ABORTION-RELATED DEATHS IN BRAZIL: A CASE-STUDY

Evidence has demonstrated that women have abortions regardless if is illegal in their country of residence, and that restrictive laws tend to increase maternal morbidity and mortality. This study aims to discuss abortion-related deaths in order to disclose how many female deaths are abortion-related and, why those deaths persist as contributing factor of maternal mortality in the Northeast of Brazil, in a context of restrict abortion laws

The RAMOS method was used to identify all death certificates of women of reproductive age of the five Health Administrative Regions of Pernambuco, a Northeaster state of Brazil. The abortion-related mortality cases were studied using both interviews and an investigation of the medical records. All death certificates and questionnaires of women of reproductive age that reported unspecified or inconclusive causes of death, any reference to abortion/miscarriage, and suicide were reviewed. Seven cases of abortion were found. For six, the presence of abortion was identified using hospitals and necropsy records and home interviews, and three abortion-related deaths were confirmed. A suicide that was committed after many attempts of abortion was also confirmed.

For those abortion-related deaths there were confirmed, the main investigator carried out a new investigation between two to twelve months after the occurrence of the deaths[1]. Relatives of each deceased woman were contacted and a new interview scheduled in their hometowns. Husbands, fathers, sisters, mothers, friends and mothers-in-law were interviewed. They were asked to confirm socio-demographic and reproductive health data, and then, they were asked for specific information about the abortion process, the circumstances of the death, their feelings and expectations. The main interviewee signed the informed consent already enrolled in this study. All abortion-related deaths were also discussed by the Maternal Mortality Committee and followed the same procedures used to classify the other maternal deaths.

Seven categories were identified and used to describe the main factors involved with those deaths: socio-demographic and reproductive health characteristics; social support versus loneliness; stage of pregnancies; the abortion seeking process; access and effectiveness of heath care; feelings and expectations of the interviewers, and quality of information.

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[1] The time between the occurrence of the death and all steps of investigation delayed these interviews.

Four women who had abortion died to abortion-related reasons in the GERES studied. The women age ranged from 18 to 27 years old. The two younger women were students; the other two were an agricultural worker and a housewife, respectively. Three women were from GERES VIII- Petrolina, and two were from the same city and died in the same month; the fourth woman was from Recife, in GERES I. All had a partner, a husband or boyfriend, and also were living close to a family member at the time of death. Two of them had three live births and for the other two those were their first pregnancies. For just one of the deceased women, the abortion was spontaneous. There was a case of suicide, which was not classified as a maternal death in order to respect the ICD (10^{th} Revision) definitions.

In general the four women tried to interrupt or keep the pregnancy secretly, without asking help or support from their partners, friends or parents. They did not look for help or talk to anyone that was interviewed. They sought a person to perform the abortion, looked for herbal teas, pharmacists or bought medicinal drugs in silence. Just the mother of the woman who committed suicide heard about a possible pregnancy, and tried to intervene.

All abortion attempts occurred around or after 12 weeks of pregnancy. According to the necropsy records of the woman who committed suicide, she was about 20 weeks pregnant. All three women that had abortions sought health care more than once before dying. All went to a local hospital and all were attended to. Some attempted to receive treatment many times for the incomplete abortion. Two died in the referral hospital and one in the local hospital of the GERES VIII.

In general, the families had no difficulty speaking about the deaths. However, they felt sad, disappointed and sometimes angry. The families of the women with induced abortions felt uncomfortable because of the fact they became public across the small city. All who were interviewed complained of the lack of communication between the health workers and the families, especially from the doctors.

Surprisingly, all abortion-related deaths were reported on the death certificates. Only the case of suicide attempt was classified as an undermined cause of death, and both the suicide and the pregnancy status were identified by the necropsy records. Although the abortion-related deaths were well-reported by the physicians who signed them, the hospital records of the two women who induced abortions were missed. The records from the local hospital as well as those from the referral hospital unexpectedly

disappeared from the *SAME* (the medical archive records), and the physicians only discuss any case if they have a patient record available.

The local epidemiologic coordinators from the two cities and the main investigator tried unsuccessfully to find them. In the local hospital, the name and time of each woman's admission was found in the emergency room book; and in the referral hospital, copies of the nurses' reports from the maternity ward and delivery room were obtained to complete the investigations. On the other hand, for the spontaneous abortion case, complete records were available, including a large explanation of the anesthetic complication pos-curettage, as reported in the death certificate.

Although these cases of abortion-related deaths cannot be generalized, they can provide different perspectives. These deaths can represent 7% of the pregnancy outcomes, 5.6% of all maternal deaths, or the leading cause of maternal death for the GERES VIII. It can also demonstrate the relative lack of family planning, the lack of referral for good obstetric care, the failure of the implantation of the N*ational Technical Guidelines for Humanized Abortion Care* (2005), an institutional violence against the women during the abortion care and yet, a consequence of the illegal condition of abortion in Brazil.

References:

Allan Guttamacher Institute. 1999. Sharing Responsibility: Women, Society and Abortion Worldwide. New York.

Albuquerque, Rivaldo. 1994. "Estudo da Mortalidade Materna no Recife, 1992-1993". PhD. Dissertation, NEPO, UNICAMP. São Paulo, Brazil.

Berer, Marge. 2004. "National Laws and Unsafe Abortion: The Parameters of Change". *Reproductive Health Matters* 12(24 Supplement): 1-8.

Berer, Marge. 2005. Medical Abortion: A Fact Sheet. *Reproductive Health Matters,* 13 (26): 20-24.

Brasil. 1997. Law No. 9,263. Brasília: Diário da União, August 20th .

Brasil. Fundação Instituto Brasileiro de Estatística, 2000. "Demographic Census – Preliminary Data". http://www.ibge.gov.br/ Rio de Janeiro, Brazil.

Brasil.Ministério da Saúde. 2005.Norma Técnica para Atenção Humanizada ao Abortamento.Brasília.

Faúndes, Anibal., and José Barzelatto. 2004. O Drama do Aborto: em busca de um consenso. Editora Komeli, 304 p, Campinas, São Paulo.

Ginff, Karen., and S. Costa. 1995. "As práticas contraceptivas e o aborto clandestino no Brasil. Reflexões sobre Gênero e Fecundidade no Brasil". Edited by UNICAMP/SP, Brazil.

Paxman, John M., Alberto Rizo, Laura Brown and Janie Benson. 1993. "The Clandestine Epidemic: The practice of unsafe abortion in Latin America". *Studies in Family Planning*, 24: 205-226.

World Health Organization, International Women's Health Coalition. 2004. Abortamento Seguro: Orientação Técnica e de Políticas para os Sistemas de Saúde. Edited in Portuguese by the Centro de Pesquisas e Controle de Doenças Materno-Infantis de Campinas - CEMICAMP, São Paulo.