

Delicia Ferrando

CLANDESTINE ABORTION IN PERU

Facts and Figures

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Foreword

Throughout the centuries, women and their partners have been constantly concerned with controlling their fertility. In former times, people's lack of understanding of the physiology of reproduction led them to try a variety of methods to limit the number of children they had, including the interruption of pregnancy as a last resort. Despite the years that have passed since then and the different strategies employed, this situation has not changed. Numerous studies show that unwanted pregnancy affects women of all social classes (both from urban and rural areas) for a variety of reasons, including women's unequal status in society, their limited possibilities for making decisions, insufficient sexual and reproductive education, as well as the barriers to their access to quality, efficient reproductive health services. As a result, women continue to resort to induced abortion to resolve the problem of unwanted pregnancy, despite the pain and guilt associated with this decision.


In an effort to prevent induced abortion, the government has long penalized it. Rather than solve the problem, this approach has led to the widespread practice of clandestine abortion. Poor women undergo abortions in unsanitary conditions, thereby putting their health at risk. This is demonstrated by the high rate of maternal morbidity and mortality associated with abortion.

Clandestine abortion is recognized in our country as a public health problem, but it is addressed as a moral, religious or legal issue. As a result, the abortion problem has become a social justice and human rights issue.

The Flora Tristán Peruvian Women's Center and Pathfinder International are pleased to present the book *Clandestine Abortion in Peru; facts and figures*. This study updates the research project "Clandestine abortion, a Peruvian reality," implemented in 1994 by the Alan Guttmacher Institute. The study was made possible thanks to the generous support of the Ford Foundation. Anthropologist-demographer Delicia Ferrando was responsible for both the study and the research project.

This study was undertaken to fulfill the objective of these institutions to generate information that contributes both to the exercise of sexual and reproductive rights within a human-rights framework as well as to the development of pertinent government policies.

Since most abortions are performed clandestinely, it is difficult to accurately calculate the extent of this practice in Peru. Nevertheless, previous estimates and the results of this study indicate that for every two pregnancies that end in a birth, at least one pregnancy is terminated. The study also demonstrates that most women who have abortions are in stable relationships with a partner and already have several children. For this reason, it is



very difficult to develop a profile of women who decide to have an abortion. Even those women who use contraceptives may resort to a clandestine abortion if their method failed or if they did not use it properly.

The results of this study bring us closer to real data on clandestine abortion in Peru. We hope that this information, together with effective interventions that respect human rights, support changes in policies, programs and services. Most importantly, we want women to enjoy a voluntary, happy and healthy motherhood.

Our work and experience have taught us that abortion is a last resort for women since it is a difficult, painful decision for the vast majority. As civil society organizations committed to improving the quality of life and health (particularly sexual and reproductive health), we present the results of this research for all interested organizations and individuals.

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CMP Director
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To the Consultative Committee, made up of representatives of different private and public national and international organizations, which participated during the different stages of the study. The different perspectives on the problem enriched the discussion, thereby permitting a comprehensive interpretation of the findings.

To the staff of the Ministry of Health's Statistics and Information Office for facilitating access to clinical statistics.

Special acknowledgement goes to Susheela Singh, Research Director at the Alan Guttmacher Institute and author of the methodology used in this study, for her comments and suggestions on the first draft of the report.

Finally, we would like to thank the 103 physicians, obstetric nurses, nurses, birth attendants, university professors, researchers and social science experts from 12 Peruvian cities and their respective rural areas who participated in the opinion survey on the practice of induced abortion in Peru, as well as the 30 women who agreed to share their personal experiences with abortion.

The data collected helped us to understand the statistical dimension of clandestine abortion as well as the human, social, and emotional context in which it is performed in this country, and to offer key information for the design of strategies and policies that will contribute to improving the reproductive health of Peruvian men and women.

The translation of this report from Spanish was provided by Kristin Keenan. Sheila Webb, Pathfinder International, edited the English text.

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Introduction

Reproductive rights embrace certain human rights that are recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right to make decisions concerning reproduction free of discrimination, coercion, and violence as expressed in human rights documents.
—**International Conference on Population and Development**

Safe, healthy, and voluntary motherhood is a human right. Most women want to fulfill a desire to procreate (although some choose not to have children) and celebrate when they become pregnant. But not all of them do so. For a variety of reasons and circumstances, thousands of women become pregnant without having planned to do so. While some accept the fact and have a child, which they ultimately want, others face the dilemma of having an unwanted child or terminating the pregnancy without regard for the legality of the procedure and the conditions under which the abortion is performed. In this context, no one can say they are “in favor” of abortion; rather, the idea is to reduce to a minimum the number of women who choose the alternative of terminating the pregnancy. To do this requires one to seriously address the conditions and causes that lead women to decide to have an abortion.

According to the Penal Code, abortion is illegal in Peru, except when the woman’s health or life is in danger. Nevertheless, the legal status of abortion does not stop women from having them. According to the Alan Guttmacher Institute, 77 million abortions occurred worldwide in 1999, 46 million of which were induced (AGI, 1999). In North America, Europe, and some Asian countries, most induced abortions are performed legally, whereas in the rest of the world, including Peru, they are performed clandestinely.

In many countries, where there is public awareness about the social and human consequences of clandestine abortion performed in unsafe conditions, as well as about the serious risk to women’s health and life, abortion has been classified as a public health problem. In Peru, the Ministry of Health recognizes that

“... [a]bortion is a public health problem affecting society as a whole and especially women. The government and civil society must address this problem through an adequate sexual education program, family planning actions and the timely treatment of abortion complications in an effort to prevent maternal deaths.” (Ministry of Health, 1996)

Unsafe, clandestine abortion is not only a public health problem, but also a threat to the enjoyment and exercise of several of the rights of women that have been recognized in international treaties and agreements ratified by Peru. By penalizing abortion, the Peruvian government violates its commitment to respect dignity, integrity (physical and psychological), intimacy, privacy, life, health and non-discrimination.

The International Conference on Population and Development, which took place in Cairo in 1994, underscored the concern for the consequences of unsafe abortion and proposed the following:

“Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counseling of women who have had recourse to abortion.”¹

It also states:

“[...] All governments and relevant intergovernmental and non-governmental organizations are urged ... to deal with the health impact of unsafe abortion ... and to reduce the recourse to abortion through expanded and improved family planning services. ... In circumstances in which abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion...”²

For its part, the Committee on the Elimination of Discrimination against Women issued some observations and recommendations to the Peruvian government with regard to the report presented by Peru at its nineteenth session (July 1998). The committee recommended the following:

“Prioritize the prevention of unwanted pregnancy through family planning and sex education... When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.” (General recommendation No. 31, section c)³

The committee concluded the following:

“Peru should review its law on abortion and ensure that women have access to full and complete health services which include safe abortion, and to emergency medical attention when complications arise from abortions.”

¹ Chapter VII. Reproductive Rights and Reproductive Health. Actions, 7.24.

² Chapter VIII. Health, Morbidity and Mortality. Actions 8.25.

³ Convention on the Elimination of all Forms of Discrimination against Women, 20th Session, 1999.

The United Nations Human Rights Committee, in its fifty-eighth session,⁴ had the following to say about Peru:

“...The Committee is also concerned that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality. These provisions not only mean that women are subject to inhumane treatment, but are possibly incompatible with articles 3, 6 and 7 of the Covenant.”

Since the Peruvian government failed to respond, the committee reiterated its concerns in the seventieth session, stating the following:

“It is a matter of concern that abortion continues to be subject to criminal penalties, even when pregnancy is the result of rape. Clandestine abortion continues to be the main cause of maternal mortality in Peru.”

“The Committee once again states that these provisions are incompatible with articles 3, 6 and 7 of the Covenant and recommends that the legislation be amended to establish exceptions to the prohibition and punishment of abortion.”⁵

One reason that Peru has not taken action on abortion is because information is lacking on its true magnitude and characteristics due to its illegal status. The data available on hospitalization, cause of death, and other health statistics are inaccurate, incomplete, and outdated. For this reason, this study calculated indirect estimates that, despite their limitations, give a general idea of the incidence of abortion without magnifying or minimizing the problem. The study's premise is that the cases of women hospitalized for abortion represent only a portion of all induced abortion cases. In order to provide a more realistic estimate, the study sought to determine the proportion of all induced abortions that result in complications, and the proportion of those that result in hospitalization. These proportions reveal how many induced abortions occur for each hospitalized, or officially recorded case, and are used as the basis of a multiplication factor for estimating the total number of induced abortions. The main data sources include official statistics on women hospitalized for the treatment of abortion complications, demographic and family health surveys (ENDES), and a survey of 103 health professionals and non-professionals familiar with the problem of clandestine abortion.

This report updates a study on induced abortion published in 1994 by the Alan Guttmacher Institute (AGI, 1994), using the same methodology. These data are made available in order to develop policies that will contribute to strategies that promote the reproductive health of individuals. The study was made possible thanks to the generous financial contribution of the Ford Foundation and the institutional sponsorship of the Flora Tristán Women's Center and Pathfinder International.

⁴ Human Rights Committee, 58th Session. Consideration of reports submitted by states parties under Article 40 of the Covenant. Concluding observations of the Human Rights Committee. Peru. International Covenant on Civil and Political Rights, CCPR/C/79/Add.72, November 8, 1996.

⁵ Human Rights Committee, 70th Session. Consideration of reports submitted by states parties under Article 40 of the Covenant. Concluding observations of the Human Rights Committee. Peru. International Covenant on Civil and Political Rights, November 11, 2000.

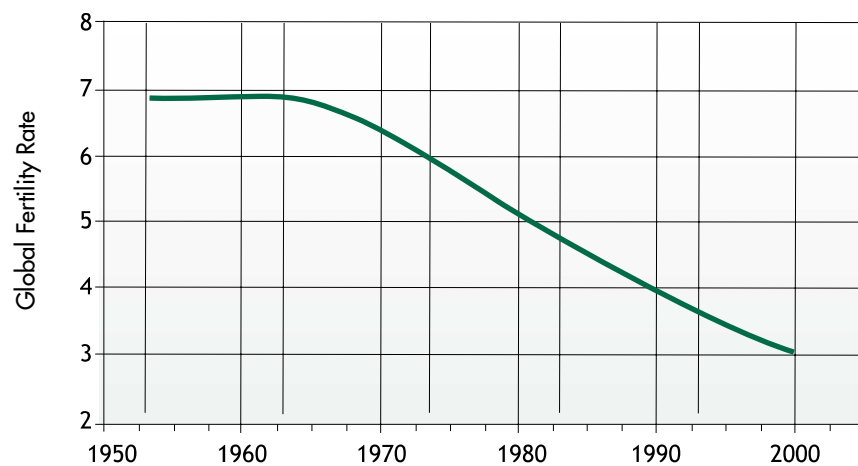
1. The Social and Demographic Context

1.1 Fertility rate and trends. The average number of children per woman, the desire for more children, and the ideal family size

The small family is, today, generally preferred in Peru, especially among younger women. According to the 2000 ENDES study (INEI 2001), adolescents aged 15 to 19 reported the lowest average ideal family size (two children versus 2.9 for women over 40). The average size of the Peruvian family, after remaining constant at seven children per woman between 1950 and 1965, decreased by more than half in the following three and a half decades, to 2.9 in 2000 (figure 1). The decrease occurred at the same time contraceptive use increased, as a response to the challenges of modern society in which women's perceived role as "mothers only" has given way to a broader role that values their contribution to the development of society.

Figure 1

The size of the average Peruvian family decreased by more than half between 1950 and 2000



Source: INEI, 2000

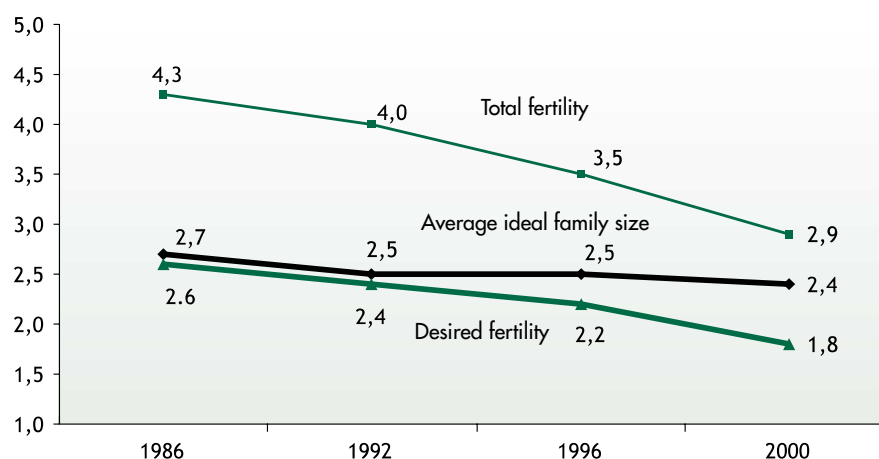
Source: INEI, 2000

Despite the decrease in the total fertility rate, the average number of children born to Peruvian women (2.9) is higher than the number that they consider ideal (2.4) (see figures 2 and 3). This figure varies little between the regions, from 2.5 in the highlands and rural areas to 2.3 in Lima. This would clearly suggest a reproductive preference revealing which women (and men, according to the 1996 ENDES survey) want fewer children than they have. In effect, the percentage of women whose ideal family size is one or two children grew from 51.9 percent in 1986 to 64.8 percent in 2000, and two percent said they did not want children.

In 2000, less than 30 percent of women in union wanted a (or another) child and 54.5 percent did not want any more children. Additionally, 12.8 percent had undergone voluntary surgical contraception and 2.7 percent were infertile.

Figure 2

Total fertility, average ideal family size and desired fertility
1986-2000



Source: INEI, 2000

The total rate of desired fertility⁶ measures the impact of unplanned births on the level of fertility and represents its theoretical level if all unwanted births could have been prevented. The desired fertility rate in Peru is 1.8 children; however, an average of 2.9 children are born. Therefore, 1.1 more births occur than are wanted. According to the ENDES 2000 study, approximately one million children (31 percent of births in the past five years) were born unwanted by their parents.⁷ In general, the total fertility rate is consistently about 37 percent higher than the desired fertility rate (figure 3).

⁶ A birth is considered wanted if the number of surviving children at the time of the pregnancy is below the ideal number of children preferred by the woman. The rates of desired fertility include births occurring in the 36 months prior to the survey, not counting the month of the interview. ENDES 2000.

⁷ Planificación de la fecundidad. Informe General, ENDES 2000. pg. 106.

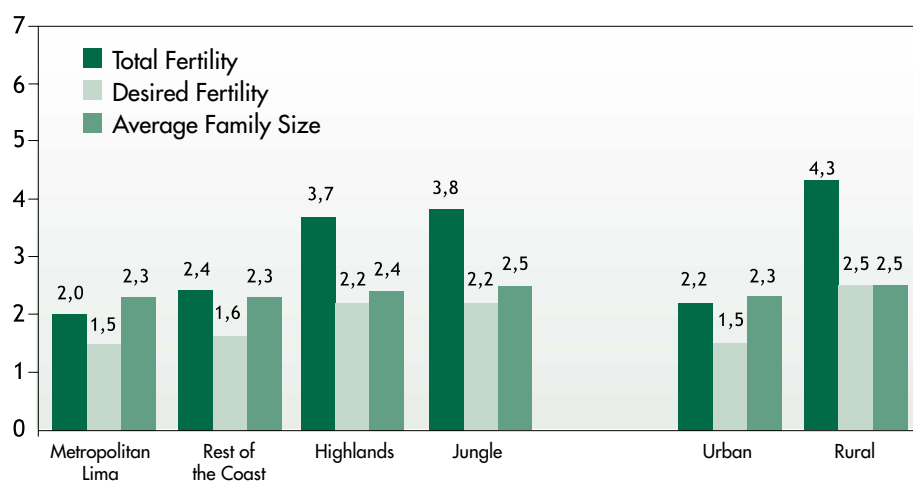
1.2 Regional fertility rates and trends

The total fertility rate (TFR) dropped most rapidly on the coast and in the big cities, particularly in Metropolitan Lima, which currently has the lowest average number of children per woman in the country (two). The jungle and the highlands, with a TFR of 4.3 children each, currently have the same levels as the national rate two decades ago. The gap between rural (4.3) and urban fertility (2.2) has remained practically unchanged.

The high fertility rate among women of the highlands, jungle, and rural areas does not correspond to their fertility preferences. The high fertility rate in these areas is due instead to limited use of contraceptives. In both rural and urban areas on the coast, in the highlands, and in the jungle, the average number of children women prefer is less than the number they actually have. Desired family size varies little among the different regions, fluctuating between 2.3 children in Lima and 2.5 children in rural areas. By contrast, the average number of children *born* (total fertility rate) fluctuates widely among regions, from 2.0 in Metropolitan Lima to 4.3 in rural areas (figure 3).

Figure 3

Total fertility, desired fertility and average ideal family size, by region, 2000



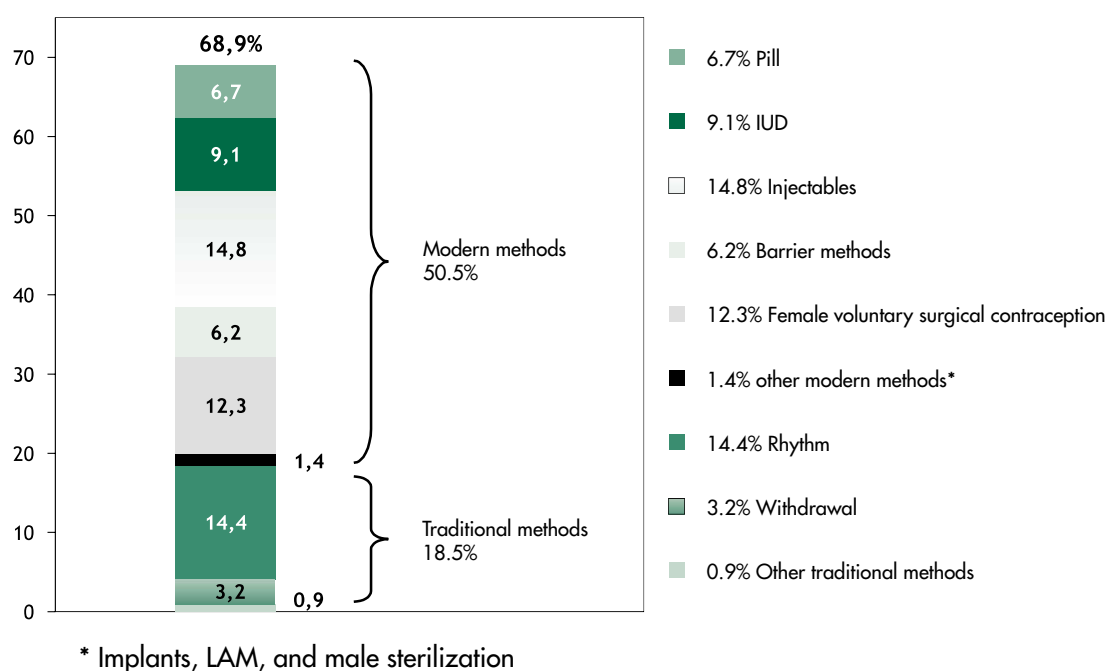
More than three-fourths of women in the highlands and rural areas, and 60 percent in Peru's other regions, do not want to have a (or another) child. A comparison between the total fertility rate and desired fertility demonstrates that women in the highlands have two children more than they want, while women in the jungle have 1.6 more than they want. Consequently, if all of these births could have been prevented, the greatest reductions in fertility would be in the highlands and in rural areas, and the lowest decrease would be in Metropolitan Lima and the rest of the coastal area where women's total fertility approximates their desired fertility.

1.3 Contraceptives and problems with their use

In their efforts to have fewer children, women and their partners are motivated to use contraceptives. In 2000, the ENDES study found that 12.3 percent of women and 0.5 percent of men had chosen a permanent contraceptive method because they did not want any more children. The demand for contraceptives continues to exceed their use. For example, in 2000, 68.9 percent of women who were married or in union used a contraceptive method: 50.5 percent used modern methods and 19 percent used traditional methods (figure 4). The prevalence of modern methods more than doubled (from 23 to 50.5 percent) between 1986 and 2000, while that of traditional methods decreased by 19 percent in the same period. The rhythm method is used by 14.4 percent of respondents, which is similar to the percentage using injectables (14.8 percent). Injectables are the preferred method; their use increased tenfold between 1986 and 2000, from 1.3 percent to 14.8 percent.

Figure 4

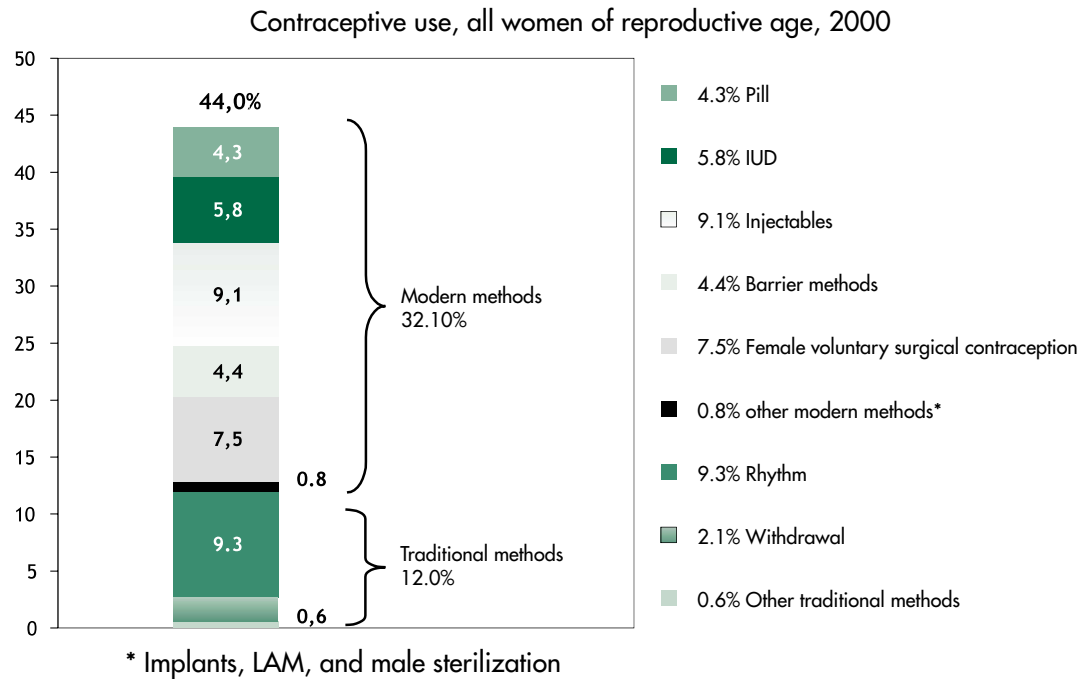
Contraceptive use, women currently in union, 2000



The picture becomes more complex when one includes an analysis of all women of reproductive age, since many of them (single, separated, and divorced) do not live under the same roof as their partner, but are nevertheless sexually active and at risk of becoming pregnant.⁸ Of all women of reproductive age, only 44 percent use a contraceptive method and just 32 percent use a modern method. The preferred methods include the rhythm method (9.3 percent), injectables (9.1 percent), voluntary surgical contraception (7.5 percent) and the IUD (5.8 percent) (figure 5).

⁸For example, 11.5 percent of women aged 15 to 19 were sexually active in 2000, which represents close to 310,000 adolescents. While some of them have formed a family and live with their partner, the vast majority are single.

Figure 5



More than 60 percent of women in union in all regions of the country use contraceptives. Women in union using modern methods live in the following areas: fifty-eight percent reside in the capital city and the rest of the country's coastal region, 50 percent live in the jungle region, and 39 percent live in the highlands. Almost a quarter of women in union in the highlands, and just over 14 percent in other regions use traditional methods with little or no information on their proper use (table 1). Therefore, a significant number of women lack adequate protection against the possibility of an unwanted pregnancy.⁹

Table 1

Use of methods by region for women in union, 2000

Methods	Metropolitan Lima	Rest of the coast	Highlands	Jungle
Any method	73.4	72.1	63.9	66.9
Any modern method	58.8	57.6	38.9	50.5
Pill	7.5	8.2	3.3	11.2
IUD	16.5	8.8	5.9	3.0
Injectables	11.3	17.1	13.9	19.7
Barrier (vaginal, condom)	10.6	5.4	4.8	2.3
Female voluntary surgical contraception	11.8	17.1	9.1	12.7
Male voluntary surgical contraception	0.7	0.2	0.6	0.4
Other (implant, LAM)	0.5	0.7	1.3	1.2
Any traditional method	14.1	14.2	23.8	14.3
Rhythm	9.7	11.4	20.6	12.8
Withdrawal	4.4	2.8	3.1	1.5
Folkloric methods	0.5	0.3	1.2	2.1

⁹ According to ENDES 2000, the rate of discontinuation of the rhythm method in 12 months of use was 37.3%, and 44.5% in the case of the withdrawal method. The main reason for discontinuation use was method failure in 17.1% and 12.8% of the cases, respectively. For the IUD, the rate of discontinuance was 15.1%, and for injectables, 40.6%; however, method failure was only mentioned by 0.5% and 1.1%, respectively.

1.4 Women at risk for pregnancy—inadequately protected women

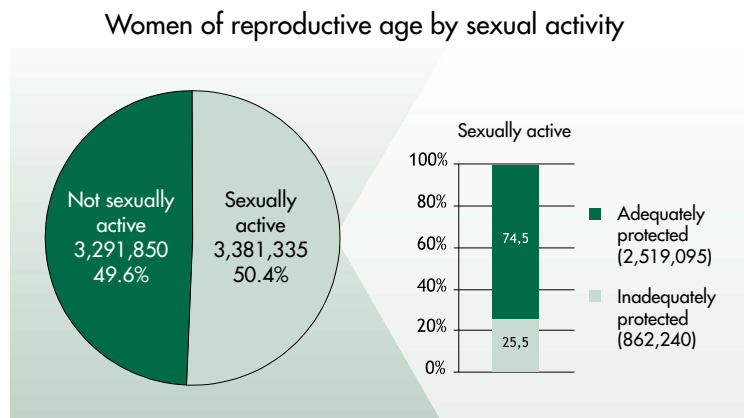
Some of the reasons why 56 percent of Peruvian women of reproductive age and 31 percent of women in union do not use any family planning method, or use these methods incorrectly, include the following: the lack of geographic, economic, or cultural access to health facilities; healthcare providers' attitudes; cultural practices; and a lack of information on the proper use of contraceptives and their side effects. These technical and human obstacles result in what is collectively known as inadequate protection,¹⁰ which is a broader concept than unmet need for family planning services because it includes in the group at risk for unwanted pregnancy, those sexually active women—regardless of whether they are in union—who do not want more children or who do not want children in the next two years but who

- do not use a contraceptive method;
- are pregnant because the method failed; or
- use periodic abstinence but do not know when their fertile period is.

While traditional contraceptive methods can be effective if properly used, only 62 percent of users of the rhythm method in Peru are familiar with its correct use, which explains this method's high failure rate compared with modern methods.

According to the 2000 ENDES study, 42.5 percent of users of the rhythm method, 31.6 percent of users of the withdrawal method, and 35.4 percent of users of folkloric methods¹¹ became pregnant within the first five years of using the method. The percentage of pregnancies occurring among users of the IUD was 3.3 percent, 2.6 percent for the injectables and 8.6 percent for the pill.¹²

Figure 6



Source: ENDES 2000

In Peru, there are nearly 6.7 million women of reproductive age. According to the 2000 ENDES study, half of these women (50.4 percent) are sexually active,¹³ including women in union (married or living together) and single women who do not live with their sexual partner. The balance between the exposure to the risk of pregnancy, the desire not to have more children, and the use of contraceptives reveals that 25.5 percent (862,240) of women aged 15 to 49 are at risk of an unwanted pregnancy (figure 6).

¹⁰ The concept of inadequate protection was used to convey unmet need for family planning in the 1994 AGI abortion study on which this study is based. For this study, the concept was refined to exclude women who did not want more children or who did not want them in the next two years and who used periodic abstinence to protect themselves against unwanted pregnancy, with knowledge of their fertile period.

¹¹ Folkloric methods include washing with herbs and douching after intercourse.

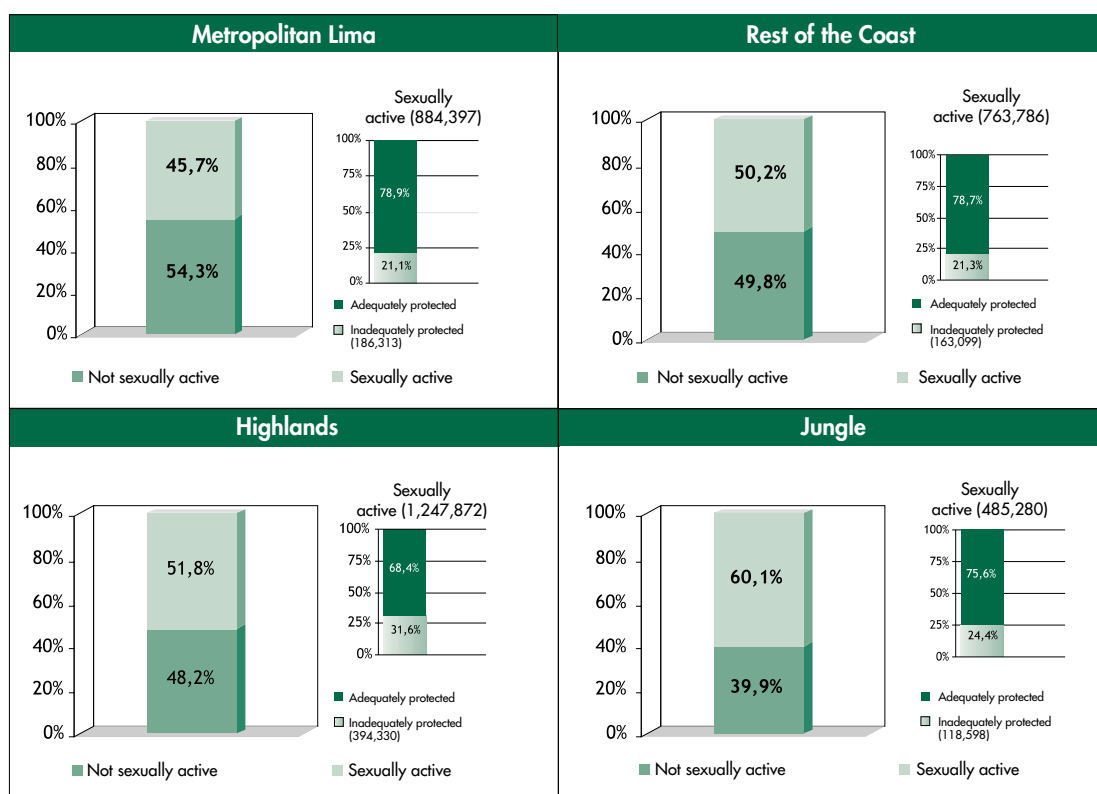
¹² According to ENDES 2000, the rate of discontinuation of the rhythm method in 12 months of use was 37.3%, and 44.5% in the case of the withdrawal method. The main reason for discontinuation use was method failure in 17.1% and 12.8% of the cases, respectively. For the IUD, the rate of discontinuance was 15.1%, and for injectables, 40.6%; however, method failure was only mentioned by 0.5% and 1.1%, respectively.

¹³ Had sexual relations within four weeks preceding the day of the interview.

More than a third (37 percent) of this group reside in the highlands, while a fourth live in Metropolitan Lima and the rest of the coast, and 14.4 percent live in the jungle region. The total percentage of sexually active women of reproductive age living in each region is as follows: in the jungle, 60 percent of all women aged 15 to 49 are sexually active; in the highlands and on the coast, just over 50 percent are sexually active; and in Lima, 45.7 percent of women in this age group are sexually active (figure 7).

Figure 7

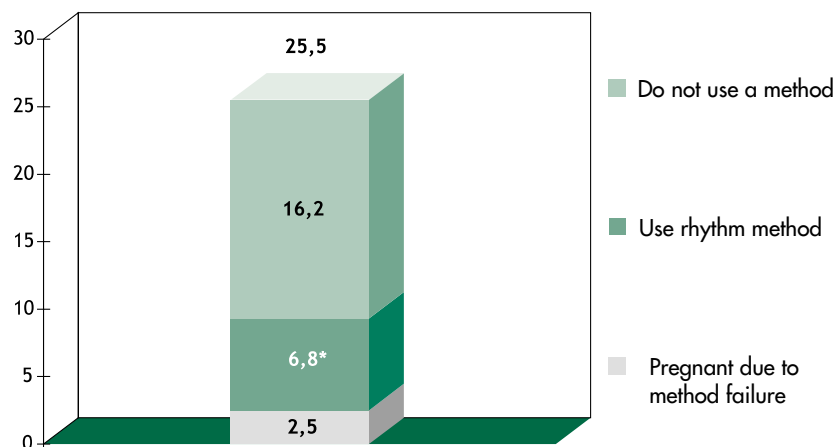
Women of reproductive age, according to sexual activity by region



The percentage of inadequately protected women (25.5 percent) includes 16.2 percent who do not want more children or who do not want them in the next two years, but who are not using any contraceptive method; 6.8 percent who do not want more children but who use periodic abstinence, although they are unfamiliar with their fertility cycle; and 2.5 percent who are pregnant because of method failure (figure 8). As previously mentioned, in 2000, 862,000 women aged 15 to 49 were inadequately protected (i.e., at risk for an unwanted pregnancy) and therefore also at risk of experiencing a clandestine abortion.

Figure 8

Women aged 15 to 49 who are inadequately protected against a possible unwanted pregnancy, 2000



The regional distribution of inadequately protected women shows that in the highlands, which has the lowest rate of use of modern contraceptives (38.9 percent), 31.6 percent of all sexually active women are inadequately protected against an unwanted pregnancy. In Lima and the rest of the coast, the inadequate protection rate for sexually active women is 21 percent and in the jungle it is close to 25 percent (table 2).

Table 2

Sexually active women by level of protection against unwanted pregnancy

Region	Sexually active women aged 15 to 49					
	Total		Adequately protected		Inadequately protected	
	Number	%	Number	%	Number	%
Peru	3,381,335	100	2,519,095	74.5	862,240	25.5
Metropolitan Lima	884,397	100	708,084	78.9	186,313	21.1
Rest of the coast	763,786	100	600,687	78.7	163,099	21.3
Highlands	1,247,872	100	853,542	68.4	394,330	31.6
Jungle	485,280	100	366,782	75.6	118,498	24.4

Source: ENDES 2000

When a woman has an unplanned pregnancy, she has the following options: continue with the pregnancy and have a child she wants; continue with the pregnancy and have an unwanted child; or interrupt the pregnancy voluntarily. The next section will attempt to accurately estimate the number of induced abortions in Peru using a combination of official sources and assumptions based on a survey of professionals and researchers familiar with the issue.

2. Abortion opinion survey of health professionals and non-professionals

An opinion survey of 103 people familiar with the topic of abortion in Peru was carried out to provide information on the circumstances in which abortion occurs. Respondents included physicians, gynecologists, general practitioners, obstetric nurses, nurses, psychologists, and traditional birth attendants in 12 cities and rural areas of the country.¹⁴ Fifty-two percent of respondents were men and 48 percent women. Fifty-nine percent work at a public health facility, 14 percent work at a private clinic, 11 percent work at a women's organization, seven percent have an independent professional practice, four percent are university professors, and four percent are traditional birth attendants.

Respondents were asked about conditions under which induced abortions are performed, based on their experience and knowledge. The questionnaire included detailed questions about sources/providers of abortion, methods and techniques used, the probability/likelihood of complications, and the probability that women suffering complications would be hospitalized for treatment. Responses were encoded and analyzed, then used to generate numerical estimations of the risk of complications and likelihood of hospitalization.¹⁵ These assumptions were then used to determine a multiplication factor for estimating the annual number of induced abortions.

The opinion survey offers valuable information because respondents are familiar with both the issue and the general conditions of the areas where they reside and work.¹⁶ Respondents had worked for an average of 15.6 years, of which 13.8 years were in the city in which they were interviewed. Sixty-eight percent had worked in rural areas of the coast, highlands, and jungle.

Additionally, 30 women who confided their personal experiences and that of women in their communities with respect to abortion were included in the survey. Their responses provided valuable data for understanding the problem.

2.1 Methods for inducing abortion

Respondents described all the methods known to them that are used to induce abortion in Peru, without regard for who performed them (professionals or un-

¹⁴ Surveys were carried out in the following cities: Lima and Callao, Cusco, Trujillo, Cajamarca, Tarapoto, Huánuco, Huancayo, Ayacucho, Huancavelica, Chíncha, Huaraz, and Iquitos.

¹⁵ Quantitative data were collected by asking a set of questions separately about each of four subgroups of women: urban poor, urban non-poor, rural poor, rural non-poor.

¹⁶ Despite this advantage, the opinion survey is based on personal perception rather than fact.

trained persons), or for whether or not they were effective. The list includes modern, effective, and safe procedures (such as dilatation and curettage and vacuum aspiration techniques), and a variety of popular but potentially very harmful methods applied by women themselves or by untrained individuals.

The most common way to terminate a pregnancy appears to be the introduction of medicines, substances, or objects into the vagina. This group includes the vaginal, oral, and combined (vaginal and oral) application of prostaglandins (a pharmaceutical product used in gastroenterology and obstetrics during labor), whose dosage varies depending on whether it is self-prescribed, suggested by a pharmacist or pharmacist's assistant, or recommended by a medical practitioner. In 1992 (when a similar opinion survey was carried out), prostaglandins were hardly mentioned; by contrast, in this survey, they were mentioned by a majority of respondents.

The use of prostaglandins to terminate pregnancy became popular in 1998 and even before that date in some areas of the jungle. Today, they are commonly used throughout the country and have reportedly led to a decrease in the frequency and severity of abortion complications. Currently, the most frequently reported complication is incomplete, uninfected abortion. Respondents said that "it has been a long time since we've treated septic abortion." One respondent said:

"[...] Before, the traditional birth attendants practiced it [abortion] with catheters, wires or knitting needles. Then they began to perform dilation and curettage. They currently use vaginal and oral prostaglandins. Now the birth attendants don't have to work because the women themselves induce their abortions."

Interviewees agreed that the procedures and methods used to induce abortion are now safer and less risky than before although some poor rural and urban women still resort to methods that threaten their health and life. For example, introducing solid objects (branches, knitting needles, catheters and wires, among others) and liquids (soapy water, hydrogen peroxide, bleach, tar, infusions made from herbs, Coca-Cola, and salty solutions) into the vagina.

"[...] the patients arrive with burns in the uterus resulting from the introduction of infusions of herbs, water mixed with detergent or with alcohol and other toxic substances."

The use of "menstrual regulators" is also common. These include injections of hormones and the application or ingestion of previously mentioned prostaglandins (to which oxytocin is often added when either of these do not work). Other common methods include taking medicines (orally), mainly aspirin and acetaminophen (*Mejoral*), in large quantities (20, 30 or 50 tablets at a time), and ingesting extracts, infusions of herbal teas, and native plants, such as rue, avocado pits, basil, maidenhair, *cchamico*, cotton leaf, bush bean leaf, nettle, oregano, marjoram, sarsaparilla, *ayrampu*, rosemary, *contoyo*, rocoto pepper (with 20 acetaminophen tablets) and *chocho* water (a grain native to Ancash Department).

In their desperation to end their unwanted pregnancies, women also resort to voluntary trauma such as falls, beatings from their husbands, and other forms of physical violence, as well as the intramuscular administration of a prostaglandin used in veterinary medicine (*Iliren*) in the northern highlands and jungle, applied in a single dose of 10 to 20 cm³ by a veterinarian or other untrained individual.

These practices reveal the grave and hidden dangers faced by women who have an unwanted pregnancy and who make the decision to terminate it. In many cases, this decision leads to wholly unanticipated consequences, such as resorting to an untrained individual or self-inducing abortion using toxic and potentially fatal substances.

2.2 Where women go to get an abortion

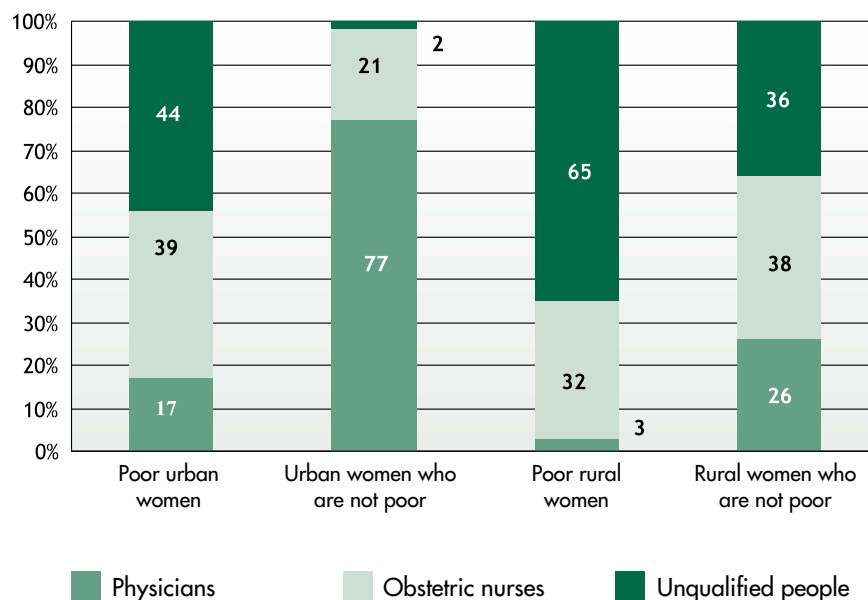
Access to healthcare providers depends on a woman's financial means and her place of habitual residence: urban or rural. Induced abortion among rural women is thought to be infrequent: “[...] *that's why they have so many children*”; *they accept their reality and although the child's father may be the brother of the husband, of her own father, brother, or step-father, the woman has it anyway*”; *they're [rural women] very stoic, they are prepared to suffer and they have lots of children.*¹⁷ However, when a rural woman does decide to have an abortion, she tends to go to the city to have it; or she visits a healthcare practitioner, an obstetric nurse or nurse (if there are any), or a traditional birth attendant; or she tries to induce it herself, depending on her economic situation.

The possibilities for accessing healthcare services are higher among urban women of financial means. According to respondents, 98 percent of this group is treated by a healthcare provider (77 percent by a physician and 21 percent by an obstetric nurse or nurse). By contrast, 56 percent of poor urban women have abortions performed by a healthcare provider, except that the majority of these are obstetric nurses or nurses. For rural women with economic means, the situation is somewhat better: 74 percent go to a healthcare provider, again, the majority of which are obstetric nurses or nurses. Poor rural women are the ones who suffer most, since only 35 percent receive qualified care, while 65 percent are treated by an untrained person (health promoter, traditional birth attendant, traditional healer, herbalist or shaman) or try to induce the abortion themselves (figure 9).

¹⁷ In many of the country's rural areas, abortion is explained and understood as an incident in which mythological Andean figures intervene. It is said that when a woman steps in a puddle, the *Iname* or the rainbow enters her body through her feet and travels to her womb in the form of a ball of blood that begins to grow. “It's a bad thing that they have to take out.” In the southern highlands, it is believed that the *apus* charge the earth with positive or negative energy. When someone enters an area charged with negative energy, she can acquire a *chacho* which produces stomach cramps, allergies, vaginal discharge and the growth in the woman's womb of a deformed being that has to be eliminated. The community helps the woman. The traditional healers give her 14 types of oil to drink, as well as other preparations, until the fetus is expelled. It is later burned to prevent it from entering the body of another woman. In some Andean regions, there are dramatic accounts of community members who say that while rural women do not have abortions, when faced with an unwanted pregnancy, they make a much more drastic decision: suicide.

Figure 9

Four groups of women, three kinds of providers



Source: Opinion survey on the practice of induced abortion in Peru 2001

Respondents agree that when a woman tries to self-induce abortion, it is a long, difficult process that is frequently unsuccessful. Because the woman hardly ever completes the abortion herself, she is almost always forced to get someone to help, which involves a chain of events and situations:

“They [the women] begin with the simplest things: they take aspirin, rue or other mixtures and when these prove ineffective, they apply a menstrual regulator or take oral contraceptives, or a large quantity of Mejoral [...] They wait, nothing happens, so they find someone to do something to them [...] some procedure [...], some manipulation[...]”

“[...] Many poor women end up in untrained hands or in the hands of unscrupulous individuals who abuse them economically or sexually.”

“They tell some adolescents and young women that having rough sex helps the process of eliminating the fetus. They tell others that the only way to open the cervix is through coitus.”

But there are also physicians who commit this type of sexual violence. One interviewee reported having treated a woman whose doctor had proposed having sex before the procedure to “soften the cervix.”

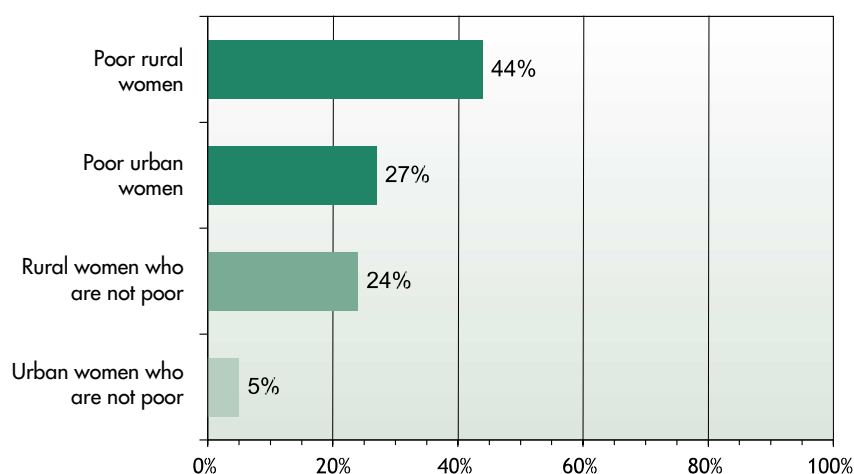
2.3 Estimation of the risk for complications

According to opinion survey respondents, whose opinion is considered reliable, the likelihood of complications for an abortion depends on who performs it. It is higher if the woman tries to self-induce or if she goes to an untrained individual than if she goes to a health provider. They estimated that approximately 71 percent of the first group would suffer some major or minor complication because the techniques and methods used are extremely dangerous. Conversely, only 25 percent of those who go to an obstetric nurse or nurse and five percent of those treated by a physician will suffer some major or minor complication.

A woman's socioeconomic condition (poor or not poor) and her place of habitual residence (urban or rural) are also factors that play an important role in the likelihood of suffering complications, even if the patient goes to the same type of provider. According to the individuals surveyed for this study, the risk is higher for poor women who live in rural areas or population centers without medical services. They estimated that of 100 women who have an abortion and suffer from complications, 44 would be poor rural women, 27 would be poor urban women, 24 would be rural women who are not poor, and five would be urban women who are not poor (Figure 10). Poor women's greater risk for complications is explained by their health status before the abortion: anemia, malnutrition, and weakness due to repeated attempts to terminate their pregnancies. The greater risk is also attributed to the following facts: the health practitioners to which poor women have access do not have the same training as those treating women with greater resources; the less-trained professionals do not implement practices to prevent infections; and economic limitations and the need to continue with their daily work cause poor women to ignore post-procedure care instructions and fail to take the prescribed medicines.

Figure 10

Complication risk per every 100 women who have an induced abortion



Source: Opinion survey on the practice of induced abortion in Peru, 2001

Using data from the ENDES 2000 survey, a composite indicator¹⁸ was developed to assess women at risk by socioeconomic condition in order to calculate a weighted national average risk for complications. The partial figures for complications for the four groups of women (urban poor, rural poor, urban not poor, rural not poor) result in a weighted average of 30.5 percent for the risk of complications, which is much lower than the 1992 estimate of 47.4 percent. The reduction in the percentage of complications is likely due to the following:

- Introduction of “medical abortion” approximately three years ago in the country, even in poorer sectors, with the use of prostaglandins (previously, only surgical abortion was known).
- Dissemination among health professionals of the manual vacuum aspiration technique for removing ovular remains, which has little risk of complication.
- Improved care by obstetric nurses, nurses, and physicians, who carry out practices to prevent infections.
- Increased knowledge of the use of antibiotics to prevent infections, even among poor women.
- Availability of health professionals familiar with the problem of unwanted pregnancy who provide comprehensive treatment to women of all socioeconomic levels.

2.4 Estimation of the likelihood of hospitalization

Poor women are more likely to be hospitalized for abortion complications, regardless of their place of residence, according to opinion survey results: 13.6 percent of poor urban women and 18.5 percent of poor rural women are likely to be hospitalized for the treatment of abortion complications. The figure is lower if a woman has economic resources and lives in the city (1.5 percent); but for rural women of financial means, the likelihood of hospitalization is also high (9.4 percent).

Using the composite indicator again, a weighted national probability for hospitalization was estimated. This figure was calculated to be 14 percent, which means that for every woman hospitalized for abortion complications, there are seven who are not hospitalized.

The weighted probability for hospitalization calculated in this study is lower than that in the 1994 study (20.6 percent) (figure 10). The decrease is attributed to the following factors:

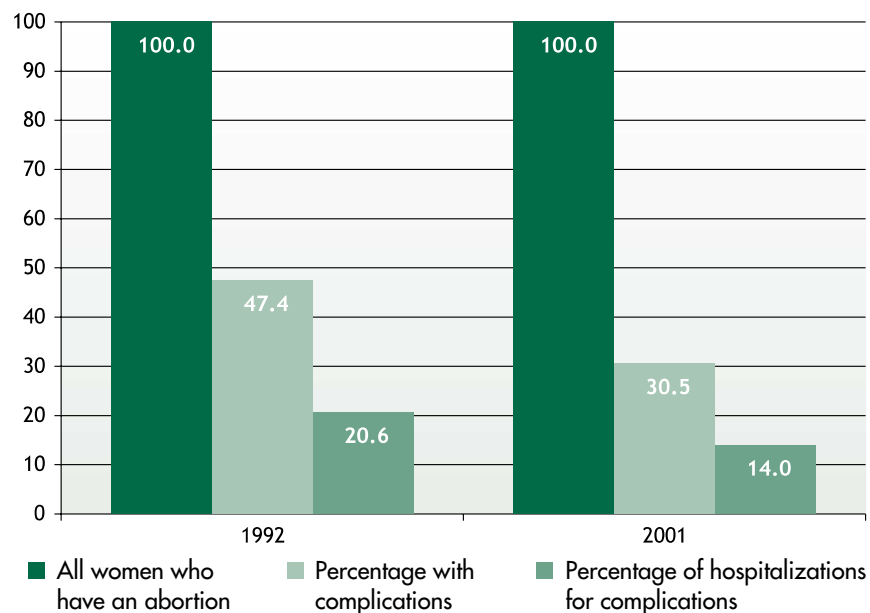
- The complications of abortions women currently suffer are much less frequent and less severe, as mentioned above.

¹⁸ Four indicators were used to determine socioeconomic level. One was associated with the woman's educational level and the other three with household conditions: connection to a sanitation system, main type of flooring, and water supply.

- Minor complications are treated in a timely manner by the same practitioner who performed the abortion or by a pharmacist, thereby preventing the woman's condition from worsening.
- Women feel less shame and fear about going to health practitioners because an increasing number of public sector providers—although not the majority—have more understanding attitudes toward postabortion patients than they once did.
- The geographic, economic, and cultural barriers that limit poor rural and urban women's access to health services have decreased.
- There are fewer norms requiring practitioners to report patients who seek treatment for abortion complications to the police.

Figure 11

Estimated risk of complications and likelihood of hospitalization, 1992 and 2001



Source: Opinion survey on the practice of induced abortion in Brazil, Colombia, Chile, Mexico, Peru and the Dominican Republic (1992).
 Source: Opinion survey on the practice of induced abortion in Peru (2001).

3. Estimation of the Number of Clandestine Abortions Performed Annually

The cases of hospitalization for abortion complications in Peru are estimated to represent only one woman of every seven who have abortions.¹⁹ The rest never go to health facilities and are not included in statistics. In order to capture this missing portion of cases, an indirect estimation technique developed by the Alan Guttmacher Institute (AGI)²⁰ was used for this study. This technique was used by Susheela Singh (AGI) in a 1994 study on induced abortion levels in six Latin American countries, and is based on three main points:

- the number of hospital admissions recorded for all causes at all public health facilities (Ministry of Health, ESSALUD or IPSS facilities, army and police hospitals), as well as those of the private sector;
- the number of hospital admissions for abortion complications; and
- the estimated number of hospital admissions for all causes.

This last point, the estimated number of hospital admissions, is critical due to the underreporting in Ministry of Health statistics, which cover only 35 percent of all hospitalizations for all causes. In 1998, the last year for which Ministry of Health statistics are available, 476,142 patients were released from public and private health facilities.²¹ Of this group, 23,692 patients, or five percent, had been hospitalized for abortion complications.

Due to the limited coverage of its health statistics, the Ministry of Health uses estimates of hospitalizations prepared by the Sectoral Technical Planning Office. In 1989, the Ministry of Health's Statistics and Information Office recorded 281,003 hospitalizations for all causes, while the Sectoral Technical Planning Office estimated the figure to be 1,040,753. It was not possible to obtain estimates for 1998, the most recent year for which official statistics are available; therefore this study estimated the figure to be 1,340,245 cases.²²

¹⁹ This figure represents the estimated weighted probability for hospitalization (see section 2.4).

²⁰ Singh, S. and D. Wulf. *Niveles estimados de aborto inducido en seis países latinoamericanos. Perspectivas en Planificación Familiar*. Special issue 1994. pgs. 3-14.

²¹ As this study was being completed, in October 2001, the Ministry of Health's Statistics and Information Office made data available on hospitalizations for 2000, for causes 630-676, as well as records of hospitalizations for all causes. The data were preliminary and had inconsistencies that suggested quality control was lacking. For example, they showed a 73% decrease in treatment as compared with 1998 figures (126,930 hospitalizations in 2000 versus 476,142 in 1998) and the information on abortion, which affects only women, included 325 cases of men. For this reason, the data were not used for this study; rather 1998 official statistics were used. In early 2002, examination of data revealed that the average number of hospitalizations for 1999 and 2000 was 550,000.

²² The estimate is based on the assumption that the number of individuals hospitalized in public and private health facilities would have grown between 1990 and 1998 at a constant rate of 2.8 percent annually, which is the growth rate observed between 1988 and 1990, the last three years for which estimates prepared by the Ministry of Health are available.

Ministry of Health statistics for hospitalizations for the treatment of abortion complications were adjusted based on coverage and quality criteria. It was taken into account that not all hospitals report statistics to the central Ministry of Health office, and that some do so only partially or with significant delays. Moreover, some patients classified as having abortion complications received treatment for other problems associated with the pregnancy (such as ectopic pregnancy). Furthermore, the records include cases of women hospitalized for miscarriage, and these had to be excluded in order to ensure that the statistics refer only to induced abortions. After these adjustments were made to MOH statistics, the number of hospitalizations for abortion complications in 1998 was estimated to be 50,259 (table 3).

Table 3

Women hospitalized in health facilities nationwide for treatment of complications of induced abortion. Adjusted figures for 1998

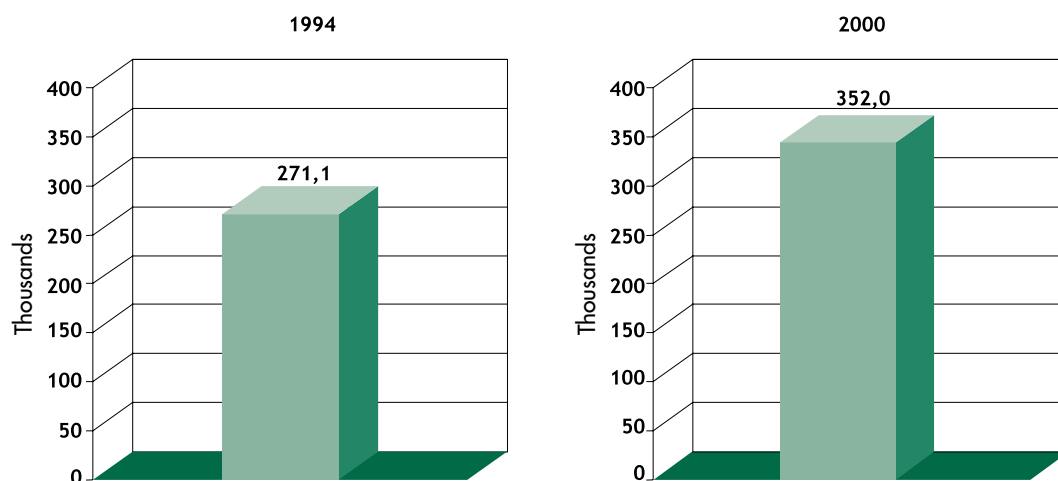
Indicator	Number or Percentage
1. Estimated hospitalizations for all causes*	1,340,245
2. Officially recorded hospitalizations for all causes	476,142
3. Percentage of recorded hospitalizations for all causes as compared with the total estimated number (2/1)	35.7%
4. Recorded hospitalizations for abortion complications	23,692
5. Percentage of hospitalizations for abortion complications adjusted with respect to the number of hospitalizations recorded (4/2)	5.00%
6. Estimated number of hospitalizations for abortion complications with respect to total estimated hospitalizations (5 x 1)	67,012
7. Number of hospitalizations for abortion complications, excluding 25 percent (the estimated percentage of miscarriages)	50,259

*See footnote 23.

Since not all women who suffer abortion complications are hospitalized, for this study, the recorded cases were multiplied by a factor that combines complication risk and the likelihood of hospitalization. This permitted the study to recover some “hidden” cases that were not officially recorded. The estimated factor used in this study is seven. Multiplying this figure by the number of hospitalizations recorded in Ministry of Health official statistics reveals that in Peru, there are 352,000 abortions annually. The estimate suggests that there is one abortion for each live birth and that each year, 5.2 percent of Peruvian women aged 15 to 49 are likely to have an abortion. Figure 12 compares this figure with that obtained in the 1994 study.

Figure 12

Estimated number of induced abortions in Peru, 1994 and 2001



Note that the percentage of abortions per 100 live births increased between 1994 and 2001 (from 43 percent to 54 percent), while the annual percentage rate of abortions per 100 women aged 15 to 49 (5.2) remained constant (table 4).

Table 4

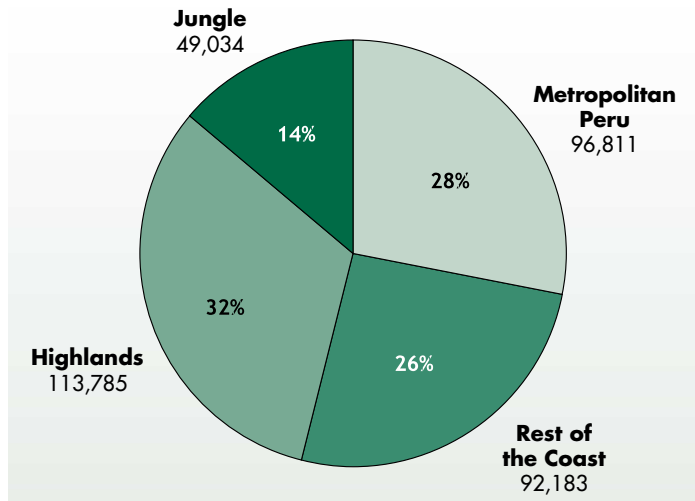
Induced abortion indicators

Indicators	Year	
	1994	2001
Number of women hospitalized for abortion complications adjusted for quality and coverage (excluding miscarriages).	54,230	50,224
Total estimated induced abortions	271,150	351,813
Per 100 live births	43	54
Annual rate per 100 women aged 15 to 49	5.2	5.2

The same procedure used for the country as a whole was used to determine the number of abortions in each of the country's natural regions. These figures are presented in figure 13. In Lima and the rest of the coast, there are approximately 100,000 abortions annually, while in the highlands there are 114,000, and in the jungle, 49,000. Just over a quarter (28 percent) of induced abortions occur in Metropolitan Lima while 26 percent take place in the rest of the coast, a third are carried out in the highlands, and 14 percent take place in the jungle.

Figure 13

Distribution of total induced abortions by region
Country total: 351,813 or 100 percent



Unplanned pregnancies

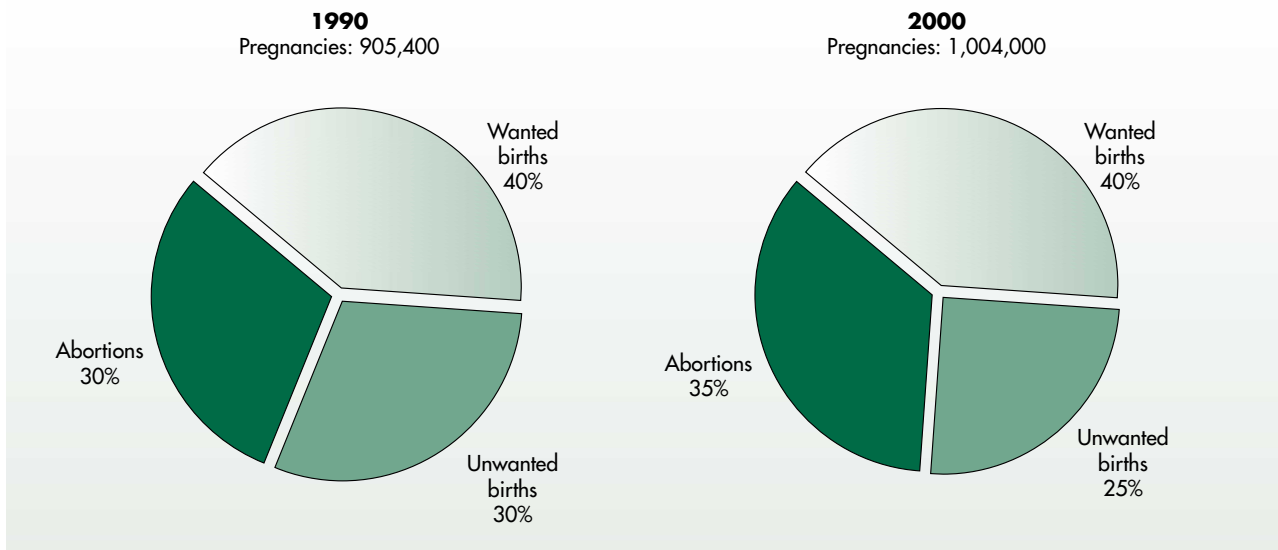
Adding the number of induced abortions to the number of births in 2000 gives the total number of pregnancies. Using this figure, and taking into account total and desired fertility (according to the number of births in the five years preceding the ENDES 2000 study, which were described in Chapter 1), it is possible to determine how the pregnancies ended: in wanted births, unwanted births, or induced abortions.

The data reveal that in Peru, of an estimated one million pregnancies occurring annually, 40 percent end in wanted births, 25 percent in unwanted births,

and 35 percent in induced abortion. Compared to 1990, pregnancy outcomes have shifted slightly with an increase from 30 percent to 35 percent in those ending in abortion. Unwanted births decreased from 30 percent to 25 percent (figure 14).

Figure 14

Distribution of total pregnancies 1990 & 2000



4. Additional data on induced abortion in Peru

4.1 Profile of women treated for abortion complications at public health facilities

According to health facility statistics, just over 62 percent of patients are under the age of 30. Among this group, 14 percent are under 20. Thirty percent have no children and 60 percent have from one to four children. Termination of the pregnancy occurs most often at seven to 12 weeks' gestation (66 percent of the total). Eighty-three percent of the women have a stable partner living with them, either in marriage (23 percent) or in a consensual union (60 percent), which dispels the common belief that abortion is more frequent among single women.

Most women do not experience terminating an unwanted pregnancy alone. Ninety-five percent of the health professionals surveyed reported that women go to a facility accompanied by someone, generally their partner (according to 61 percent of survey respondents) or friends (according to 35 percent). In small towns and rural areas, it is generally the partner who seeks the provider or the facility, finds out about the method and the cost of the procedure, and then brings the woman in for treatment.

4.2 The most frequent complications of induced abortion

According to opinion survey respondents, there are a variety of complications of induced abortion. These vary in severity from minor complications, such as incomplete abortion, which can be treated on an outpatient basis, to severe complications, including death of the woman due to infection or hemorrhage. Hemorrhage is the most frequent complication although the number of cases has decreased. It is estimated²³ that only between five and six percent of the women who go to public health facilities with incomplete abortions suffer from an infection.

²³ Pathfinder International. Program for the Comprehensive Treatment of Incomplete Abortion in Peru. Documentation of the strategy developed and implemented by the Ministry of Health and Pathfinder International. Prepared by Ferrando, D., March, 2001.

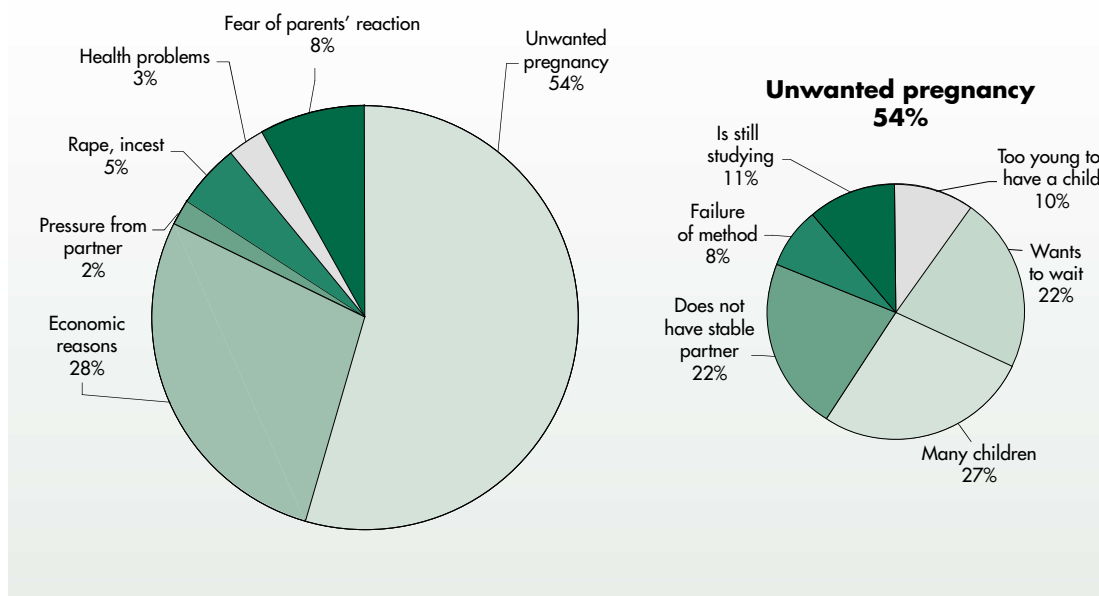
4.3 Reasons for which women seek abortion

This study examined the reasons why women would risk doing something that is illegal in the country and that potentially threatens their life and health when resorting to unsafe techniques performed by untrained individuals. Some women were willing to discuss their experiences, and the professionals interviewed also gave their opinions on the subject.

Fifty-two percent of the interviewed women who had abortions said that they first sought abortion because 1) they “had not expected or wanted this pregnancy” mainly because at the time of conception they already had several children and felt their family was complete; 2) although they wanted more children, the timing was not good; or 3) they did not have a stable partner living with them. Perhaps this was the case for many adolescents; but they also offered many additional motives: they wanted to continue their studies; they were too young to become mothers; and they feared their parents’ reaction. Economic problems were the second most reported reason (28 percent) for inducing abortion. Figure 15 lists these and other reasons mentioned for induced abortion.

Figure 15

Reasons for having an abortion



4.4 Recommendations for reducing the number of abortions performed in unsafe conditions and abortions in general

Survey respondents were aware of the huge problem that unplanned pregnancies represent for women because of the risk that they will seek an abortion. For this reason, they recommended some measures that could serve as policy elements.

The suggestions refer mainly to preventive actions, particularly providing family planning information and education at all health facilities, as well as assuring access to contraceptive methods to all individuals who voluntarily decide to use them. Providing sexual education for adolescents is the second most important recommendation, while the third is the use and dissemination of emergency oral contraceptives at all health facilities, particularly for adolescents and young people. Survey respondents recommended that since there is a law permitting the use of these contraceptives, healthcare providers should be trained in their proper use and they should be made available to those requiring them.

Other recommended measures for decreasing the consequences of abortion relate to the provision of care and involve two aspects of this: showing understanding and empathy toward women who have decided to end their pregnancies (“help women who decide to have an abortion”); and offering these women quality professional care, thereby minimizing the risks to their physical health. Survey respondents suggested training service providers in safe techniques for removing ovular remains. They also recommended “*implementing health services to provide quality care to women with this problem [abortion].*”

Professionals likewise mentioned changes in the legal status of abortion. Just over 15 percent believe that it should be legalized or decriminalized to prevent increasing costs of treatment services and to improve the quality of care. Many also agreed that abortion should be legal in cases in which clinical exams show that the unborn child would have serious physical or cognitive abnormalities, as well as in cases of rape.

Conclusions

This study explores the practice of induced abortion in Peru as a public health problem and as an issue that concerns the sexual and reproductive rights of individuals, which are basic human rights.

- A quarter of the sexually active women in the country (approximately 862,000) continue to have inadequate contraceptive protection and are totally defenseless to the risk of an unwanted pregnancy, which is why abortion is viewed as an alternative to terminate these pregnancies.
- An estimated 352,000 abortions are carried out every year in the country. Women who have abortions come from all socioeconomic backgrounds and generally live with a stable partner.
- Most Peruvian women prefer to have a small family. Official figures (ENDES) show a decrease in the average number of children born per woman, to 2.9 in 2000, while the desired fertility rate is 1.8 children per woman.
- Part of the decrease in fertility is due to clandestine abortion, which has considerable costs in terms of women's health, safety, and dignity, as well as economic costs to the patient. Treating abortion complications also strains the limited resources of the public health system.
- Thirty-one percent of children (more than one million) born between 1995 and 2000 were unwanted.
- As specialized surveys demonstrate, despite significant advances in the dissemination of family planning services, many people still receive poor quality services, if any. Only 68.9 percent of women in union and 44 percent of women of reproductive age use a contraceptive method, according to data available for 2000.
- To prevent unsafe abortions, and abortions in general, we must improve sexual education and the supply of contraceptive services and information; we must achieve greater equality between the sexes; and we must increase public awareness of men and women's reproductive responsibility. All of these measures have positive effects in the medium and long term, but there is a short term that must be addressed because unwanted pregnancies continue to occur, and the majority of them will end in induced abortion.

- There is international concern for the consequences of illegal induced abortion, as demonstrated by the recommendations of the United Nations Human Rights Committee and the Committee on the Elimination of Discrimination against Women, due to the effects this problem has on women's physical and emotional health as well as its impact on society as a whole.

It is worrisome that the Peruvian government, as a signatory to the agreements on reproductive rights of different international forums, has not taken efficient, effective action to address this issue. It appears to take little note of the fact that the United Nations Human Rights Committee has expressed in two sessions its concern about the legal status of abortion in the country, a position that has led to the inhumane treatment of women, especially the poorest women.

If the greater international emphasis on addressing the problem of induced abortion were accompanied by the concern of the Peruvian government, women and society would benefit, and great strides would be made toward improving women's reproductive health and the quality of life of their families.

It is hoped that the findings of this study will contribute to the understanding of the problem of abortion and to improving current health policy, which, in turn, will enable women and their partners to attain their reproductive goals under voluntary, safe, and healthy conditions.

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