Refugee and Internally Displaced Women's Abortion Knowledge, Attitudes and Practices: Addressing the Lack of Research in Low- and Middle-Income Countries

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Induced abortion is common: In 2017, an estimated 56% of all unintended pregnancies worldwide ended in abortion.[1] Despite the frequency with which women terminate pregnancies, however, 135 countries impose restrictions on induced abortion beyond gestational age limits,[2] which lead some women to seek unsafe abortion. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy carried out by individuals who lack the requisite training and skills, in a setting that does not meet minimum medical standards, or both.[3] An estimated 25 million unsafe abortions occur annually—nearly all (97%) in low- and middle-income countries (LMICs), where abortion is more likely to be heavily restricted.[3] Unsafe abortion results in 22,800–31,000 maternal deaths each year.[4] Furthermore, in developing regions, nearly seven of every 1,000 women are treated in a health facility for abortion complications.[4] The legalization and derestriction of abortion are necessary steps in reducing maternal morbidity and mortality from unsafe abortion, but there are additional obstacles to services that must also be addressed.

The various barriers that preclude women from seeking safe abortion services where available are well documented.[5–8] Inadequate public health systems in LMICs restrict service availability. For example, abortion has been legal in India for decades, but unsafe abortion remains a serious concern; approximately 70% of India's population lives in rural settings, and safe abortion services are rarely available in rural health centers.[5] After arrival at a facility, women may be deterred or prevented from obtaining abortion services because of provider bias or conscientious objection.[6] Cost is another barrier that may preclude women from accessing the services they need and desire.[7] Furthermore, lack of knowledge about available services and the stigma associated with abortion may prevent women from seeking services.[8]

Barriers to abortion particularly affect young people—a vulnerable group who are more likely to experience unintended pregnancy and unsafe abortion.[1] However, there is much research aimed at learning about adolescents' and youths' abortion knowledge, attitudes and practices, including two literature reviews published in the last two years that explore the topic in LMICs.[9,10] The same wealth of published research does not exist for refugees and internally displaced persons (IDPs), who represent another population that is recognized by the United Nations as being vulnerable. Sustainable Development Goal 10, Reduced Inequalities, calls for no one to be left behind, including refugees and IDPs.[11]

Refugee Women's Need for Comprehensive Abortion Care

Refugees and internally displaced women are exposed to particularly high levels of sexual violence, and may also need to engage in transactional sex for survival.[12] In addition, they are more likely to have reduced access to contraceptives. As a result, compared with the general population, refugees and IDPs may more commonly experience unintended pregnancies and, thus, may have a greater need for abortion services. However, refugees and IDPs face substantial barriers to accessing safe abortion care, which increase their chances of turning to unsafe abortion. There are numerous reasons why unsafe abortion is prevalent among refugees and IDPs: They may lack information about the legality or availability of safe abortion services in their new environment, or abortion may be highly stigmatized in their culture or in their host culture, which could prevent them from seeking safe and legal services.[12,13] In addition, refugees may be financially burdened or unable to communicate adequately with providers if a language barrier exists.[12]

The lack of appropriate services for refugee and internally displaced women forces us to reckon with a staggering figure: According to the United Nations Population Fund, an estimated 25–50% of maternal deaths in refugee settings are due to complications from unsafe abortion.[14] Despite the severity of this problem, however, there are no current estimates of the prevalence of unsafe abortion in refugee or internally displaced settings, or even reliable statistics indicating the extent to which safe induced abortion occurs in this context. Furthermore, there is a dearth of research on refugee and internally displaced women's abortion knowledge, attitudes and practices (KAP) in LMICs. Without this information, we cannot adequately address the epidemic of unsafe abortion, nor can we ensure that refugees and IDPs have access to high-quality reproductive health services that meet their needs as a population.

What is Known?

To gauge what is known about abortion KAP among refugee and internally displaced women in LMICs, we conducted an initial review of PubMed and of the first 300 entries on Google Scholar for peer-reviewed journal articles published in English in the past 10 years. This

search yielded 16 articles from nine countries: Burkina Faso, Colombia, the Democratic Republic of the Congo (DRC), India, Myanmar, Somalia, South Sudan, Thailand and Uganda. Articles that addressed the topic ranged from those that center the experiences of refugee and internally displaced women through focus group discussions (FGDs), in-depth interviews (IDIs) and surveys, to those that focus on abortion as a secondary health outcome or evaluate the implementation of a program supporting access to safe abortion care services.

• *Research that centers women's abortion experiences.* To our knowledge, only one study has explored refugee and internally displaced women's abortion KAP in LMICs as a primary outcome. Nara and colleagues focused on Congolese refugees' experiences with postabortion care (PAC) in Uganda, the largest refugee-hosting country in Africa.[15] Abortion is legally restricted in Uganda, and permitted only to save the life of the woman or in cases of rape, incest or fetal anomaly. Congolese refugees face extreme difficulty navigating these legal restrictions and, as a result, unsafe abortion is common among this demographic. While PAC is legal in Uganda, it is often inaccessible due to lack of awareness and provider bias.

The authors conducted a reproductive health needs assessment of Congolese refugees living in Kampala and the Nakivale Refugee Settlement, which included IDIs with key informants (i.e., policymakers, health providers and nongovernmental organization representatives), as well as FGDs and IDIs with Congolese refugee women of reproductive age. Most refugees did not discuss their own abortion experiences, but instead those of other women in their communities who used unsafe practices—including using detergents, herbs, crushed bottles and large doses of oral contraceptives—to try to induce abortion. Key informants explained how refugees and health providers fear the perceived legal consequences of induced abortion, as well as PAC.

Provider bias served as an additional barrier to PAC among refugees. One refugee described how she received medication from a pharmacy to end her pregnancy, but was not given information on how to use it, and experienced severe bleeding. When she went to the hospital for PAC, hospital staff questioned why she tried to induce an abortion. Her friend implored the doctors to treat her, and after five hours, she received manual vacuum aspiration and antibiotics. She believed that providers were punishing her for attempting to induce an abortion. Another refugee, who used an herbal abortifacient, waited nearly a month to seek PAC—despite experiencing weeks of sharp abdominal pain—because she feared that providers would tell members of her community that she attempted to induce an abortion. The research highlights the need for providers who not only know the existing laws but can treat complications from unsafe abortion in a nonjudgmental and confidential manner, since fear of provider bias impedes Congolese refugee women from accessing PAC in Uganda.

• *Research that focuses on abortion as a secondary health outcome.* The majority (10) of the articles we found described studies that employed qualitative, quantitative or mixed-methods research techniques to examine at least one dimension of KAP—knowledge, attitudes or practices—related to induced abortion.[16–25]

Two of the articles described studies in which refugee or internally displaced women discussed their knowledge of abortion. A study by Ward included IDIs with Tibetans living in Dharamsala, India, and found a confused understanding of reproductive health interventions: Female participants would mention "abortion and sterilization" and continue on to speak about contraceptive use.[16] Gure et al. explored reproductive KAP of internally displaced Somali women through FGDs.[17] Participants discussed the illegality of abortion, and were aware of self-induction techniques considered to be unsafe, such as the misuse of common medications, and believed that the use of these techniques was widespread. They also knew of "*Xaqitaan*" ("sweepers"), who are illegal abortion providers in Mogadishu; women were wary of these services due to the belief that these providers used unsafe methods.

Seven articles described studies that touched on women's attitudes toward abortion. Results from interviews with internally displaced young mothers in Bogota, Colombia revealed that they believed that carrying an unplanned pregnancy to term was more honorable than having an abortion.[18] FGDs with women in humanitarian settings in Burkina Faso, the DRC and South Sudan mentioned abortion as a negative practice that conflicts with religious beliefs.[19] In Gure et al.'s study of reproductive health attitudes among displaced women in Somalia, many participants expressed that abortion was forbidden in their culture and, thus, they opposed the practice.[17]

Results from a survey of a sample of refugee and internally displaced youth in Kampala, Uganda revealed that the vast majority of young women and men (93% and 87%, respectively) reported that they behaved differently toward individuals who had had an induced abortion;[20] most (80–81%) also believed that abortion service recipients were "bad girls." Results from a survey on family planning KAP among individuals on the Thailand-Myanmar border showed that only 4% of respondents believed that it is acceptable for women to terminate a pregnancy because they are poor, have other children or became a widow during pregnancy;[21] 87% believed that such women should instead carry the fetus to term and keep it, and 9% that they should carry the fetus to term and opt for adoption. In another study on the Thailand-Myanmar border, which focused on adolescent women, some participants reported that they had considered abortion when they had experienced an unintended pregnancy, but did not seek services because of fear and traditional beliefs.[22]

In a study examining how abortion attitudes are influenced by government policy, Tibetan refugees in India spoke about abortion in the context of the Chinese government forcing Tibetans to undergo abortion or

sterilization procedures.[16] Many participants described being a decimated ethnic minority that is "underpopulated" and portrayed forced abortion as a tool of genocide. While abortion was generally discussed as a negative phenomenon for these understandable reasons, one refugee explained her belief that "Abortion is ultimately about the individual's choice, the individual's way of thinking and whether the individual is ready for a baby or not." This was the only article we found that discussed any positive attitudes associated with abortion.

Five articles discussed refugee and internally displaced women's practices related to abortion, and each spoke to the prevalence of unsafe abortion procedures. In one study, two women on the Thailand-Myanmar border had attempted to self-induce abortion and then had sought out a traditional birth attendant to complete the procedure.[23] Internally displaced women living in camps in the DRC participated in a survey on family planning knowledge and use that touched upon the topic of abortion:[24] Forty-two percent of respondents reported ever experiencing an unintended pregnancy, 21% reported having had an induced abortion, and 61% had self-induced an abortion. Research on gender-based violence among displaced women in Colombia revealed that several participants experienced forced abortion that coincided with rape:[25] Using physical violence, captors in conflict settings and intimate partners in postconflict settings attempted to induce abortion for these women.

The last two articles on abortion practices did not include participants' firsthand experiences; instead, women participating in FGDs mentioned the practices of women in their communities. In a study about women's reproductive health knowledge in Mogadishu, Somalia, participants revealed that many displaced Somali women resort to the unsafe abortion technique of medication misuse, such as aspirin or drugs used to treat malaria or allergies.[17] Participants in FGDs in Burkina Faso, South Sudan and the DRC discussed how women in their communities engage in unsafe abortion practices, but specific methods were not named in the article.[19]

• *Research that evaluates program implementation.* The remaining four articles were evaluations of the Safe Abortion Referral Programme (SARP) on the Thailand-Myanmar border.[26–29] These studies used primary data from interviews with women who received or were denied abortion services through the program and from logbooks of abortion service provision, and each addressed at least one dimension of abortion KAP. One article reported that women were aware of the illegality of medication abortion and, thus, would recommend induced abortion only to women whom they believed would otherwise use an unsafe method or had a "good reason" to terminate their pregnancy.[26] Other studies found that more than half of participants knew about SARP through informal connections,[27] and noted that outside of the referral system, most women interviewed did not know where they could legally obtain an abortion in Thailand.[28]

The women in these studies sought out medication abortion to avoid poverty, job insecurity, unstable or abusive relationships and the potential hazardous side effects of other induced abortion methods, as well as to allow them to continue working to support their families and provide for the needs of their other children.[26,27] In cases where women received induced abortion services through SARP, but remained pregnant at follow-up, the women carried the pregnancies to term.[26,28,29] In cases where women were refused services through the program, they either sought out informal services—such as pummel massage, traditional medicines or alcohol—or carried the pregnancy to term.[27,28]

Research participants in this group of studies were exposed to a specific intervention on the Thailand-Myanmar border, and the purpose of these evaluations was to better understand the mechanism of the referral program, unlike other studies included in our literature review. We did not, therefore, feel that these results could be generalized.

Much Remains Unknown

From the studies we found in the literature, we were able to draw few conclusions about the abortion knowledge, attitudes and practices of refugee and internally displaced women in LMICs. Too little research has directly explored such women's knowledge of and attitudes toward induced abortion, and even less has examined their practices. In some studies, no distinction was made between host community, migrant or refugee research participants. The one study we found that examined refugee's abortion KAP as a primary outcome examined women's experiences with accessing treatment for complications related to self-induced abortion, not their experiences with trying to access safe abortion services.[15] Researchers often struggle to secure funding for studies related to safe abortion and sometimes face pressure to focus on "less controversial" issues.[30] This could, at least partially, explain the dearth of research on refugee and internally displaced women's KAP related to induced abortion in LMICs.

In the articles we identified, certain countries were overrepresented, such as Thailand, while other countries were severely underrepresented, particularly those in Western Asia that host Syrian refugees. Currently, the countries producing the most refugees are Syria, South Sudan and the DRC,[31] yet we did not find any relevant studies that included Syrian refugees or IDPs. Similarly, nine out of the 10 countries with the largest refugee populations–Bangladesh, Ethiopia, Iran, Jordan, Lebanon, Pakistan, Sudan, Turkey and Uganda–are LMICs,[31] yet we only found research on refugee and internally displaced women's abortion KAP in one of these, Uganda. More research on this topic is needed, and future research should focus on LMICs that host large populations of refugees and IDPs.

Call to Action

The need for this research is urgent: The number of individuals displaced due to persecution, conflict, violence or

human rights violations was nearly 80 million worldwide at the end of 2019—almost double that in 2010.[32] There is a clear upward trend in the size of the forcibly displaced population each year, and we should not expect this to change anytime soon. Abel et al. modeled the short-term effects of climate change on conflict and forced migration, and found that conditions caused by climate change—particularly conflict and severe drought—had contributed significantly to the number of individuals seeking asylum between 2011 and 2015.[33] And according to a 2018 World Bank report, an estimated 143 million individuals could be internally displaced by climate change by 2050;[34] even if steps are taken to minimize harmful impact to the environment, as many as 40 million individuals around the world may still be affected.

The root causes of displacement are accelerating, and we need to meet the challenge that this presents. The increasing number of refugees and IDPs will need targeted programming to meet their sexual and reproductive health needs. We cannot design and implement appropriate programming for LMIC refugees and IDPs, properly advocate for these populations and effectively address the epidemic of unsafe abortion without understanding these women's existing knowledge, attitudes and practices related to abortion.

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