

Health Professionals' Perceptions About Induced Abortion in South Central and Southeast Asia

By Susheela Singh, Deirdre Wulf and Heidi Jones

Although the legal status and the availability of induced abortion are highly variable in South Central and Southeast Asia, findings from a 1996 survey of 232 knowledgeable health professionals indicate that women of all socioeconomic levels obtain abortions, and many procedures take place in settings that may increase the risks to the woman's health. Overall, the vast majority of nonpoor urban women seeking abortions are believed to go to medically trained providers; however, roughly one-third to one-half of poor women in both urban and rural areas turn to a wide range of nonmedical providers or induce their abortion themselves. Of all women having abortions in these countries, about one-third are thought to experience medical complications, and only about half of these are hospitalized for treatment; thus, an estimated one in seven women having an abortion are hospitalized for the treatment of complications. The estimated abortion rate of 30 abortions per 1,000 women aged 15–44 suggests that each year, 3% of women in South Central and Southeast Asia have an abortion; therefore, according to the survey results, about 1% are likely to suffer medical complications.

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In developing countries, induced abortion is a generally undocumented, often ignored and frequently dangerous procedure obtained by millions of women. In parts of the world where abortion is illegal or allowed only on very narrow grounds, or where it is legal but difficult to obtain, many women go to extreme measures to avoid unwanted births. These measures often involve clandestine abortions performed under unsanitary conditions and by unskilled practitioners using dangerous techniques. Unsafe abortions put many women at grave risk of impaired health and, sometimes, of dying.

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During the years leading up to and following the 1994 United Nations International Conference on Population and Development in Cairo, increased global attention was given to the adverse health implications of the widespread use of clandestine abortion in many parts of the developing world. However, the lack of reliable information on abortion has hampered the design of effective policies, programs and strategies to address the issue. Health planners need better information about morbidity and mortality risks related to clandestine abortion, in order to provide women with improved treatment and with appropriate postabortion care, including contraceptive counseling and services. Better knowledge of the reasons women have abortions will enable health care planners to identify subgroups of women who are in need of improved access to fertility control.

Health researchers recognize that levels of clandestine abortion in Asia are high;¹ however, very little reliable information is available about practices there. This article looks at the conditions under which women in South Central and Southeast Asia have induced abortions, as reported in a survey of health professionals across the region. The approach taken here parallels that used in an earlier study carried out in Latin America.²

The legal status of abortion varies widely among the countries of Southeast and

South Central Asia, and even where abortion is legal, a range of complex service systems operate. Of the nine countries that make up Southeast Asia, only two—Singapore and Vietnam—permit abortion on request. In five—Cambodia, Indonesia, Laos, Myanmar and the Philippines—induced abortion is permitted only to save the life of a pregnant woman. In Indonesia, however, qualified physicians are permitted to offer menstrual regulation services,³ and in Indonesia and the Philippines, although the laws on induced abortion are relatively restrictive, they are not strictly enforced.⁴ (Information on enforcement in the other countries is not available.)

In the two remaining countries of Southeast Asia, induced abortion can be performed on somewhat broader medical grounds—in Malaysia, for genetic reasons, to save a woman's life, or to preserve her physical or mental health; and in Thailand, in cases of rape or incest, or to save a woman's life or preserve her health. In Malaysia, the annual rate of legal abortion (based on registration of procedures by providers) is only about seven abortions per 1,000 women aged 15–44, but in both countries, clandestine abortion is believed to be quite common.⁵

According to indirect estimates made by the World Health Organization (WHO) and others using a standardized methodology, 4.2 million abortions occur each year in Southeast Asia;⁶ 1.3 million of these are performed in Vietnam and Singapore.⁷ Other estimates range so widely that at best they can give only a general indication of the incidence of abortion, but they suggest that the procedure is common in Indonesia (between 750,000 and 1.5 million annually), the Philippines (155,000–750,000) and Thailand (300,000–900,000).⁸ Little or nothing is known about the extent of abortion in Cambodia, Laos and Myanmar.

Of the eight countries of South Central Asia, only one—India—permits abortion under broad circumstances. In India, abortion in the first 20 weeks of pregnancy has been legal and an official government health service available on broad social and medical grounds since 1971. However, the level of access to government services is uneven. Various small-scale stud-

Table 1. Number of health professionals surveyed, by geographic area, Survey of Opinions on Abortion Practice in South Central and Southeast Asia, 1996

Geographic area	Total	Medical	Non-medical
Regional total	232	156	76
South Central*	101	62	39
Afghanistan	3	1	2
Bangladesh	26	19	7
India	37	20	17
Iran	3	2	1
Nepal	12	10	2
Pakistan	11	5	6
Sri Lanka	9	5	4
Southeast	131	94	37
Cambodia	5	4	1
Indonesia	27	11	16
Laos	1	1	0
Malaysia	4	2	2
Myanmar	7	5	2
Philippines	49	42	7
Singapore	1	1	0
Thailand	30	26	4
Vietnam	7	2	5

*Bhutan is excluded because no sources could be identified.

ies indicate that private doctors in India perform legal abortions for a fee not much higher than that charged in the public sector.⁹ In addition, other analyses find that very few private doctors report these procedures to the government data collection system.¹⁰ It is believed that roughly 6.7 million induced abortions are performed annually in India, even though only about 632,000 are reported in government statistics.¹¹

In Bangladesh, menstrual regulation by vacuum aspiration is available as a public health measure up to 10 weeks' gestation; however, providers' reports suggest that it may be provided up to 12 weeks' gestation.¹² Estimates of the number of procedures carried out each year range from 241,000 menstrual regulations in 1985¹³ to 800,000 total abortions (menstrual regulations and other procedures) for the late 1970s.¹⁴

In Sri Lanka, where abortion is permitted only to save the life of the woman,¹⁵ the number of clandestine abortions has been

*In particular, the International Planned Parenthood Federation secretariat, London; International Projects Assistance Service, Carrboro, N. C., USA; Center for Reproductive Law and Policy, New York; Fédération Internationale de Gynécologie et d'Obstétrique, London; Marie Stopes International, London; Médecins sans Frontières, Brussels, Belgium; WHO, Geneva; and Economic and Social Commission for Asia and the Pacific, Bangkok, Thailand.

†Contact information for potential respondents in India came primarily from a list of participants at the United Nations' Fourth World Conference on Women, held in Beijing in 1995, and may have been less accurate than information provided directly by individuals.

estimated at 125,000–175,000 each year.¹⁶ In Afghanistan, Iran and Pakistan, abortion is permitted only to save a woman's life, and in Nepal, it is permitted only if performed as a "benevolent" act (but the law does not define this term). Very little is known about the incidence of abortion in these four countries, and virtually no information is available for Bhutan.

WHO estimates that six million clandestine abortions occur annually in South Central Asia. Combining this estimate with the number of reported legal abortions, 74 million total abortions are estimated to occur in this subregion each year.

We report here on a survey undertaken in early 1996 of professionals in Southeast and South Central Asia who are knowledgeable about induced abortion. The objective was to gain insights into the conditions under which abortion is performed and the consequences of the procedure carried out in both legal and clandestine settings, by both medically trained personnel and traditional practitioners of varying skills, under both safe and unsafe medical conditions, and in both the private and the government sectors. However, the findings reflect respondents' perceptions about conditions in their country and therefore paint only a general picture of abortion in these subregions.

Methodology

The survey questioned a purposive sample of health professionals about various aspects of abortion: the methods used; the providers women go to; the probability that women having an abortion experience complications or are hospitalized for treatment if they have complications; where women seek treatment; the major reasons why women have abortions; and the differences in these factors between urban and rural women and between better-off and poor women. The questionnaire was designed to be self-administered and was pretested in Thailand and the Philippines.

With the help of various organizations* and researchers, we identified 374 potential respondents in all countries of Southeast and South Central Asia except Bhutan. To be eligible for inclusion, individuals had to have had direct experience treating abortion complications; providing abortions; formulating policy on the issue; administering health care services for women seeking abortions or being treated for abortion complications; or doing research on abortion.

The survey was mailed in January 1996, and then again in February to those who had not yet responded. Further follow-up

of nonrespondents was carried out by fax and, in a small number of cases, by telephone. In all, 232 professionals completed the questionnaire (see Table 1), for a response rate of 62%.

In India, we sought to include a particularly large number of information sources (96) because the country represents such a large proportion of the region's population. However, the response rate for India was especially low (39%),[†] and this affected the overall response rate: Excluding India, the response rate was 72%.

Because the questionnaire was in English (except in Thailand, where it was translated into Thai), some professionals who were knowledgeable about the topic but not highly educated or high-ranking may have been deterred from participating. This problem may have been especially pronounced in countries with no history of English-speaking colonial rule (Afghanistan, Iran, Nepal, Cambodia, Indonesia, Laos and Vietnam). In the remainder, there is a greater probability that individuals in all socioeconomic strata have some facility with English.

To be able to present results at a more detailed level than the subregional, we grouped together some countries with similar demographic and cultural profiles and few respondents: Afghanistan, Iran and Pakistan; Myanmar, Laos and Cambodia; and Sri Lanka and Malaysia. (The last two, although they are in different subregions, are similar in that both are characterized by low desired family size, fertility, and infant and maternal mortality rates, and by high levels of contraceptive use.) Nepal, with 12 respondents, could not be grouped with India, where abortion is legal, or with Pakistan, which has a very different cultural and religious setting, and therefore is presented separately. Vietnam, with only seven respondents, is also shown separately, because the fact that abortion is legal and accessible makes it deserving of independent attention. Singapore, where abortion also is legal and available, is otherwise too different from Vietnam to be grouped with it; therefore, the respondent from Singapore was included in the regional grouping but not in any country grouping.

Where the numbers of respondents are quite small, the results provide only an approximate picture of actual conditions. In addition, even in countries represented by the largest numbers of participants, the majority were from urban areas; thus, the findings are likely to yield a more accurate profile of conditions in urban than in rural areas. Overall and subregional results are

Table 2. Percentage of health professionals who reported that particular abortion methods are commonly used, by geographic area, according to type of provider

Geographic area	Physicians			Nonphysicians				
	Vacuum aspiration	D&C	Prostaglandins/injectables	Hormones/drugs	Indigenous medicine	Catheter	Other objects	Massage
Regional total	64	62	18	27	40	10	51	19
Subregion								
South Central Asia	62	67	20	33	44	9	64	7
Southeast Asia	69	51	14	13	29	15	18	49
Country								
Afghanistan/Iran/Pakistan	40	87	20	44	31	19	38	0
Bangladesh	84	32	8	28	44	4	68	4
India	64	67	22	32	47	6	71	9
Indonesia	91	30	4	8	33	0	17	79
Myanmar/Laos/Cambodia	40	80	30	15	46	8	23	62
Nepal	83	75	0	36	64	27	36	0
Philippines	36	48	48	38	18	72	0	49
Sri Lanka/Malaysia	62	54	0	0	17	33	67	17
Thailand	53	63	3	17	24	21	45	14
Vietnam	71	86	0	0	20	0	0	0

Notes: In this and subsequent tables, the respondent from Singapore is included in the regional total but not in any country grouping; not all respondents answered every question; and regional and sub-regional data are weighted by the percentage distribution of women aged 15–44 by country. Vacuum aspiration includes menstrual regulation.

presented as averages weighted according to each country's proportion of the region's women aged 15–44.¹⁷

In all, 68% of respondents were medical service providers (Table 1); most of these were doctors, and a small number were midwives, nurses and other health care workers. Some 13% of participants were health administrators or policymakers, and 19% were researchers or professors. Medical and nonmedical participants' responses to key questions were compared and found to be extremely similar, suggesting that the variation in participants' occupations by country did not significantly affect the comparability of results.

Most respondents had a medical degree (76%) or other postgraduate degree (15%); 6% were nurses, and the remaining 3% had a bachelor's degree. Overall, about half were employed in the public sector, and about half had at some time worked for six months or more in a rural area of their country. The mean age of all respondents was 47 years; this mean varied from 40 to 54. Most respondents had gained their experience with abortion in a hospital setting (72%), but substantial proportions had acquired it in a clinic or health center (45%), or through private practice (36%); variability across countries was by far greatest in the last two groups.

Results

Commonly Used Abortion Methods

Respondents were presented with a comprehensive list of abortion methods and were asked to check off all those used in their country. Between eight and nine out of 10 mentioned vacuum aspiration and

dilatation and curettage (D&C), and roughly six in 10 mentioned insertion of a catheter, massage, teas and other traditional methods. One-half reported that hormonal methods (prostaglandins, introduced vaginally or orally) were in use. Respondents also mentioned a wide range of herbal and other natural substances, manufactured products and physical techniques used to induce abortions.

Table 2 presents a summary of the methods believed to be most commonly used by physicians and by nonphysicians. Overall, two-thirds of respondents said that physicians commonly use vacuum aspiration or menstrual regulation* and D&C. Generally, D&C is perceived to be used more often, and the difference is often considerable (as in Afghanistan, Iran and Pakistan; Myanmar, Laos and Cambodia; the Philippines; Thailand; and Vietnam). Only in Bangladesh and Indonesia is the use of vacuum aspiration or menstrual regulation thought to be much more common than the use of D&C.

Almost two in 10 health professionals said that doctors sometimes provide or prescribe prostaglandins or injectables to induce abortion. In the Philippines, the use of these methods is believed to exceed that of vacuum aspiration or menstrual regulation, and to equal that of D&C.

The responses describing methods used by nonphysicians were less consistent and more wide-ranging. The most frequently cited methods overall were objects (other than a catheter) inserted into the vagina or uterus, followed by indigenous methods based on herbal solutions. Respondents from South Central Asia most often re-

ported that the insertion of foreign objects into the vagina is a common traditional method. In the Philippines, the catheter was cited as by far the most common method used by nonphysicians, but for Southeast Asia as a whole (and particularly in Indonesia and Myanmar, Laos and Cambodia), massage was the most frequently identified traditional method.

In countries where a substantial proportion of doctors are believed to prescribe hormones (Afghanistan, Iran and Pakistan; India; and the Philippines), nonphysicians are also thought to administer these methods, which are available over the counter, quite frequently. However, in Bangladesh and Nepal, where the use of hormonal prescriptions is thought to be almost nonexistent among physicians, nonphysicians are sometimes believed to administer these methods. In Vietnam, the use of traditional methods by nonphysicians is thought to be negligible, but roughly three-quarters of both physicians and nonphysicians are believed to perform vacuum aspiration (not shown).

A Wide Range of Providers

There is a perhaps outdated general impression that where abortion is not legal, poor or rural women wanting to terminate an unwanted pregnancy must turn to unskilled practitioners working in unsani-

*While the use of these two terms may appear redundant, because the same medical procedure is used for both methods, a distinction has to be made between them. In Bangladesh and Indonesia, menstrual regulation is legal under precise criteria for gestational age and provider qualifications. Since menstrual regulation is performed at an early stage of pregnancy, it is sometimes done in the absence of a positive pregnancy test.

Table 3. Health professionals' estimates of the percentage distribution of women seeking abortions, by type of provider and residence, according to poverty status and geographic area

Poverty status and geographic area	Urban				Rural				Total
	Physician	Nurse/mid-wife	Lay practitioner	Self-induced*	Physician	Nurse/mid-wife	Lay practitioner	Self-induced*	
NONPOOR									
Regional total	74	11	6	8	45	24	20	11	100
Subregion									
South Central									
Asia	80	10	5	5	48	24	18	9	100
Southeast Asia	61	15	10	14	36	24	25	15	100
Country									
Afghanistan/									
Iran/Pakistan	59	19	12	10	17	31	29	23	100
Bangladesh	56	23	11	9	22	35	31	12	100
India	88	6	2	4	59	21	14	6	100
Indonesia	57	16	9	18	26	26	31	17	100
Myanmar/ Laos/									
Cambodia	34	25	24	17	11	32	40	17	100
Nepal	46	17	26	10	21	18	41	21	100
Philippines	32	20	20	28	14	23	37	27	100
Sri Lanka/									
Malaysia	94	2	1	3	72	6	17	6	100
Thailand	83	9	2	6	50	26	13	11	100
Vietnam	89	11	0	1	77	18	4	2	100
POOR									
Regional total	43	19	24	13	27	20	38	15	100
Subregion									
South Central									
Asia	48	18	24	11	29	20	38	13	100
Southeast Asia	33	23	25	19	22	21	39	18	100
Country									
Afghanistan/									
Iran/Pakistan	15	23	41	21	11	25	34	30	100
Bangladesh	21	30	36	13	8	28	48	16	100
India	59	15	18	8	36	18	36	9	100
Indonesia	24	28	25	24	13	18	47	22	100
Myanmar/ Laos/									
Cambodia	9	24	43	24	6	27	46	21	100
Nepal	19	17	46	18	12	12	50	26	100
Philippines	7	23	42	28	5	19	51	24	100
Sri Lanka/									
Malaysia	65	6	19	10	41	6	46	7	100
Thailand	37	25	23	16	22	27	33	18	100
Vietnam	82	16	1	1	64	30	5	1	100

*Includes abortions women induced using preparations purchased from pharmacies and a range of other methods.

tary settings and using dangerous or ineffective methods. Another common misperception is that all better-off women seeking an abortion in these regions can obtain a safe medical procedure. While neither of these extremes is entirely accurate, a woman's access to abortion services probably depends largely on where she lives and how great her financial resources are. Therefore, we assessed the options available to four groups of women: non-poor urban and rural women, and poor urban and rural women.* Respondents were asked to estimate what percentage of women seeking an abortion use doctors; nurses or midwives; untrained traditional providers; pharmacists; and self-

*Nonpoor women were described as "those who are, relatively speaking, better off," but were otherwise left to the respondent to define. "Urban" and "rural" were not defined.

induced procedures. (In presenting the results, we combine the last two categories because of the potential for overlap and to simplify interpretation.)

As might be anticipated, respondents said that the majority of nonpoor urban women seeking an induced abortion go to physicians (80% in South Central and 61% in Southeast Asia—Table 3). Physicians also are thought to be the most common choice among nonpoor rural women (48% in South Central and 36% in Southeast Asia) and among poor urban women (48% and 33%, respectively). Also as expected, informants reported that among poor rural women in both subregions, lay practitioners are the most commonly used source (38–39%); however, a fair proportion of poor rural women are believed to obtain services from physicians (29% in South Central Asia and 22% in Southeast Asia).

It is of interest to examine this picture in the light of prevailing legal restrictions on abortion. In Vietnam, where abortion is a government health service, virtually no women, even those who are poor, resort to traditional providers. In Bangladesh, however, where menstrual regulation is permitted, both poor urban and poor rural women seeking an abortion are very likely to go to a traditional provider. And in India, where abortion is legal but often difficult to obtain from government facilities, 36% of abortions among poor rural women are thought to be provided by traditional practitioners. On the other hand, even in countries with stringent restrictions on abortion, the largest proportions of non-poor urban women reportedly go to a doctor to terminate an unwanted pregnancy.

As for other sources of abortion, informants reported that nurses and midwives provide services to an estimated one in 10 nonpoor urban women and to roughly two in 10 of the other subgroups. In addition, some women induce their abortion themselves, using drugs purchased from a pharmacist or a variety of other methods (8–15%).

In summary, the results suggest that reliance on medically trained providers diminishes from urban to rural areas and from the nonpoor to the poor. Yet, even among nonpoor urban women, a surprisingly high proportion (about one in seven) obtain their abortion from a traditional provider or induce it themselves. The patterns of nonpoor rural women and poor urban women are notably similar.

At the country level, a comparison of Vietnam and the Philippines highlights two contrasting scenarios. In all groups except the rural poor, Filipino women appear somewhat more likely than Vietnamese women to avail themselves of the services of nurses and trained midwives. However, 64–75% of poor women and of rural women seeking abortion in the Philippines are believed to use traditional practitioners or induce the abortion themselves, while almost all Vietnamese women, regardless of their poverty status or residence, are thought to go to skilled providers. Respondents believe that in Sri Lanka and Malaysia as well, physicians and other medically trained providers perform the vast majority of abortions among nonpoor urban women, poor urban women and nonpoor rural women.

India, because of its size and the fact that abortion is legal there, exerts a strong influence on the overall distribution by type of provider for South Central Asia. Thus, the proportion of nonpoor urban

Table 4. Health professionals' estimates of the percentage of women having an abortion who have a complication and the percentage of those with a complication who are hospitalized, by poverty status and residence, according to geographic area

Geographic area	% with complication					% with complications hospitalized				
	All	Nonpoor urban	Nonpoor rural	Poor urban	Poor rural	All	Nonpoor urban	Nonpoor rural	Poor urban	Poor rural
Regional total	34	19	31	31	39	47	64	57	53	40
Subregion										
South Central	34	17	32	31	40	46	66	57	52	37
Southeast	32	22	30	29	37	51	58	58	55	46
Country										
Afghanistan/ Iran/Pakistan	29	19	27	33	30	34	50	44	44	24
Bangladesh	40	21	34	36	43	54	63	58	52	53
India	34	14	31	28	41	47	70	59	53	37
Indonesia	39	27	36	31	44	34	53	52	43	25
Myanmar/Laos/ Cambodia	46	28	39	45	49	58	54	52	59	59
Nepal	42	26	36	39	45	46	53	54	59	41
Philippines	42	32	41	47	51	65	69	69	63	59
Sri Lanka/Malaysia	25	7	24	25	33	88	91	85	94	84
Thailand	34	12	27	28	38	66	70	75	69	64
Vietnam	11	12	8	6	12	40	33	38	37	43

women seeking abortions who use doctors, nurses or midwives is thought to be somewhat higher in South Central than in Southeast Asia (90% vs. 76%), largely because this proportion is very high in India (94%). And despite the legality of abortion, health professionals believe that one-quarter of poor urban women seeking abortions and more than two in five poor rural women turn to lay practitioners or induce the abortion themselves.

A more unexpected finding is that among nonpoor women seeking abortions in Indonesia and in Afghanistan, Iran and Pakistan, where abortion is legally very restricted, roughly three-quarters of those in urban areas and one-half of their rural counterparts obtain abortion services from physicians, nurses or trained midwives. Reliance on trained practitioners is believed to be relatively low in Nepal and in Myanmar, Laos and Cambodia, although even in these countries, about 60% of nonpoor urban and about 40% of nonpoor rural women seeking abortions are believed to obtain them from trained providers.

Medical Complications

The survey asked participants their perceptions about abortion-related complications that require medical treatment: incomplete abortions, excessive blood loss, damage to the vagina or cervix, perforation of the uterus, infection of the uterus and surrounding area, and sepsis or septic shock. Participants were asked to estimate the proportion of women in each poverty and residence group who experience each of these complications if they obtain an abortion from the various kinds of provider.

Informants said that about one in 10 nonpoor urban women served by a physician experience complications. The average proportion for rural areas was higher—one in seven.* In urban areas, among both poor and nonpoor women, participants estimated that three in 10 women served by nurses or midwives, four in 10 going to a pharmacist for drugs, half of those using a lay practitioner and six in 10 of those who induce their own abortion experience a medical complication. The risks associated with abortions performed by each type of provider were judged to be slightly higher in rural than in urban areas, but very similar for nonpoor and poor women.

Respondents believe that women who obtain abortifacient drugs from a pharmacy are likely to have a very high rate of medical complications. However, the survey did not ask specifically what types of drugs these might be. If they are prostaglandins, like misoprostol, then the major risks are likely to be blood loss and possible infection from an incomplete abortion.¹⁸

To estimate the overall risk of abortion-related complications experienced by the four subgroups of women, we multiplied the proportion going to each type of provider by the proportion experiencing such complications, then summed the products for all five provider categories. Table 4 shows the results, including the weighted average for each country, each subregion and the entire sample.[†]

The likelihood of serious health risk is lowest among nonpoor urban women and highest among their poor rural counterparts. The probable risk of medical complications is believed to be four in 10

among poor rural women having an induced abortion, three in 10 among the urban poor and the rural nonpoor, and two in 10 among the urban nonpoor.

At the subregional level, the pattern of risk varies little from the overall results, and women in both subregions are believed to have roughly the same risk of complications from induced abortion (32–34%). But at the country level, more diverse patterns emerge. Again, the Philippines and Vietnam illustrate the extremes. In the Philippines, health professionals believe, about half of poor women having an abortion suffer medical complications, compared with four in 10 nonpoor rural women and three in 10 nonpoor urban women. In Vietnam, the risk is thought to be minimal among all groups.

By contrast, in each subgroup, the risk

*The question was worded in terms of how many out of 10 women would experience a complication; consequently, the answers may be biased upward. Some respondents who thought the fraction was between zero and one out of 10 are likely to have rounded up to one to avoid extreme underreporting. Additionally, since physicians know the most about possible complications, their responses are particularly likely to be biased upward.

†In the absence of data on the distribution of women by income level according to residence, the educational level of women of reproductive age is used as a proxy for poverty level in weighting at the country and subregional levels. The assumption made is that women with incomplete primary schooling (5–7 years, depending on the country) are poor, and that women with higher levels of schooling are nonpoor. (The cutoff points were higher for the Philippines, Sri Lanka and Malaysia—9–10 years—because overall levels of education are much higher in these countries.) These distributions were obtained from data gathered for the Demographic and Health Surveys. In the absence of such survey data, we assigned Myanmar, Laos and Cambodia together the distribution of Pakistan; Vietnam the educational and residence distribution of Indonesia; and Nepal that of India.

Table 5. Health professionals' estimates of percentage of women having an abortion who are hospitalized for complications, by poverty status and residence, according to geographic area

Geographic area	All	Nonpoor urban	Nonpoor rural	Poor urban	Poor rural
Regional total	15	12	18	16	15
Subregion					
South Central Asia	15	11	18	16	15
Southeast Asia	16	13	17	16	17
Country					
Afghanistan/Iran/Pakistan	9	10	12	14	7
Bangladesh	21	13	19	19	23
India	15	10	18	15	15
Indonesia	13	14	18	14	11
Myanmar/Laos/Cambodia	27	15	20	26	29
Nepal	19	14	20	23	19
Philippines	27	22	29	30	30
Sri Lanka/Malaysia	21	6	21	24	28
Thailand	22	9	20	19	24
Vietnam	4	4	3	2	5

of complications is thought to be very similar in India and Thailand, even though abortion is legal in the first but not in the second. Finally, the estimate that only one-quarter of poor urban and nonpoor rural women in Sri Lanka and Malaysia who have abortions experience complications is not surprising, given respondents' belief that roughly three-quarters of these women who have abortions obtain them from medically trained practitioners.

Women in Myanmar, Laos and Cambodia are believed to have the highest risk of experiencing serious medical complications from an induced abortion (46%); those in Bangladesh, Indonesia, Nepal and the Philippines are estimated to have a moderate risk (about 40%). As expected, Vietnamese women are thought to have the lowest risk (11%).

Hospitalization for Complications

In many areas of the developing world, the likelihood that a woman experiencing complications from an unsafe abortion will receive treatment for her condition may depend chiefly on whether she lives near a hospital or maternity clinic and whether she can afford to pay for services. Furthermore, out of fear or ignorance, women suffering abortion-related complications may be deterred from going to a hospital emergency room. Many might opt to stay at home and hope the condition will clear up without medical intervention, or might try to treat it by taking a modern or traditional drug. In addition, women with less serious complications may go to a private doctor and receive treatment that does not require hospi-

*The possibility of upward bias should be taken into consideration because respondents' direct experience with abortion-related complications may have led them to overestimate the prevalence of complications and the need for hospitalization.

talization. For these reasons, the survey asked respondents to estimate women's chances of receiving treatment for abortion complications, according to their residence and poverty status.

Overall, informants estimated that between four and six in 10 women experiencing a complication from abortion will be hospitalized; the only substantial variation by subregion was found in estimates for poor rural women and nonpoor urban

women (Table 4). By combining these data with the estimates of the proportion of women having an abortion who are likely to experience a serious complication, we obtained estimates of the proportion seeking an abortion who are thought to be hospitalized for complications.* This proportion is relatively consistent, regardless of women's poverty status and residence: 12% of nonpoor urban women and 15–18% of others (Table 5). Therefore, although rural women probably have poorer access to hospitals than urban women, they are thought to have a higher complication rate and thus a generally similar rate of hospitalization for complications.

In the Philippines, nonpoor urban women having an abortion are believed to be hospitalized at almost twice the rate (22%) as the average for this subgroup. This estimate reflects perceptions that in the Philippines, these women have a high abortion-related complication rate and an above-average chance of hospitalization. In fact, for all four subgroups, perceived hospitalization rates in the Philippines are higher than the subregional averages. Similarly, respondents in Myanmar, Laos and Cambodia, in Sri Lanka and Malaysia and in Thailand reported that poor rural women having an abortion are more likely than average to be hospitalized.

Only in Afghanistan, Iran and Pakistan and in Indonesia do health professionals believe that poor rural women having an abortion are less likely than all other groups to be hospitalized. (The same appears to be true in Vietnam, but the proportion is based on too few responses to be meaningful.) In Afghanistan, Iran and Pakistan, this difference results from the respondents' view that poor rural women are much less likely than poor urban women to be within reach of a hospital, given that the two

groups are estimated to run very much the same risk of experiencing medical complications from an abortion (30–33%). And in Indonesia, where poor rural women are thought to have an even higher probability of complications (44%), their access to hospitals is also perceived to be much lower than average.

Because the likelihood of hospitalization depends on the accessibility of services, rather than on the type of provider or women's socioeconomic status, it varies less within and between countries than the likelihood of complications. The country averages range from less than one in 10 in Vietnam and in Afghanistan, Iran and Pakistan to about one in four both in Myanmar, Laos and Cambodia and in the Philippines. At the subregional and regional levels, an estimated one in seven women having abortions are hospitalized for a medical complication.

Use of Public Health Sources

The respondents were asked to assess whether women with abortion complications commonly, sometimes or rarely seek treatment from government and private hospitals and clinics; doctors' and nurses' offices and homes; trained and untrained traditional birth attendants' homes; and pharmacies, dispensaries and drugstores. Overall, four in five respondents think that poor women commonly use public hospitals or clinics, whereas close to half believe that nonpoor women commonly use these sources.

By subregion, participants differed only in their perceptions about nonpoor rural women. Some two-thirds of those from Southeast Asia believe that these women go to a public hospital or clinic if they have an abortion complication, compared with fewer than half of those in South Central Asia. This finding suggests that nonpoor rural women in South Central Asia may be more likely than their Southeast Asian counterparts to seek care from private sources. Given that in India, respondents believe that about three out of five nonpoor and one in three poor rural women seeking abortions go to physicians, this seems plausible.

Why Women Have Abortions

Respondents were given a list of the most common reasons for women to seek an abortion and were asked to rate each as very frequent, frequent, somewhat frequent or infrequent. Broadly, overwhelming proportions of respondents in both subregions reported that unplanned pregnancy is a very frequent or frequent

reason for women to have an induced abortion. More specifically, a variety of reasons may explain why a woman would not welcome a pregnancy—predominantly, economic difficulties (63–68%).

The only other choice listed by a substantial proportion of informants was that the woman was not married, but this reason carried far less weight in South Central than in Southeast Asia. This contrast may result from the societal assumption in much of South Central Asia that women simply do not have intercourse before marriage. (Age at marriage is quite low in this subregion—ranging from 14.1 years in Bangladesh to 18.1 in Pakistan¹⁹—and adolescent girls are closely supervised by their families.)

Small proportions of participants think that women frequently or very frequently have abortions because of their young age or because they have learned that the fetus is deformed. Protection of the life of the pregnant woman is thought to be a significant factor in Bangladesh, Indonesia and Vietnam (one-third to one-half). Only in India and Nepal do substantial proportions of respondents perceive rape or incest as a frequent reason for abortion (close to one in four).

What is known about childbearing aspirations and patterns of contraceptive practice in these countries? Table 6 summarizes pertinent findings from the most recent Demographic and Health Surveys in the seven study countries that have had such a survey. A comparison of the total fertility rate and desired family size suggests that women in Bangladesh, Pakistan and the Philippines are having somewhat more children than they want; the reverse is true in India, Indonesia, Sri Lanka and Thailand. The commonly held opinion that unplanned pregnancies are the major reason why women in these two subregions have abortions is consistent with the available data on levels of unplanned fertility: Some 24–47% of women in these countries reported that their last birth was unplanned (i.e., not wanted at the time it occurred or not wanted at all).

What accounts for these rates of unplanned childbearing? In all of the countries except Sri Lanka and Thailand, 50–88% of women of childbearing age are not using any contraceptive method; 15–21% in the Philippines and Sri Lanka rely on traditional methods (primarily withdrawal and periodic abstinence). Furthermore, large proportions of women stop using their method because of side effects, particularly in Bangladesh, Indonesia and Thailand (27–41%). Addi-

tionally, in most of these countries, roughly 20% of women aged 15–44 have an unmet need for family planning.

In these circumstances, the chances are high that many women will face an unintended and often unwanted pregnancy, and that many will choose to have an abortion. Of the countries included in Table 6, the Philippines demonstrates perhaps the most overwhelming degree of family planning problems: Filipino women have nearly two children more than they would like, and an estimated 31% of Filipino women of reproductive age have an unmet need for contraception.²⁰

Postabortion Counseling

Respondents were asked if they think that women receive contraceptive counseling either from their abortion provider or from staff at a hospital where they are treated for a complication. About one-fifth believe that most women in the region who have an abortion obtain counseling from their provider, but about three-fifths believe that most women who are treated for a complication are counseled at that time. Vietnam and Indonesia stand out, with 50% of health professionals reporting that most women are counseled by providers. In Bangladesh and India, the proportions who think that most women obtaining an abortion receive contraceptive counseling from the provider are unexpectedly low, given that menstrual regulation and abortion, respectively, are permitted.

Discussion

Because of the wide range of countries, cultures and abortion situations represented in our study, it is not easy to make broad generalizations from the findings. Nevertheless, we can say with confidence

that women of all socioeconomic levels in South Central and Southeast Asia are obtaining abortions, primarily to terminate unplanned pregnancies, many of which are unwanted because of economic problems, and that these procedures are performed by practitioners with a wide range of skill and in greatly differing conditions of safety. The findings illuminate two aspects of the abortion issue in Asia: the impact of the procedure's legal status and availability, and the health problems likely to result from clandestine abortion.

Legality and Availability

The legal status and availability of abortion in these countries can be broadly categorized into four types of settings, which have an important impact on the conditions under which women obtain abortions:

- *Abortion is legal, and safe abortion services are available.* Vietnam and Singapore are the only countries in our study that fit this description. The estimated complication rate in Vietnam is much lower than average for Southeast Asia. (The maternal mortality ratio also is much lower than the subregional average—105 maternal deaths per 100,000 live births compared with 330 per 100,000.²¹)

- *Abortion or menstrual regulation is legal, but the availability of safe abortion services is poor and many women obtain clandestine abortions.* Only Bangladesh and India fall into this category. The proportion of women in Bangladesh who know that abortion is legal or where to obtain services is low.²² In addition, an estimated 25–33% of women seeking menstrual regulation from a provider with formal training in the method are rejected for various reasons, 87% of them because the pregnancy is too advanced.²³ Furthermore,

Table 6. Fertility-related measures that may contribute to levels of unplanned pregnancy, seven countries

Measure	Bangladesh (1993–1994)	India (1992–1993)	Indonesia (1991)	Pakistan (1990–1991)	Philippines (1993)	Sri Lanka (1987)	Thailand (1987)
Total fertility rate	4.1	3.6	2.8	5.9	3.8	2.4	2.1
Desired family size	2.7	3.8	3.4	5.3	2.2	3.3	2.8
% of women 15–49 whose last birth was unplanned	33	24	24	24	47	39	33
% of married women 15–49 using no method	55	59	50	88	60	38	35
% of women 15–49 using a traditional method	9	4	3	3	15	21	1
% of users who discontinued a method for health reasons	41	15	27	u	18	10	27
% of women 15–44 with unmet need for family planning	19*	20*	19	28	31	19	11

*Based on currently married women 15–49; for a complete description of the measure, see: reference 20. Note: u=unavailable. Sources: Bangladesh—S. N. Mitra et al., *Bangladesh Demographic and Health Survey, 1993–1994*, Macro International, Calverton, Md., USA, 1994, Table 6.4, p. 86; India—International Institute for Population Sciences, *National Family Health Survey, India, 1992–93*, Bombay, 1995, Table 7.5, p. 188; other countries—see: reference 20.

rural women are in purdah, which means that many cannot obtain this service unless female family welfare visitors are trained to perform menstrual regulation and are permitted to provide it at women's homes. Given these circumstances, it is not difficult to understand the high level of reliance on traditional methods and providers, and the high rates of complication and hospitalization.

In India, small-scale studies show that government providers may be uncaring toward women, fail to ensure confidentiality, require women to obtain the consent of their husbands (even though this is not legally necessary) and often require that women obtaining an abortion accept sterilization or an IUD.²⁴ Conditions such as these help explain why so few Indian women obtain abortions through the official health system.

• *Abortion is legally restricted, but a substantial proportion of procedures are performed by health professionals.* Many of the countries in these subregions reflect this situation. For example, given the broad range of providers in Indonesia, abortion probably is widely used,²⁵ despite large increases in contraceptive prevalence over the past 20 years. The proportion of women seeking abortion who are believed to obtain safe medical procedures varies widely by poverty status, but is higher than expected.

Likewise, in the Philippines, medical professionals provide abortions, although it is illegal to do so. However, the proportion of women seeking abortions who go to medically trained providers is believed to be lower in the Philippines than in any of the other countries in our study. The strong opposition to abortion voiced by several Filipino doctors participating in the survey—which generally reflects the attitudes of the Filipino medical community²⁶—supports this perception.

Sri Lanka, Malaysia and Thailand, which are more economically advanced and have better health infrastructures than other Southeast Asian countries, illustrate that the safe medical provision of abortion can go a long way toward offsetting the potential serious consequences of clandestine abortion. In these countries, urban women seeking abortions reportedly rely on medically trained providers with some frequency, and these providers are thought to use mainly safe methods (vacuum aspiration and D&C). In addition, self-induced procedures are believed to be rare in urban areas. However, rural women and poor women often lack access to safe abortion services.

• *Abortion is highly restricted; the vast majority of procedures are clandestine, and a high proportion are unsafe.* This is the case in Afghanistan, Iran and Pakistan; Myanmar, Laos and Cambodia; and Nepal. Although the desire for large families is a widespread norm in these countries, abortion has been, and continues to be, a traditional practice; in some countries, it may be increasing in prevalence, especially in urban areas.²⁷ However, large proportions of women seeking abortions, particularly those who are poor, go to traditional providers, and in some of these countries, the complication rate exceeds two-fifths of women having abortions.

Health Problems

The estimated annual abortion rate for the two subregions combined is 30 abortions per 1,000 women aged 15–44. The estimated rate is higher for Southeast Asia (36 per 1,000) than for South Central Asia (25 per 1,000), which is characterized by more traditional and conservative cultural, social and religious norms, and is less developed and less far along in the demographic transition.²⁸

The overall rate suggests that about 3% of women in Southeast and South Central Asia have an abortion each year.²⁹ If, as our findings indicate, one-third of women who have an abortion experience a medical complication, then each year, one in every 100 women in these subregions are likely to suffer at least some loss of productive days (at their job or at home) or even die as a result of an abortion-related health problem. Only about half of the women who experience complications from abortion are believed to receive hospital care; most who do not probably get no medical treatment whatsoever.

Unsafe abortions exact a severe toll not only on women's health but also on their chances of survival. In South Central Asia, WHO estimates that the maternal mortality ratio due to abortion is 81 deaths per 100,000 live births, representing 14% of all maternal deaths, or an estimated 33,000 abortion-related deaths each year. For Southeast Asia, the ratio is 43 abortion-related deaths per 100,000 live births, and these deaths account for 13% of all maternal deaths, or an estimated 5,000 abortion-related deaths annually.³⁰

One somewhat counterintuitive conclusion of our study is that in most countries, the proportion of women suffering abortion-related complications who are believed to receive treatment in a hospital is similar in rural and urban areas. What factors other than the possible over-

reporting of the likelihood of complications and hospitalization might account for these views? Do the respondents' perceptions reflect the belief that rural women's access to hospitals is generally as good as that of urban women in this part of the world? Or is the availability of hospital beds in rural areas overestimated by this predominantly urban sample?

The World Bank provides comparative country data on a health service indicator that may shed some light on the availability of hospital care: the number of people per hospital bed.³¹ Examination of the two most extreme cases supports the plausibility of survey responses to the question on hospitalization. In Indonesia, Pakistan and Afghanistan, where there are 1,502–2,945 people for every hospital bed, respondents believe that only one in four poor rural women with a severe medical complication (and slightly more than four in 10 poor urban women) will be hospitalized. By contrast, in Sri Lanka and Malaysia, where the population-to-bed-ratio is only 369–432 people per bed, an estimated eight in 10 poor rural women with complications (and nine in 10 poor urban women) are considered likely to be hospitalized.

A number of other considerations support the high estimates of likely hospitalization offered by health professionals in most countries. The density of population in some countries may mean that even rural women live close enough to a hospital that distance does not constitute a serious barrier to care. Furthermore, even in countries where access to hospitals is poor, abortion-related complications may be viewed as serious and life-threatening illnesses, and all possible efforts may be made to provide transportation to the nearest hospital for women suffering such complications. Finally, even poor women in urban areas have some access to private doctors and clinics. This factor might account for part of the perception that half to two-thirds of poor urban women in most countries, and almost all in Malaysia, receive treatment for abortion-related health complications.

While many women with serious abortion-related complications receive hospital treatment, our findings indicate a continuing need for improvements in access to such care. The findings also illustrate the need for improved contraceptive counseling, to be provided both by those who perform abortions and by those who treat complications. Few respondents believe that most women receive contraceptive counseling from their abortion provider, and although a substantial pro-

portion think that most women hospitalized for abortion complications receive such counseling, findings from other studies suggest that the latter perception may reflect what should happen, rather than what does.³²

At the very least, all medical and non-medical staff likely to be involved in postabortion care should be trained to provide sensitive counseling and referrals to other appropriate reproductive health care services. Women must have access to a broad range of contraceptive methods at prices that they can afford. This would lead to improvements in effective contraceptive use and would give women greater freedom to implement their fertility preferences. Levels of unplanned pregnancy are high in Asia: Of all pregnancies in this region (excluding China), 18% end in abortions and 19% in unplanned births.³³

Many of the abortion methods thought to be widely used in these two subregions of Asia were also cited in the Latin America survey.³⁴ The consistency across these two very different regions suggests that knowledge of safe medical techniques among doctors may be worldwide, and that lacking better options, women the world over are likely to use similar kinds of traditional, and often highly unsafe, methods when faced with an unwanted pregnancy.

Physicians who provide abortion services are believed to use D&C almost as commonly as they use vacuum aspiration, a less-invasive and more cost-effective procedure. Although information was not obtained on whether physicians vary the procedure they use depending on the length of gestation, this result suggests that D&C may be used even when it is not the most appropriate method. Clearly, more physicians and paramedics must be trained in vacuum aspiration. This would be beneficial not only in countries where abortion is legal, but also in countries where abortion is legally restricted, because it would increase the chance that women hospitalized for abortion complications would be treated with this method when appropriate.

Because quantitative data on abortion are often nonexistent, many participants had great difficulty assessing the situation in their country. Furthermore, respondents living in countries in which public opinion is strongly opposed to abortion probably had had fewer opportunities to discuss the subject openly with their colleagues (e.g., in professional forums); as a result, their responses may have been based primarily on their personal experi-

ence. Finally, because the health professionals in this survey were largely urban-based (and even though about half had work experience in rural areas), the results describing probable conditions in rural areas must be considered less dependable than those concerning urban areas. Additional interviews of rural health professionals would have been a valuable supplement to this study.

Although the study represents only part of the search for better information about abortion in Asia, it points to a number of program and policy areas in which more in-depth research—especially at the country level—is needed. So long as the termination of unwanted pregnancies remains an unexamined and undocumented issue in this part of the world, policymakers and public officials can claim ignorance about the problem of clandestine abortion or, worse, deny its existence.

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Resumen

Si bien el status jurídico y la disponibilidad de aborto inducido varía muchísimo en el Asia sud-central y sudeste, los resultados de una encuesta realizada en 1996, de 232 expertos profesionales de la salud indican que las mujeres de todos los niveles socioeconómicos se someten a abortos y muchos de estos procedimientos se realizan en condiciones que pueden aumentar los riesgos para la salud de la mujer. En general, se cree que la vasta mayoría de las mujeres con medios económicos de los centros urbanos que procuran abortos acuden a profesionales médicos idóneos; sin embargo, aproximadamente una tercera parte hasta la mitad de las mujeres pobres de los centros urbanos y de las zonas rurales recurren a una amplia gama de servicios no médicos o se inducen ellas mismas el aborto. De todas las mujeres que se someten a abortos en estos países, se cree que aproximadamente un tercio sufre complicaciones médicas, y sólo alrededor de la mitad de ellas son hospitalizadas para recibir tratamiento; en consecuencia, se estima que una de cada siete mujeres que se someten a un aborto son hospitalizadas debido a complicaciones de este procedimiento. La tasa estimada de 30 abortos por cada 1.000 mujeres de 15-44 años sugiere que anualmente, el 3% de las mujeres del Asia sudcentral y sudeste se someten a un aborto; por lo tanto, de acuerdo con los resulta-

dos de la encuesta, es probable que aproximadamente el 1% sufran complicaciones médicas.

Résumé

En dépit d'importantes variations dans le statut légal et l'accessibilité de l'avortement provoqué dans le sud de l'Asie centrale et en Asie du Sud-Est, les observations d'une enquête menée en 1996 auprès de 232 prestataires de soins de santé bien informés indiquent que les femmes de tous niveaux socio-économiques ont recours à l'avortement et que beaucoup des procédures réalisées le sont dans un cadre susceptible d'accroître les risques pour la santé de la femme. Dans l'ensemble, la grande majorité des femmes urbaines non indigentes qui cherchent à obtenir un avortement semblent s'adresser à des prestataires médicaux formés; en revanche, entre un tiers et la moitié des femmes pauvres, en milieu urbain autant que rural, font appel à un vaste éventail de prestataires non médicaux ou provoquent elles-mêmes leur avortement. De toutes les femmes qui se font avorter dans ces pays, environ un tiers souffriraient de complications médicales, et la moitié seulement de ce tiers seraient hospitalisées à ce titre. On estime ainsi à une sur sept le nombre de femmes avortées hospitalisées pour le traitement de complications. Le taux estimé de 30 avortements par millier de femmes âgées de 15 à 44 ans laisse entendre que chaque année, 3% des femmes dans le sud de l'Asie centrale et d'Asie du Sud-Est subissent un avortement; selon les résultats de l'enquête, environ 1% serait par conséquent susceptible de souffrir de complications médicales.