Clandestine Abortion in Latin America: A Clinic Profile

By Jennifer Strickler, Angela Heimburger and Karen Rodriguez

Context: *Most research on abortion in Latin America has focused on women who are hospitalized with abortion complications, but little is known about the characteristics of women who are able to obtain clandestine procedures performed by trained personnel working in sanitary conditions.*

Methods: *Analysis of medical records for 808 clients of an urban clandestine abortion service in South America was supplemented with observation of clinic operations for six weeks in 1995.*

Results: *Nearly nine in 10 clients had at least a secondary education, about three-quarters were younger than 30 and a similar proportion were unmarried. Fifty-four percent had never given birth, and 13% had had at least one prior abortion. Three-fifths of women had not been using a contraceptive method when they conceived; among users, three-fifths had been using a traditional method. Three percent experienced mild complications related to the procedure (e.g., heavy bleeding or pelvic pain), and another 2% reported serious complications (e.g., pelvic infection, hemorrhage or suspected uterine perforation).*

Conclusions: *To reduce the need for abortion, it is important for family planning programs to include women who are young, unmarried and highly educated in their outreach efforts.*

International Family Planning Perspectives, 2001, 27(1):34–36

Most published studies about abortion in Latin America are based on information from women who have been hospitalized for abortion complications.[1] In light of concern about abortion-related morbidity and mortality, this approach makes sense. However, it excludes women who suffer no complications from abortion, and it thus may create inaccurate impressions about the characteristics of women who have abortions. In particular, hospital-based studies probably underrepresent women of relatively high socioeconomic status who are able to obtain abortions from trained medical personnel in sanitary conditions—a group that has been mentioned as a priority study population for research on abortion in Latin America.[2] The apparent lack of abortion among women with moderate or high income and educational levels could lead policymakers to conclude that contraceptive use has eliminated the need for abortion among the middle class.

In this research note, we describe women who obtain pregnancy terminations at a relatively safe clandestine abortion service in a small South American city. To protect the identities of the abortion providers, we have not revealed specific details about the clinic or the country in which it is located.

Data and Methods

Our analyses include both quantitative and qualitative data. Quantitative data were drawn from the records of all women who were seen between January 1992 and June 1995. (Patients were identified by number only, to protect their privacy.) We collected information about clients' socioeconomic characteristics, pregnancy and contraceptive histories, sources of emotional support and complications experienced during or after the procedure, as well as the length of the pregnancy. The total number of patients seen during the study period is 873; however, the records for 65 patients have been lost, leaving a total sample of 808 women.

To supplement the data from the medical records, we observed clinic operations for six weeks in the summer of 1995, at the invitation of the clinic staff. Activities we observed included staff's making appointments, providing counseling, performing pregnancy terminations, keeping records, maintaining equipment and relocating the clinic; in addition, with the women's permission, we observed 15 interviews with prospective abortion patients. We also conducted in-depth interviews with providers; data from these interviews are analyzed in detail elsewhere.[3] In this research note, we present simple distributions and cross-tabulations of selected patient characteristics, supplemented by qualitative information drawn from observations.

These data are unique and provide insight into the use of clandestine abortion services. However, they describe only this group of women and are not generalizable to all women who obtain clandestine abortions.

The Clinic

The clinic has been providing clandestine abortion services since 1990, when threats of violence forced a previous abortion provider in the city out of business. It changes its location on a regular basis to protect its identity. The staff consists of two physicians, who perform the abortions, and three counselor-educators. The physicians were instructed in abortion techniques by a U.S.-trained colleague. Both physicians have other, full-time positions in family practice; thus, they do not depend on the abortion practice for their income. The counselor-educators have had no formal medical training but are college-educated; all three are self-described feminists.

Jennifer Strickler is assistant professor of sociology, University of Vermont, Burlington, VT, USA. Angela Heimburger is regional staff associate, Population Council, Mexico City; and Karen Rodriguez is meeting service officer, United Nations, New York. This research was supported by a grant from the Center for Latin American Studies at Tulane University, New Orleans, LA, USA.

Each week, 5–10 abortions are performed at the clinic for women whose last menstrual period was 6–15 weeks earlier. For women who are in the first trimester of pregnancy, manual vacuum aspiration is used to terminate the pregnancy. Women who are 12–15 weeks pregnant receive a prostaglandin cervical suppository, with instructions to seek hospital care when bleeding commences. All equipment is chemically sterilized and removed from the clinic site daily.

Obtaining an Abortion

In a country where abortion services are illegal or severely restricted, a woman with an unwanted or mistimed pregnancy is in a very precarious position. Some women resort to self-induced abortion, and many clandestine abortion providers use ineffective or unsafe techniques. Obtaining a safe pregnancy termination requires two resources: money and personal connections.

The clinic we studied uses a network of referral sources: acquaintances, psychologists, professors, physicians and other health service providers, who contact the office with the name and phone number of women requesting abortion services. For the clinic's protection, prospective clients are never given its telephone number. When the clinic receives a referral, a counselor calls the woman to arrange a meeting in a neutral location, often a public park or a crowded coffee shop.

At the initial meeting, the counselor conducts an interview and an educational session. In the interview, the counselor ascertains that the woman is clear on her decision to terminate the pregnancy, collects a medical and reproductive history, and asks whether the woman has any emotional support from her sexual partner or anyone else. The interview serves to weed out people who are not genuinely seeking an abortion, and to establish that the woman is sure of her decision and has no contraindications that would threaten her health.

After the interview, the counselor explains the procedure that is used to terminate the pregnancy, describes the instruments involved (speculum, tenaculum and cannula) and discusses the use of local anesthesia. She briefly discusses the legal status of abortion and the importance of abortion as a choice for women with an unwanted pregnancy. The objectives of this counseling are to empower the woman to take responsibility for her decision, provide her with information about her body and the procedure, and explore any beliefs she may hold about abortion's being morally wrong or sinful, to ensure that she is comfortable with her decision to terminate the pregnancy.

The woman is also counseled about the need for confidentiality for the providers, and she must agree not to reveal the location of the office to anyone else. Finally, a date for the abortion is set, a meeting place near the clinic is arranged and a fee is agreed upon. The clinic has sliding fees, which range from $20 to $200; the woman pays the counselor in cash at the time of the procedure. To put this price in context, the country's per capita gross national product was approximately $1,400 in 1993.[4]

On the date of the procedure, the counselor meets the woman and escorts her to the office. A partner, friend or relative may accompany the woman, if she chooses. At this point, she meets the physician, who performs a gynecologic examination and takes a medical history. With the counselor at the woman's side, the pregnancy is terminated in less than 20 minutes. Afterward, the woman rests until she is feeling well and bleeding is controlled, normally half an hour. Women are referred to the local family planning program for follow-up information on contraception. Clinic staff do not provide contraceptive counseling at the time of the abortion because they believe that patients are too preoccupied to absorb the information and most patients know how to obtain contraceptives.

Before the woman leaves the clinic, she is given a prescription for prophylactic antibiotics to prevent pelvic infection and instructions to contact the clinic (through her original referral source) if she has any symptoms of infection (i.e., fever, abdominal pain or heavy bleeding) or hemorrhage. All women receive follow-up phone calls from the counselor to screen for signs of complications; if there is any concern, they return to the clinic for medical follow-up. The providers report that only one patient has required emergency hospitalization in all of the clinic's years of practice.

Patient Characteristics

Eighty-seven percent of women obtaining abortions at the clinic had at least a secondary education, and 29% were currently enrolled in school (Table 1). According to these findings, the clinic clients were more highly educated and more likely to be in school than are women in the general population.[5] Roughly three in four abortion patients were younger than 30, and the same proportion were unmarried.

Some 46% of patients had had no previous pregnancy, and 54% had no children. Only 9% had had three or more births, in a country where the total fertility rate is approximately three births per woman. The low fertility of these women is at least in part due to their being generally young and unmarried; it also suggests, however, that they are using abortion to space or postpone births. Thirteen percent of women attending the clinic had had a prior induced abortion.

We had expected that the difficulty of finding an abortion provider would delay the procedure for many women. However, 64% of the women were 6–8 weeks pregnant (as measured from the date of their last menstrual period), 30% had been pregnant for 9–12 weeks and only 6% were more than 12 weeks pregnant. Adolescent women were more likely than

Table 1. Percentage distribution of abortion clients, by selected characteristics

Characteristic	%
BACKGROUND	
Education (N=771)	
≤primary	13.2
Secondary	48.9
Postsecondary	37.9
Currently in school (N=793)	
Yes	28.8
No	71.2
Age-group (N=788)	
<20	13.3
20–24	30.7
25–29	28.6
30–34	15.1
≥35	12.3
Marital status (N=774)	
Unmarried	77.9
Married	22.1
PREGNANCY HISTORY	
Previous pregnancies (N=783)	
0	45.6
1–2	41.6
≥3	12.8
Previous births (N=800)	
0	54.1
1–2	37.3
≥3	8.6
Prior induced abortions (N=361)	
0	87.5
≥1	12.5
CIRCUMSTANCES OF PREGNANCY/ABORTION	
Weeks since last menstrual period (N=792)	
6–8	64.1
9–12	30.3
>12	5.6
Used method at conception (N=442)	
Yes	38.7
No	61.3
Role of partner (N=733)	
Supportive	53.3
Unsupportive	9.4
Partner does not know	35.2
Other	2.0
Total	100.0

Table 2. Percentage of patients experiencing postabortion complications, by duration of pregnancy (in weeks since last menstrual period), according to severity of complication

Duration	N	Total	Mild	Serious
Total	**792**	**4.6**	**2.6**	**2.0**
6–8	508	3.6	2.2	1.4
9–12	240	5.4	2.5	2.9
>12	44	11.4	9.1	2.3

those aged 20 or older to be more than 12 weeks pregnant—12% vs. 5% (not shown).

Three-fifths of the women reported not having used a contraceptive at the time of conception. This proportion also varied by age: 27% of teenagers, compared with 41% of older women. Of those who had been practicing contraception, 60% had used traditional methods and 40% modern methods (not shown).

Almost two-thirds of the women had told their partner about the abortion, and one-third had concealed either the pregnancy or the abortion. Of those who had informed their partner, the vast majority (53% overall) described him as "supportive" (Table 1). Given this high level of support, it is noteworthy that during our six weeks of observation, we never saw a male partner accompany a woman to the clinic for her abortion.

Abortion Complications

We assessed the incidence of mild and serious abortion complications. Mild complications are heavy bleeding; pelvic pain; vagal reaction (drop in blood pressure, feeling faint); subsequent menstrual irregularities; and severe guilt, anxiety or depression. These conditions may require medical attention, but they are not threatening to life or long-term health. Serious complications are pelvic infection, hemorrhage, retained fetal tissue, fever and suspected uterine perforation.

The vast majority of women had no ill effects from the abortion. However, 3% suffered from mild complications, and 2% had severe complications (Table 2). Women who were more than 12 weeks pregnant experienced the highest rate of mild complications (9%), possibly because of the duration of the pregnancy. The experience of these women, however, is not strictly comparable to that of women who had their abortion earlier in pregnancy, because at later gestations, the clinic only provides a prostaglandin insert, and women go to a hospital for uterine evacuation. Medical follow-up included pharmaceutical treatment (antibiotics or methergine, a drug used to stem heavy bleeding) and uterine reevacuation. None of the women required hospitalization for complications of the abortion procedure.

Discussion

Clearly, our results are suggestive rather than conclusive. However, given the dearth of information about abortion in Latin America, this study provides insight into several aspects of clandestine abortion.

The profile of abortion patients presented here is quite distinct from that found among women hospitalized for complications in the late 1970s,[6] the majority of whom were married, had two or more children, and had had fewer than eight years of schooling. These differences may be partly due to changes over time in the type of women who have abortions (i.e., abortion patients may be becoming younger and better educated). They also may reflect variations in access to safe abortion services (i.e., hospital admissions data overrepresent women who are unable to obtain safe clandestine services). However, recent research in several Latin American countries suggests that young women and unmarried women are at particularly high risk for abortion.[7]

Our findings illustrate many of the difficulties in gathering information on illegal and clandestine behavior. We cannot draw conclusions about the determinants of having an abortion, or estimate population-based abortion rates. However, it seems that unintended pregnancies occur among women who are young, highly educated and unmarried. Latin America may be following the precedent set by the United States (and much of the developed world) of increasing premarital sexual activity; family planning programs should target these women in order to reduce the need for abortion.

References

1. Nunez L, Rutas del aborto, paper presented at the Encuentro de Investigadores Sobre Aborto Inducido en America Latina y el Caribe, Bogotá, Colombia, Nov. 15–18, 1994; and Fonseca W et al., Caracteristicas medicas do aborto provocado ente mulheres admitidas em hospitais de Fortaleza, *Revista Materinidade Escola Assis Chateaubriand,* 1996, 2(1):9–12.

2. Llovet JJ amd S Ramos, Induced abortion in Latin America: strategies for future social research, *Reproductive Health Matters,* 1998, 6(11):55–63.

3. Rodriguez K and Strickler J, Clandestine abortion in Latin America: provider perspectives, *Women and Health,* 1999, 28(3):59–76.

4. World Bank, *World Tables, 1995,* Baltimore: Johns Hopkins University Press, 1995.

5. United Nations, *The World's Women, 1995: Trends and Statistics,* Social Statistics and Indicators Series, New York: United Nations, 1995, Series K, No. 11.

6. Paxman J et al., The clandestine epidemic: the practice of unsafe abortion in Latin America, *Studies in Family Planning,* 1993, 24(4):205–226; and International Fertility Research Program (IFRP), *Abortion in Latin America,* Research Triangle Park, NC, USA: IFRP, 1980.

7. Misago C and Fonseca W, Determinants and medical characteristics of induced abortion among poor urban women in north-east Brazil, in: Mundigo A and Indriso C, eds., *Abortion in the Developing World*, London: Zed Books, 1999, pp. 217–227; and Zamudio L et al., The incidence and social and demographic characteristics of abortion in Colombia, in: ibid., pp. 407–446.