classified as induced abortions. Women who were age 14-17 (38.6%) or who were age 18-19 (30.3%) were more likely to have pregnancy losses classified as induced abortions compared to women age 20-29 (24.2%) or women age 30 or higher (18.3%).The quality of the male-female relationship was an important factor as to whether or not pregnancy losses were classified as induced abortions. Women who were never in union (46.3%) or who were divorced, separated or widowed (54.8%) were more likely to have pregnancy losses classified as induced abortions compared with women in consensual union (23.6%) or married women (18.0%). (Table 2) Women with a loss of a first pregnancy were more likely to have been classified as having had an induced abortion (31.3%) compared to women who did not have the loss of a first pregnancy (21.6%). There were no significant differences in the percentages of pregnancy losses

attributed to induced abortion with number of living children or level of education.

Some 65% of the abortions were induced by persons with medical training compared to 29.7% by persons without medical training and 5.2% were self-induced. When abortions were induced by persons with medical training 51.3% used curettage and 34.1% inserted a foreign object. When abortions were induced by persons without medical training, 56.5% inserted a foreign object, 11.2% used curettage, and 19.4% administered an oral abortifacient. When women self-induced abortion, oral abortifacients (83.3%) were most often used. Bleeding in any amount was most likely to occur irrespective of the method used. Infection was more likely to occur with curettage (42.9%) or when foreign objects were inserted (40.5%) compared to oral abortifacients (4.3%) or use of injection (10.5%). A fever of 38 degrees centigrade or more was also more likely to occur with curettage (25.9%) or when foreign objects were inserted (37.0%) compared to oral abortifacients (7.1%) or injection (7.9%). Lesions were also more likely to occur following curettage (22.9%) or insertion of foreign objects (38.9%) compared to oral abortifacients (1.4%) or injection (0%).

Women admitted to the hospital with abortions which were classified as induced were more likely to have complications of fever (27.7% v 3.1%), infection (33.2% v 5.7%), or lesions (21.2% v 0%) compared to women who were classified as having spontaneous abortions. Women who were classified as having induced abortions were also more likely to require blood transfusion (11.9% v 6.2%), be hospitalized for 4 or more days (15.7% v 7.6%), and more likely to die compared to women classified as having spontaneous abortions (6 per 1000 case fatality rate v 0.3 per 1000 case fatality rate).

Women admitted with abortions which were classified as induced were also more likely to be using a contraceptive method during the month of conception compared to women with spontaneous abortions (39.8% v 18.6%). However, women admitted with induced abortions were less likely to say the pregnancy was desired (2.3% v 34.9%) compared to women with spontaneous abortions. Women with induced abortions were also more likely to think the use of contraceptives was not necessary (17.4% v 7.8%), and reported less sexual activity following their pregnancy loss (9.4% v 3.6%), but were more likely to express an intent to use contraceptives following their abortion (77% v 49.4%) compared to women whose abortions were classified as spontaneous.

Among the women who stated that they did not intend to use contraceptives in the future, 32.5% of the women with induced abortions compared to 6.0% of women with spontaneous abortions said they intend to discontinue sexual relations. Women with induced abortions were also more likely to cite objections of partner, family or religion as a reason for not using contraceptives compared to women with spontaneous abortions (15.8% v 2.5%)31.

Induced Abortion in Latin America: Social, Cultural, and Technical Aspects

Several Brazilian studies were undertaken in the 1990's to evaluate the effects of misoprostol which was used, for a limited period of time as an abortificient. One study interviewed 1603 women with abortion-related complications (mostly incomplete abortion) who were admitted to seven public hospitals in Rio de Janeiro, **Brazil** between April-December, 1991. Abortions were classified as induced if the women admitting terminating the pregnancy or if there were signs of intervention such as cervical laceration, perforation, foreign bodies or evidence of chemical burns. Based on this evaluation, 803 women were classified as having had an induced abortion. Among the women classified as having had an induced abortion, 20% were age 18 or younger, 38% were 19-24, 23% were 25-29, 13% were 30-34, 5% were 35-39 and 1% were age 40 or more.

Fifty-six percent (56%) of the women were single and were living alone, 10% were married, and 34% were cohabiting. Twenty-nine percent (29%) had no children, 51% had one or two children, 15% had three or four children and 6% had five or more children. In regard to educational status, 5% were illiterate, 31% had completed 1-4 primary grades, 41% had completed 5-8 primary grades and 23% had incomplete secondary education or more. 26% of the women were repeating abortion.

Some 57% of the women had used misoprostol alone or along with other methods, 13% had used oral drugs, 11% had used herbal teas, 9% intramuscular injections, 4% catheter insertion, 3% abortion clinics, 2% abdominal pressure and 1% intravaginal potassium permanganate. Heavy bleeding was observed in 19% of misoprostol cases compared with 16-25% for other abortion methods except abortion clinics which was only 5%. Infection was observed in 17% of the misoprostol cases compared to 18-21% for oral drugs, teas or injections, 43% for abortion clinics and 50% for catheter insertion. Blood transfusions were required in 1% of misoprostol cases compared to 11% for catheter insertion, 5% for herbal teas, and 2% of oral drugs and none for other abortion methods. Curettage was required in approximately 85% of the cases except for women who had abortions in abortion clinics where it was 60%. Systemic collapse occurred in 1% of misoprostol abortions compared to 2% for other oral drugs, 5% if herbal teas were used, 3% for catheter insertions, and 10% for abortions in abortion clinics32.

Demographic Data:
Latin American Postabortion Women

Location	Year	No. of Women	Under Age 20 %	Single %	Nulliparous %	Repeating Abortion %	Education None %	Education Primary Only %
San Paul, Brazil	1978-82	2588	16	---	---	44.4(a)	---	---
Boliva	1983-84	990	12	21	18	47	10	39
Mexico	1980-88	156	14	49	61	15	---	---
Lima, Peru	1993	225	---	21	29	---	---	26
Rio de Jaeiro(d), Brazil	1991	803	20(b)	56	29	26	5	72
Fortaleza (d), Brazil	1992-93	102	17	46	25	36	---	58
Fortaleza (d), Brazil	1990-92	593	31(c)	70	---	---	---	---

a) 62% under age 20 and 42% over age 20 were repeating abortion
b) Under age 19
c) Under age 21
d) Misoprostol abortions

Another study of 1840 women who were treated for complications of abortion at the Instituto Materno-Infantil de Pernambuco in **Brazil** during 1988-1992, found that serious infections defined as tubal/ovarian abscess or septicemia were lower in women who had attempted abortion with misoprostol (0.8%) compared to other unspecified types of induced abortion (14.6%) . Women age 24 or under were less likely to have a serious infection (1.4%) compared to women age 25 or more (3.1%), Women who were nulliparous were more likely to have a serious infection (2.5%) compared to women of parity one or more (1.5%), and women with a gestational age of 10 weeks or less were less likely to experience serious infection (1.4%) compared to women at 11 or more gestational weeks (3.0%). Approximately 30% of the women in this study were considered anemic by having a hemoglobin level of 8 g/dl or less or had hemorrhagic shock33.

A World Health Organization (WHO) study published in 1985, reported that overall 41% of pregnant women in Latin America were anemic (hemoglobin of less than 11.0 g/dl) compared to 9% of pregnant women in more developed countries. If this study had utilized the WHO definition of anemia, a considerably greater number of women in this study would have been considered anemic. Anemia during pregnancy significantly increases the risk of pregnancy-related death. One study found that an anemic woman is five times more likely to die of pregnancy-related causes compared to a woman who is not anemic34. The WHO has estimated that 2067c of maternal deaths in Africa are directly due to anemia with additional deaths caused indirectly by anemia, especially obstetric hemorrhage35.

In another study between July, 1992 and February, 1993, 102 women residing in Fortaleza, in Northeast Brazil with a known history of misoprostol use for induced abortion were interviewed. These women were known by the researchers or were acquaintances of women who were interviewed. Seventeen percent (17%) were age 16-19, 57% were age 20-29, 25% were age 30-39, and 2% were age 40-49. Forty-six percent (46%) were never married, 15% had been married and 39% were currently married. Twenty-four percent (24%) had 0-3 years education, 34% had 4-7 years, 28% had 8-10 years and 14% had high school or more. Twenty-five percent (25%) had no live born children, 60% had 1-3 children, 15% had 4-12 children and 16% reported between one to five dead children. Seventy-seven percent (77%) were rated as being in low social classes and 81% were Catholic. Twenty-two percent (22%) were the head of a family, 39% were wives, 26% were daughters, 12% shared their home with friends, and 2% were live-in housemaids.

Sixty-four percent had no induced abortions prior to misoprostol use, 20% had one previous induced abortion, 10% had two previous abortions and 6% had from three to eleven previous induced abortions. Seventy-two percent (72%) of the women said they would accept the right to abortion but only 52% were favorable to misoprostol. Fifty-seven percent (57%) had not used any contraceptives. The most frequent stated reasons for abortion were rape, no stable partner and poor economic conditions. The researchers believed that abortion reform legislation was needed to accommodate new fertility control technologies, such as abortifacient pills36.

An earlier study of 2588 **Brazilian** women treated for post-abortion complications at the Hospital of Santo Andre, State of San Paulo, during 1978-1982, compared the characteristics of women who were under 20 years of age with those who were age 20 or more. Sixteen percent (16%) of the women in the study were

under age 20. Those who were under 20 were more likely to have a greater gestational age, were more likely to have had a pregnancy end in abortion, and were more likely to have had one or more previous abortions (62.2% v 42.2%) compared to women over age 20. Women under age 20 were also more likely to be maritally unstable with many women working in domestic service as maids. It was noted that these women often had no legally recognized employment status, live in worse conditions, and experience less job stability, which might result in an abortion if pregnancy occurs.

Seventy-seven percent (77%) of the women had their menarche before the age of 14, and 81.4% had started their sexual life before they had reached the age of 14. The beginning of sexual relations at younger ages was found to lead to a tendency to have a first pregnancy at an earlier age. The author concluded that the incidence of abortion, especially among adolescents was unacceptably high and that abortion was being used as a contraceptive method in the absence of efficient and efficacious reproductive planning37.

Whether or not contraception will reduce the high incidence of induced abortion, and particularly repeat abortion, is problematical. In an attempt to determine whether or not counseling women to use contraceptives following induced abortion would reduce the incidence of repeat abortion, a study was undertaken of more than 3000 women who were admitted to hospitals with complications of induced or spontaneous abortion. Researchers in Kenya, Zimbabwe, Zambia, Nigeria and Mexico divided women into two groups. One group participated in a single session of contraceptive counseling after treatment for their complications, and the other group had no counseling session. One year later, researchers interviewed the women to determine contraceptive use and the incidence of repeat pregnancy and abortion. It was found that the counseling did not significantly reduce the rate of repeat abortion38. A recent study of 1661 French Canadian women found that non-compliance with scheduled follow-up visits for contraceptives following abortion was as high as 50% with younger women and women repeating abortion among those least likely to return39.

Conclusions

The reasons why Latin American women have abortions are similar to many of the reasons why U.S. women have abortions, i.e. relationship problems, can't afford baby, or too young or immature40. Based upon limited available studies, it also appears that Latin American women experience the same type of psychological reactions to abortion as U.S. women.

The attitude of the Latin American male and the quality of the relationship as to whether or not he offers financial and emotional support to his pregnant partner in support of childbirth is an important factor in determining the outcome of a pregnancy. Because a large number of abortions are for socioeconomic reasons, many Latin American women who become pregnant and have an abortion appear to have desired to carry the child to term. By resorting to abortion, many of these women appear to have violated their moral or religious beliefs in the process.

A wide variety of illegal abortion techniques were identified. Although definitions of complications were frequently imprecise and the number of studies limited, it appeared that the complications from illegal abortion among hospitalized Latin American women were less life-threatening compared to hospitalized African women41. However, one Brazilian study of women with abortion complications reported a high incidence of anemia which would indicate an increased risk of pregnancy-related death.

Footnotes

1 The Relationship of Abortion to Trends In Contraception and Fertility in Brazil, Colombia and Mexico, S

Singh, G Sedgh, Int'l Family Planning Perspectives 23(1):4, March 1997 [Back]

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