

## **Causes and Consequences of Unwanted Pregnancy from Asian Women's Perspectives**

*Sandra M. Kabir*

### ***Abstract***

*Shortcomings of contraceptives and of family planning delivery systems are major reasons for unwanted pregnancy and unsafe abortion in Third World countries. Family planning and health programs should provide empathetic counseling for contraceptive choices and pregnancy termination, adjust management systems and procedures to facilitate women's access to services and information, and offer comprehensive services to meet their multiple reproductive health needs.*

### **Who are the women who have unwanted pregnancies and induced abortions in Third World countries?**

- They are young and unmarried, forced to begin sexual relations very early to prove their fertility or to satisfy a boyfriend.
- They are the victims of rape or incest.
- They are married, without or with children.
- They are rich and poor, and come from both urban and rural areas.
- They live in a wide variety of social, cultural, religious, legal, and political environments.
- They may have safe abortion services readily available to them. Too often, they do not and they resort to unsafe means out of desperation, especially if they are poor.
- They have many compelling reasons for terminating their pregnancies, but they are criticized, even rejected, by families, friends, and society.

In Bangladesh, for example, most women who seek menstrual regulation (early abortion) from clinics of the Bangladesh Women's Health Coalition are married. On average, they are 25-29 years old and have two living children. Their

economic and educational levels are slightly higher than the average for the country. The majority of Coalition clients were not using contraception 3 months prior to seeking menstrual regulation, but over 88% accept a method of contraception afterwards [1]; 94% of these clients are continuing to use contraception 1 year later [2]. (A study is underway to follow these clients for 4 more years.)

Although record-keeping systems are inadequate or nonexistent and many abortions are not reported, it is estimated that, worldwide, 40-60 million induced abortions are performed each year [4]. Every year, hundreds of thousands of these women die unnecessarily or suffer disastrous consequences, including sepsis and sterility, from clandestine abortion. In Bangladesh, it has been reported that at least 7800 women die due to abortion complications each year [6] [7].

### **Why do women have unwanted pregnancies?**

A major reason for unwanted pregnancy is the shortcomings of contraceptives and family planning delivery systems. "Millions of women who want to limit or space births do not use modern contraceptives because they fear the technology; they find services unavailable, inaccessible, or unacceptable; they are restrained by partners, family, or the community; or they lack information"[3]. Whether a woman wants to space births, or delay childbearing, she faces difficult decisions. Should she try to follow a natural method and abstain during the fertile period, perhaps risking anger or rejection by her partner and exposing herself to a higher risk of conception? Or, to reduce the risk of accidental conception and the need for cooperation from her partner, should she risk the possible side-effects of hormonal contraceptives or the IUD? What about a woman who has had all the children she wants? Should she choose surgical contraception when there is a high risk that one or more of her children might die?

Many girls and women have little information with which to make these decisions. They probably know little or nothing about sexuality and reproduction. They may not know when they are fertile and when they are not. They may be unable to raise the subject of contraception with their partners and may have little influence over their own or their partner's behavior in any case. Many women who are forbidden to use contraception by a husband or mother-in-law do not have the social support to act independently.

### **What do women with unwanted pregnancies experience?**

Women bear the physical, emotional and usually the financial burdens and heartache of an unwanted pregnancy. Hardly anything is more debilitating or

depressing than becoming pregnant at an inopportune time, whether pregnancy came about because of failed contraception, non-use of contraception, rape, or incest.

Deciding whether to carry the pregnancy to full term or to have an abortion presents a painful dilemma. A woman may not be mentally or physically prepared to bear a child. Often she must weigh serious risks to her own health and the health of her existing children against another pregnancy. When abortion is her chosen option, she faces continuing conflict. Is the abortion legally restricted, unavailable, and expensive? Will she have to go to an untrained practitioner because of these circumstances? To what risks is she exposed if she uses clandestine services? Humiliation or disrespectful treatment by a male doctor are possible additional hurdles.

Frequently a woman has no one to turn to for moral support and sympathy before, during or after an abortion even when medically safe services are available. Empathetic counseling is not commonly thought to be an important and integral part of abortion services in Third World countries. Women thus often endure an abortion without prior, full information on the procedure, including possible risks or side-effects. Worst of all, many women seeking abortion are not given contraceptive information, services or referral.

It is increasingly recognized that poorly performed abortions are a leading cause of maternal death throughout the developing world [5]. Clandestine abortion, however, leads not only to death, but also to appalling morbidity. Women suffer terribly from infection, physical damage such as a perforated uterus, and sterility. Women can linger on the verge of death for several days from a septic abortion. In many places, such as Bangladesh, the chances of being treated at a hospital are small. When these women become incapable of looking after their families they may be abandoned by their husbands or the husband may take another wife. The sick woman is then left at the mercy of a co-wife or wives.

### **Why do thousands of women die, or suffer serious health consequences and humiliation from induced abortion?**

The fundamental answer is that attitudes, laws, and regulations in many countries are still very conservative and deny women access to safe abortion services. Even when abortion is allowed under some circumstances, doctors may, not know the law, or they may refuse to provide care; they may also charge high fees. This means that richer women, or women who are willing to do anything to get money including prostitute themselves, can obtain a safe abortion. But poor, or less desperate, women cannot. Such inequity is inexcusable.

Many women are deprived of safe abortion services because of inadequate or complete absence of information about the existence of safe services. Social customs, such as purdah, may prevent women from leaving their homes to visit a clinic. In addition, many countries have laws that require the husband's or guardian's consent for an abortion, or that state that abortion services cannot be provided to unmarried women. In settings where a woman's anonymity cannot be assured, lack of confidentiality is a strong deterrent to seeking safe abortion services.

### **What can be done?**

The most fundamental change needed is recognition that a woman has multiple reproductive health needs throughout her life cycle and a basic right to control what happens to her own body. Family planning and health programs have taken a narrow view of women, as mothers or at risk of pregnancy. Most have not provided safe abortion services, nor have they dealt with other key aspects of women's sexual and reproductive lives: sexual taboos and abuse; reproductive tract infections; cancer; malnutrition, chronic anemia and stunted growth, which have their roots in the neglect of female children. Specifically, the following actions are needed.

#### **Improve the quality of contraceptive services**

Increasingly, Third World governments have recognized the importance of contraceptive services and have invested in them. Less attention, however, has been given to the quality of the services that are offered. Improved quality depends on giving priority to improving program management. Are family planning workers properly trained, supervised, and monitored? Do they get their supplies regularly? Are they rewarded for the development of strong rapport with the community, and sympathetic relationships with the women, or only for contraceptive acceptance? Are clinic hours suited to women's schedules? The answer to such questions is still too often "No."

Planners should accommodate women's preferences in terms of timing, location, type of provider, and cost. For instance, some women may not find a service acceptable if it is provided by a man. Some may be unable to accept a service if waiting time is too long or charges are too high. Clinics should also permit women to bring their children with them.

Information on contraceptive methods must be comprehensive. This does not mean simply listing the various methods available; it means providing information on possible side-effects, contra-indications, and modes of use. Women who are fully informed can then come to their own decisions about

contraception, choose a method with which they feel most comfortable and safe, and use it effectively.

As important, no one type of contraceptive method should be promoted. Rather, choices should be offered. A single contraceptive method, or even two, may not meet the needs of all women (or men) throughout their sexuality active lives. A young woman who has occasional sexual encounters, a woman with two children, and a woman who does not want any more children all use different criteria in deciding whether to contracept and how. Women or couples who would prefer the man to use contraception have almost no choice at all! Condoms require well-motivated couples and vasectomy is appropriate only at the end of childbearing.

The primary concern when choosing a contraceptive method should be the woman's preference, and the benefits to her. In Bangladesh, for example, some women's health advocates have been critical of injectable contraceptives. But many women prefer Depo-Provera to other available methods, such as the IUD or oral contraceptives, because they perceive amenorrhea - a common side-effect of Depo-Provera - as beneficial. Methods such as the IUD, which cause increased or breakthrough bleeding, are harder to manage for several reasons. Under Islam, menstruating women cannot pray or have sexual intercourse. Most women cannot purchase sanitary napkins but use rags or the end of the sari they are wearing to soak up menstrual blood. Moreover, one injection of Depo-Provera is effective for 3 months; the woman does not have to remember to take a pill every night, coerce or badger her partner to use a condom, or undergo the discomforts of an IUD insertion.

Women have many questions that must be clearly answered by service providers: Can different types of contraceptives, such as the pill or injectables, be used interchangeably? Can the same method be used for long periods of time? With what consequences? Can a contraceptive be used safely during lactation?

A particularly important challenge for service providers and the delivery system itself is contraceptive side-effects. Service providers too often dismiss women's concerns about side-effects with a disparaging remark such as: "It's all psychological or imagined." Women treated in this way are not likely to become satisfied or effective users of contraception, and their risk of unwanted pregnancy increases. Providers need to know about the consequences of contraceptive side-effects for women, and be trained and encouraged to treat women's concerns with respect.

Acceptance by the community, not just by women, of a reproductive health program is essential to establish and ensure a well-utilized program, especially

one as personal and, at times, as controversial as family planning. Program staff must respect local mores and also directly engage the support of the community. For example, when the Bangladesh Women's Health Coalition first establishes a clinic, the local community leaders are consulted on various key decisions such as location and appointment of a consulting physician. Staff are trained and supervised to respect local customs, especially with regard to women.

### **Across the board provision of safe abortion services for all women who want or need them**

It is a basic right of women to have easy access to safe abortion services. Safe abortion is also a necessary health intervention. "Safety" encompasses every aspect of abortion, from the time a woman recognizes an unwanted pregnancy to the time she has completely recovered from a pregnancy termination. Safe services put women at minimal risk of death, infection, or permanent sterility. They provide psychological support, treat the woman with respect and do everything possible to minimize pain. Safe services protect women from political, sexual and other forms of harassment both inside and outside clinics.

Contraception after abortion is an option that most women choose, but only if given the opportunity. Health services that do not provide contraceptive information and services after a safe abortion, or treatment for a botched abortion, are guilty of paramount neglect. Conversely, clinics that make contraceptive acceptance a requirement are guilty of coercion. The woman must decide if she wishes to contracept or not. If she does, she must be free to decide which method to use.

Actions to insure safe, available services vary across countries, but include: training a wide range of providers, not just physicians, in early safe abortion techniques; subsidizing services for poor women; educating the public to ensure that women know that safe services are available; designing and implementing administrative and medical guidelines to ensure that women with unwanted pregnancies are treated humanely and provided with necessary emotional support and contraceptive services; and changing restrictive laws and policies. We must remember that much can be done even where laws are restrictive and laws should not be used as an excuse for inaction.

### **Appointment of more women to decision-making bodies that influence reproductive health strategies**

Women's views are rarely heard at the senior levels of health, research, and contraceptive agencies. While not all women will have women's needs at heart, increasing their numbers in decision-making positions should increase the

possibility that women's concerns will be taken fully into account on critical issues such as abortion services, contraceptive research and development, and health and family planning program design and implementation. Among the many key issues women focus on are contraceptive safety, development of male methods, liberalization of abortion laws, quality of health and family planning services, including community-based distribution programs, and approaches to health services that reflect a commitment to women as active participants in defining and meeting their own health needs.

**Mobilization of women to improve reproductive health services and policies, foster understanding of women's total health needs, and build alliances for reproductive rights**

A political movement to create awareness among women about their rights to reproductive health services is essential, given competition for scarce resources and male domination in decision-making. Alliances are needed among women health professionals, feminists, women's health advocates and development professionals. At the same time, women must be helped to build strong organizations that command respect. Mobilizing women as individuals and building strong organizations require widespread consciousness-raising for several reasons. Women tend to put their own health and wellbeing last on the agenda, giving priority to their children and families; women professionals may not all be fully attuned to women's perspectives; many if not most women have had very little access to necessary information about their reproductive health.

**More rational allocation of resources to women's health overall and to neglected health problems**

Third World governments and donor countries have recognized key components of women's health, such as contraception, AIDS, and "Safe Motherhood," but the resources allocated are limited. This means that some problems, such as reproductive tract infections or female cancers, receive few or no resources. Both financial and political support must be built in order to expand resources for women's health. The political climate in donor nations too often determines foreign assistance allocations critical for reproductive health services in many Third World countries. One example of political influence with disastrous results has been the "Mexico City Policy" of the Reagan Administration, which denies funding for abortion services even in countries where laws are liberal. The consequences of this policy - the suffering of millions of women who require abortion services - is shameful and reprehensible.

## Conclusion

We cannot be complacent about unwanted pregnancy and unsafe abortion. Much remains to be done - and surely we will do it better if women and men, doctors and other health professionals, across countries and cultures, join in new alliances for a common cause.

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