GUTTMACHER INSTITUTE

In Brief

Facts on Abortion and Unintended Pregnancy in Asia

INCIDENCE OF ABORTION

• The estimated annual number of abortions in Asia fell slightly between 1995 and 2003, from 26.8 million to 25.9 million. In 2003, the majority of abortions occurred in Eastern Asia (10 million)—which includes China, the world's most populous country—and in South Central Asia (9.6 million), which includes India.

• The annual abortion rate for Asia declined between 1995 and 2003, from 33 to 29 abortions per 1,000 women aged 15–44.

• Of the nearly 26 million abortions performed in 2003, about 16 million were safe procedures and 10 million were unsafe.* More than half of the safe abortions occurred in China, where abortion is permitted on broad grounds and is performed by medically trained professionals.

• The rate of safe abortion in Asia declined from 21 per 1,000 women aged 15–44 in 1995 to 18 per 1,000 in 2003. The unsafe abortion rate was nearly unchanged: 12 per 1,000 in 1995 and 11 per 1,000 in 2003.

• In Eastern Asia, the estimated abortion rate in 2003 was 28 per 1,000 women of childbearing age; all of the procedures in this subregion were safe. In South Central Asia, the rate was 27 per 1,000—18 unsafe and nine safe abortions per 1,000.

• Southeast Asia was the subregion with the highest abortion rate in 2003—39 per 1,000 (23 per 1,000 unsafe and 16 per 1,000 safe); most of the safe abortions in this area occurred in Vietnam. The lowest rate was in Western Asia—24 per 1,000 (eight per 1,000 unsafe and 16 per 1,000 safe); the high proportion of safe procedures in this subregion reflects the broad access to safe abortion services among women in Turkey, Armenia, Azerbaijan and Georgia.

LEGAL STATUS OF ABORTION

• Abortion is not permitted for any reason in four Asian countries: Iraq, Laos, Oman and the Philippines.

• In 14 countries, abortion is allowed to save the life of a woman; three of these countries also allow it in cases of fetal impairment (East Timor and Iran) or rape, incest or other grounds (Bhutan). Seven more permit abortion to preserve a woman's physical health (as well as to save her life), and some of these countries also permit the procedure on the grounds of fetal impairment (Kuwait, Qatar and South Korea) or rape or incest (South Korea).

• Abortion is permitted to preserve a woman's mental health (as well as to save her life and preserve her physical health) in four countries and territories (Hong Kong, Israel, Malaysia and Thailand), three of which also allow the procedure on the grounds of rape and fetal impairment (Hong Kong, Israel and Thailand) or in cases of incest (Hong Kong and Israel).

• Three countries and territories (Cyprus, India and Taiwan) permit abortion on broad socioeconomic grounds and for all of the previous reasons. In addition, abortion is allowed in cases of rape or fetal impairment in Cyprus and India and in cases of incest or fetal impairment in Taiwan.

• Seventeen countries allow abortion without restriction as to reason. All of these countries impose gestational limitations, with the exceptions of China, North Korea and Vietnam, which have different regulatory mechanisms.

• Because abortion is broadly legal in the region's two most populous countries—China and India—only an estimated 28% of women of childbearing age in Asia live in countries with restrictive abortion laws.[1]

• In the past decade or so, five Asian countries have amended their abortion laws. Cambodia reformed its law in 1997 to allow abortion on request through the 12th week of pregnancy and in certain circumstances during the second trimester. In 2002, Nepal enacted legislation permitting abortion without restriction as to reason, but with procedural requirements, and in 2004 Bhutan authorized abortion to save the life of the pregnant woman and in cases of rape and incest. The following year, Thailand added the protection of a woman's mental health, including the prevention of mental

*In this report, abortions are categorized as safe or unsafe using standard World Health Organization (WHO) definitions. WHO defines unsafe abortion as a procedure meant to terminate an unintended pregnancy that is performed by individuals without the necessary skills, in an environment that does not conform to the minimum medical standards or both.

Legality of Abortion

Countries and territories in Asia can be classified into six categories, according to the reasons for which abortion is legally permitted

Reason	Countries and territories
Prohibited altogether, or no explicit legal exception to save the life of a woman	Iraq, Laos, Oman, Philippines
To save the life of a woman	Afghanistan, Bangladesh, Bhutan (a,b,d), Brunei Darussalam, East Timor (c), Indonesia, Iran (c), Lebanon, Myanmar, Sri Lanka, Syria (e,f), United Arab Emirates (e,f), West Bank and Gaza, Yemen
To preserve physical health (and to save a woman's life)*	Jordan, Kuwait (c,e,f), Maldives (f), Pakistan, Qatar (c), Saudi Arabia (e,f), South Korea (a,b,c,f)
To preserve mental health (and all of the above reasons)	Hong Kong (a,b,c), Israel (a,b,c,d), Malaysia, Thailand (a,c)
Socioeconomic grounds (and all of the above reasons)	Cyprus (a,c), India (a,c,e,h), Taiwan (b,c,e,f)
Without restriction as to reason	Armenia, Azerbaijan, Bahrain, Cambodia, China (g,i), Georgia (e), Kazakhstan, Kyrgyzstan, Mongolia, Nepal (g), North Korea (i), Singapore, Tajikistan, Turkey (e,f), Turkmenistan, Uzbekistan, Vietnam (i)

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. *Notes:* Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal impairment or (d) other grounds. Some restrict abortion by requiring (e) parental or (f) spousal authorization. Two countries (g) have abortion laws that prohibit sex-selective abortions, and one (h) bans sex-selective abortion as part of a separate fetal imaging law. Countries that allow abortion on socioeconomic grounds or without restriction as to reason have gestational age limits (generally the first trimester); abortions may be permissible after the specified gestational age, but only on prescribed grounds. A few countries (i) do not specify gestational limits, and regulatory mechanisms vary. Because their abortion laws differ from those of China, Hong Kong and Taiwan are listed as separate entities.

distress because of fetal impairment, as a legitimate ground for abortion. Also in 2005, Iran passed legislation permitting abortion during the first four months of pregnancy in cases of fetal impairment, as well as "when disease endangers the life of a pregnant woman"—substantial changes from its previous law, which prohibited abortion altogether.

PROVIDERS OF CLANDESTINE ABORTIONS

• Although abortion is permitted only on narrow grounds in Pakistan, a survey of knowledgeable health professionals in that country suggests that two-thirds (68%) of women who have clandestine abortions obtain the procedure from doctors, nurses or midwives. The remaining one-third have an elevated risk of complications, because they go to traditional providers (24%), rely on pharmacists or other commercial outlets (5%) or self-induce (4%).*

• Urban women having clandestine abortions in Pakistan are much more likely than rural women to use the services of doctors (41% vs. 22%).

• Since poor Pakistani women who have clandestine abortions are more likely than better-off women to turn to unsafe methods and untrained providers, they are thought to have a higher rate of complications (45% vs. 31%).

• In some Asian countries—notably Cambodia, India and Nepal—abortion laws are liberal, but many pregnancy terminations are performed in substandard conditions. Bangladesh is a special case: Despite the country's very restrictive abortion law, early menstrual regulation† has been widely available since 1977.

• Even though abortion is broadly legal in India, the country's system of abortion provision has many shortcomings, and only two in five of the estimated 6.4 million abortions that occur there annually are considered safe. Conditions in public health facilities are often substandard, and private-sector facilities, where most trained abortion providers work, often charge high fees; as a result, many women are unable to afford a safe abortion. Access is particularly poor in rural areas (where 70% of the population resides) because there are relatively few trained providers. In addition, abortions are often performed under unhygienic conditions—particularly when carried out by traditional providers, but even when done by trained personnel in clinics or hospitals.

HEALTH CONSEQUENCES OF UNSAFE ABORTION

• The World Health Organization estimates that almost one in eight maternal deaths in Asia result from unsafe abortion.

• About 2.3 million women in the region are hospitalized annually for treatment of complications from unsafe abortion.

• The most common complications from unsafe abortion are incomplete abortion, excessive blood loss and infection. Less common but very serious complications include septic shock, perforation of the intestines and inflammation of the peritoneum.

• Because poor and rural women tend to depend on the least safe methods and providers, these women are the most likely to experience severe complications from unsafe abortion.

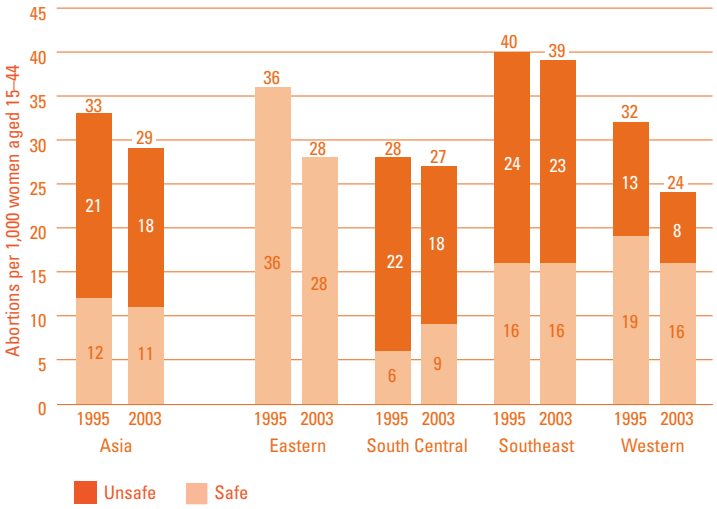
• In countries where abortion is highly restricted by law, even procedures performed by

*The sum of the percentages exceeds 100 because of rounding.

†Menstrual regulation is considered "an interim method for establishing nonpregnancy" in Bangladesh. Procedures are permitted to be carried out by a trained paramedic within eight weeks of the woman's last menstrual period or by a physician within 10 weeks of her last menstrual period.

Abortion Rates in Asia

Although abortion rates fell in Asia between 1995 and 2003, they hardly changed in South Central and Southeast Asia



doctors may be risky, because some physicians have inadequate training or experience and provide abortion services under unhygienic conditions. For example, in Nepal, where abortion has been legal since 2002, about half of women treated for serious abortion complications reported that their abortion had been performed by a doctor. A study in Thailand found that 11% of procedures done by obstetricians and gynecologists resulted in severe complications, as did 27% of those carried out by general physicians.

• In the Philippines, where the influence of the Catholic Church is strong, women who terminate a pregnancy face social stigma and, in some cases, become guilt-ridden and fixated on doing penance for their perceived "sin."

• Women with untreated complications often experience long-term health consequences—such as anemia, chronic pain, inflammation of the reproductive tract and pelvic inflammatory disease—that can result in infertility.

• Postabortion services, like most other health services in certain parts of Asia (particularly the South Central and Southeast subregions), are of poor quality, largely because government spending on all health care is low. Common shortcomings include inadequate access, delays in providing treatment, shortages of trained health workers and medical supplies, use of inappropriate methods and high costs imposed on the patient. These factors deter some women, particularly poor women and those who are young and unmarried, from obtaining needed treatment.

UNINTENDED PREGNANCY AND CONTRACEPTIVE USE

• Most abortions in Asia, as elsewhere in the world, are a response to unintended pregnancies, which are themselves often the result of women's inadequate access to and use of contraceptive methods.

• The overall pregnancy rate in Asia declined from 156 per 1,000 women aged 15–44 in 1995 to a projected rate of 127 per 1,000 in 2008.

• Between 1995 and 2008, the rate of intended pregnancy declined from 92 to 78 per 1,000, and the rate of unintended pregnancy from 64 to 49 per 1,000.

• In 2008, the proportion of pregnancies that were unintended was higher in Southeast (48%) and Western Asia (44%) than in Eastern and South Central Asia (33–38%).

• In Eastern Asia, a very low proportion (6%) of all pregnancies resulted in unplanned births, largely because of the high level of effective contraceptive use and the widespread access to safe abortion services in China; another contributing factor is China's one-child population policy.

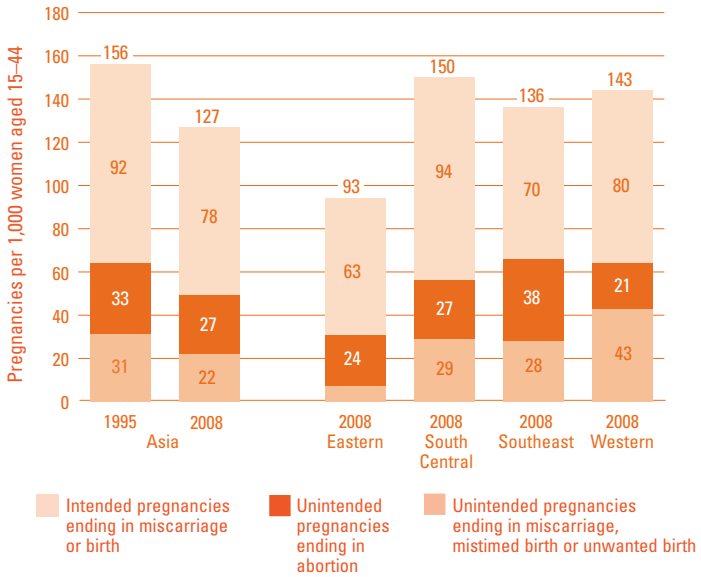
• The prevalence of contraceptive use among married women aged 15–44 in Asia rose from 57% to 68% between 1990 and 2003, an increase of 19%. The increase helps account for the decline in overall pregnancy rates in Asia.

• The relatively high level of contraceptive use in the region is mainly due to the very high rate in China.

• However, many women in Asia have an unmet need for contraceptives—they are not practicing contraception even though they do not want a child soon or want no more children. On average, an estimated 13% of married women of childbearing age in the 12 Asian countries for which national survey data are available (including India and excluding China) had an

Pregnancy Rates in Asia

Rates of both intended and unintended pregnancy declined between 1995 and 2008.



Note: Rates may not add up to totals because of rounding.

unmet need for contraceptives in 2002–2007, a decline from the mid-1990s average of 18%. Levels of unmet need among unmarried, sexually active women are unknown, because most national contraceptive and fertility surveys in Asia do not include unmarried women.

• When married women who say they do not want to become pregnant are asked why they are not using a contraceptive method, the most common answer is that they have sex too infrequently—suggesting a lack of understanding of their risk of unintended pregnancy.

• The next most common response is that they do not like the side effects or perceived health risks associated with modern contraceptives, suggesting that there is need for improved contraceptive services that provide a broad range of contraceptive options.

RECOMMENDATIONS

• Programs and policies that improve women's and men's knowledge of, access to and use of contraceptive methods should be established or strengthened, as contraception is the surest way to prevent unintended pregnancy and the need for abortion.

• To reduce the number of clandestine and unsafe procedures, the grounds for legal abortion should be broadened in many countries, and safe abortion services should be implemented under the criteria permitted by existing laws.

• To reduce the high levels of morbidity and mortality that result from unsafe abortion, provision of high-quality postabortion care should be improved and expanded.

• Because rates of morbidity and mortality from unsafe abortion are disproportionately high among poor and rural women throughout the region, equitable access to family planning services and postabortion care should be emphasized in health policies and programs.

• If pregnancy termination is permitted on broad grounds but safe and legal abortion services are not available in all areas and to all groups, countries should provide equitable access and legal rights for all women.

Unless otherwise indicated, the information reported in this fact sheet is from Singh S et al., Abortion Worldwide: A Decade of Uneven Progress, *New York: Guttmacher Institute, 2009.*

REFERENCE

1. Special tabulations of data from Singh S et al., *Abortion Worldwide: A Decade of Uneven Progress,* New York: Guttmacher Institute, 2009.

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10/2009