From concept to measurement: operationalizing WHO’s definition of unsafe abortion

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Although unsafe abortions are, by definition, risky, safety cannot be dichotomized because risk runs along a continuum. Risk is lowest if an evidence-based method is used to terminate an early pregnancy in a health facility; it is highest if a dangerous method, such as the use of caustic substances orally or vaginally or the insertion of sticks into the uterus, is employed clandestinely to terminate an advanced pregnancy. There is a spectrum of risk between these two extremes. Along that spectrum, for example, lie cases of self-administration of misoprostol or the use of outdated procedures, such as sharp curettage, by skilled health-care providers.

The immediate determinants of the risks of an induced abortion, such as the termination method used and gestational age, are influenced, in turn, by underlying social determinants: i.e., the legal context, the availability of safe abortion services, the level of stigma surrounding abortion, the degree of women’s access to information on abortion, and a woman’s age and socioeconomic status. The legal context and the level of safety are closely intertwined, but the association is context specific. For example, where restrictive laws are liberalized, women can receive safe care in certain contexts; conversely, where liberal laws are poorly implemented, women sometimes abort with delay and under unsafe conditions. Thus, illegal abortion is not synonymous with unsafe abortion, as indicated by the original definition: “… legality or illegality of services, however, may not be the defining factor of their safety […] the safety of abortion must be considered within both the legal and legally restricted contexts.”

Rates of induced abortion are difficult to measure because of frequent underreporting or misclassification in surveys, hospital records and health statistics. In light of this, WHO has historically used a pragmatic operational construct that measures safety in terms of only one dimension – legality – in developing its regional and global estimates of rates of unsafe abortion. However, the widespread informal use of misoprostol has added a layer of complexity to the concept of “safety”. As a result, it has become essential to apply a multi-dimensional risk continuum to measure abortion safety. The adverse outcomes associated with unsafe abortion need to be measured as well. Since deaths resulting from unsafe abortion have decreased in recent years, perhaps because of safer methods, the focus should now be broadened from mortality to morbidity as well. A multi-dimensional assessment of the safety of induced abortions, as described, makes estimation more difficult, but the more nuanced measures involved could generate more innovative research and improve the data collected locally and nationally.

Assessing the safety of induced abortion does not suffice, however. In the longer term, global consensus will be needed on the broader indicators used to assess the provision of safe abortion in line with WHO guidance – i.e., indicators capturing access, equity, quality of care and linkages to post-abortion contraception.

References