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Research Article

Pregnancy Termination Cases by the Family Planning Center of a Tertiary Hospital in Greece

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Abstract

Objectives: Globally about one in five pregnancies will end in an abortion and lifetime average is about one abortion per woman. The objective of our study is to describe the cases of pregnancy termination in our center and their social and economic background.

Materials and Methods: We present 2456 cases of pregnancy termination during a 7-year-time period (2012 - 2019). The number of births during the same time frame in our hospital was 28308. This produces an abortion rate of 8%. The age of these patients varied from 14 to 48 years. Their marital status was 55.7% married, 39.9% single, 3.7% divorced and 0.7% widowed.

Results: Geographic distribution of women presented: European 77.4%, African 10.2%, Asian 10.7%, American 1.1% and Australian 0.6%. Domestic population covers 38% of the cases. Adolescents were 3% of the cases. Most women originated from Albania. The parity of women presenting for abortion was varying from null (30%) to more than 3 (13,2%), with one and two accounting for 26,7% and 30,1% respectively.

Conclusion: Evaluating conditions leading to pregnancy termination helps forming family planning strategies. The community must invest in a combined approach, essentially focusing not only on abortion service provision, but also on preventive aspects, such as continuous education and access to appropriate form of contraceptives.

Keywords: *Pregnancy Termination; Abortion; Migration; Family Planning Center*

Introduction

The reality of abortion is often minimized, yet even in current times, globally about one in five pregnancies will end in an abortion, regardless of whether it is legal or safe. Worldwide, the lifetime average is about one abortion per woman [1,2]. To consider abortion in isolation from the context of women's lives guarantees acrimony and is a well-documented cause of increased maternal mortality [3]. Hippocrates, whose oath is famous for not permitting abortion, also reportedly described methods to terminate a pregnancy for medical indications in his Corpus Hippocraticum [4]. The United Nations resolution on the recognition of maternal mortality as a violation of human rights is a landmark decision in highlighting the need to urgently address unsafe abortion and prevention of unintended pregnancy [5].

The right of a woman to her private life has been the basis on which a number of international bodies have upheld the right of a woman to have an abortion. The right to freedom of expression and access to information has been used to argue for the right of women to receive

information about abortion options. In 2003, World Health Organization (WHO) published international standards and guidelines for safe abortion care [6]. In 2018 World Health Organization (WHO) WHO launched a new guideline to help health-care workers ensure safe medical abortion care [7]. The International Federation of Gynecology and Obstetrics, responsible for a major initiative on these issues, stated that women everywhere should have the right to safe, effective and affordable methods of contraception and safe abortion services [8]. In 2005, the UN Human Rights Committee (UNHRC) made a decision establishing that denying access to legal abortion violates women's most basic human rights, the first time an international human rights body has held a government accountable for failing to ensure access to legal abortion services. In 2008, the Parliamentary Assembly of the Council of Europe gathered in Strasbourg, debated and voted upon a historic report aiming to decriminalise abortion across the continent. The resolution on legal abortion was adopted and invited the member states of the Council of Europe to decriminalize abortion, guarantee women's effective exercise of their right to abortion, ensure that women and men have access to contraception at a reasonable cost, of a suitable nature for them, and chosen by them [9]. Modern methods of contraception have only been in existence for the last 40 - 50 years and today a woman wishing to have two children would typically spend roughly 5 years pregnant, post-partum or trying to become pregnant, and almost three decades trying to avoid pregnancy. Many women have no sufficient access to reproductive health services; many have little or no control in choosing whether to become pregnant. Faced with life-altering consequences of actions they may not be able to control, many women will seek to end the pregnancy, legally or illegally, by whatever means are accessible, available and affordable. A woman's likelihood of having an abortion is similar regardless of whether she lives in a developed or developing region, but due to population distribution most abortions occur in developing countries. On the other hand, abortion-related complications include short term events such as incomplete abortion, sepsis, hemorrhage and damage to internal organs. Long term consequences include secondary infertility, effects on early pregnancy loss and miscarriage, ectopic pregnancy, future obstetric complications (placenta previa, placental abruption) and future perinatal complications (low birth weight, pre-term birth) [10].

Unsafe abortion practice consequently contributes to 13% of global maternal mortality [3]. Contrary to common belief, most women seeking abortion are married or living in stable unions and already have several children. In the United States, one in three women will have an abortion by the age of 45 years [11]. Legal restrictions on abortion do not affect its incidence, only its safety. For example, the abortion rate is 29 in Africa, where abortion is illegal under many circumstances in most countries, and is 28 in Europe, where abortion is generally permitted on broad grounds. Legal abortion has gone hand in hand with sharp increases in contraceptive use, which in turn has been a major factor in declining abortion rates [12]. The decline in abortion incidence was greater in developed countries where nearly all abortions are safe and legal than in developing countries, where more than half are unsafe and illegal [13].

Most teenage women are biologically mature and often look like adults long before they reach mental maturity. This creates the dilemma of how much their reproductive behavior should be determined by their autonomy and how much adult guardians and professionals should attempt to modify it [15,16]. Consideration needs to be given as to whether early marriage and childbearing violate an individual's reproductive rights. Children (age under 18) have the right to privacy. Adults have the right to marry and found a family. Professionals have a duty to protect children from exploitation. These conflicting factors must be taken together so that the overall best interests of the child are promoted, taking into account the individual teenager's competence and circumstances. It should not be forgotten that a proportion of teenage childbearing takes place in some countries because of restrictive abortion laws. In countries in which teenagers have a free choice, as many as 81% of conceptions end in abortion Teenage pregnancy is strongly associated with social disadvantage. This includes unemployment, poverty and discrimination. However, clearly, this is not the whole story, as there are many less affluent countries in the Western world that do not have such high teenage fertility. While social deprivation indices are useful measures, the explanation of higher teenage pregnancy rates in deprived areas is probably multifactorial. It includes personal factors, such as low self-esteem, lower educational and occupational aspirations, less knowledge of contraception and sexual health services and higher gender power differentials. The proportion of births that take place to women aged less than 20 years is 1.7% in Sweden, 6.5% in England and Wales and 10.4% in the USA [17-19]. Women who begin childbearing in adolescence seemingly face a range of adverse social and

economic consequences during pregnancy and later in life [20-22]. Teenagers who give birth are less likely to complete schooling and so they jeopardize their ability and opportunity to obtain higher-paid jobs. Teenage mothers are more likely to be in social housing, be unemployed or their partner unemployed, be on benefits, or experience partnership dissolution by age 30. Teenage mothers are also more likely to remain as single parents throughout their adult life. It tends to be more difficult for them to find and retain a partner and they are more likely to partner with unemployment-prone and lower-earning men [23,24].

Materials and Methods

The Family Planning Center of the 1st Department of Obstetrics and Gynaecology, Athens University Medical School, Alexandra Hospital, provides consultation for couples creating their own future family, preserving their sexual health and also receives patients who desire to discontinue an undesirable pregnancy. Although in Greece abortions can be granted without restriction as to reason, there are some limitations which are imposed. These include restriction by gestational age before the limit of 12 weeks and having parental consent if aged less than 16 years. The procedures are performed mainly using surgical method under anesthesia, with dilation followed by suction curettage in Day Care Hospital Unit.

We present in review 2456 cases of pregnancy termination under the supervision of our Center during a 7-year-time period (2012 - 2019). The number of births during the same time frame in our hospital was 28308. This produces an abortion rate of 8%. The age of these patients varied from 14 to 48 years. Their marital status was 55.7% married, 39.9% single, 3.7% divorced and 0.7% widowed. They came in alone, or accompanied by their partner, their female friend or parents (Figure 1). Their professional and educational status covers a wide range of reported fields (Figure 2).

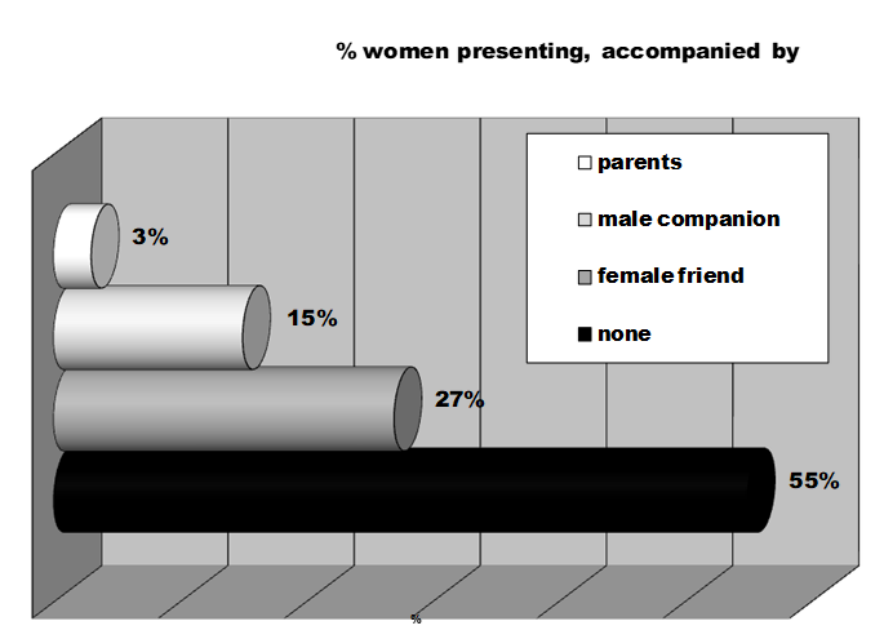

Figure 1

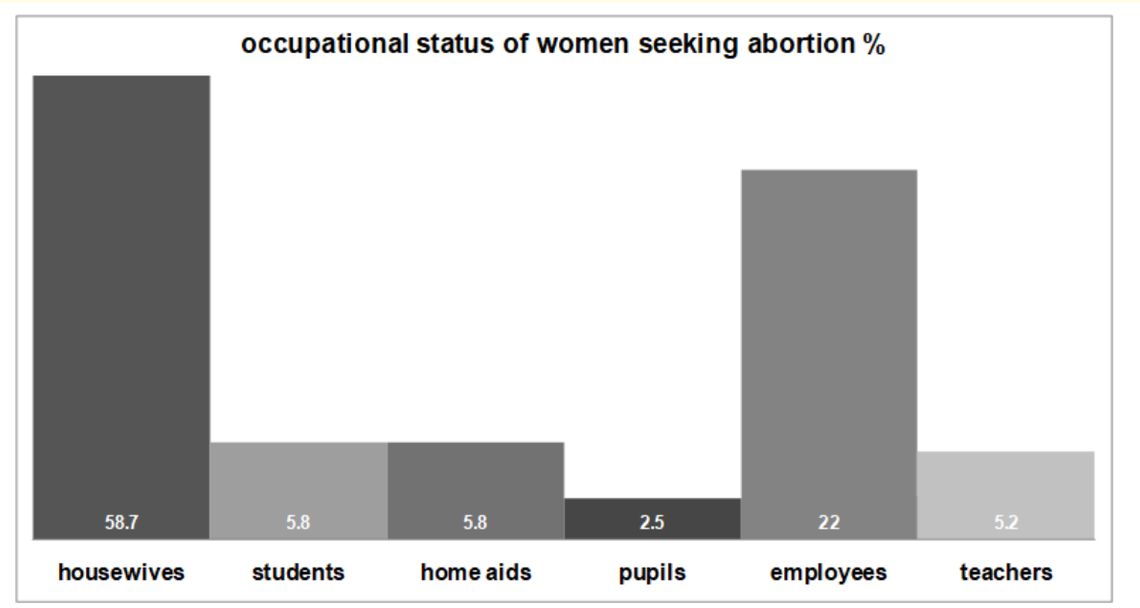

Figure 2

Results

Greece being a junction between Europe, Africa and Middle East, hosts or facilitates vast travelling or migrating populations. Therefor our data describes not only national statistics, but also much wider regional and ethnical characteristics of women finally presenting to our center. Geographic distribution of these women and description of family conditions in moving populations concerning 44 countries in 5 continents are presented: European 77.5%, African 10%, Asian 10.8%, American 1% and Australian 0.7%. Domestic population covers 33.4% of the cases. Percentage of adolescents (under 18 years of age) was 3.1% of the total number, with native born holding the majority (70%). Most women originated from the neighbor country of Albania, followed by the ones from Eastern Europe. The unsuccessful contraceptive methods used, were described (Figure 3). The history of previous abortions was documented, as well as the time interval from the last desired pregnancy (Figure 4 and 5). The parity of women presenting for abortion was varying from null (30%) to more than 3 (13%), with one and two accounting for 27% and 30% respectively.

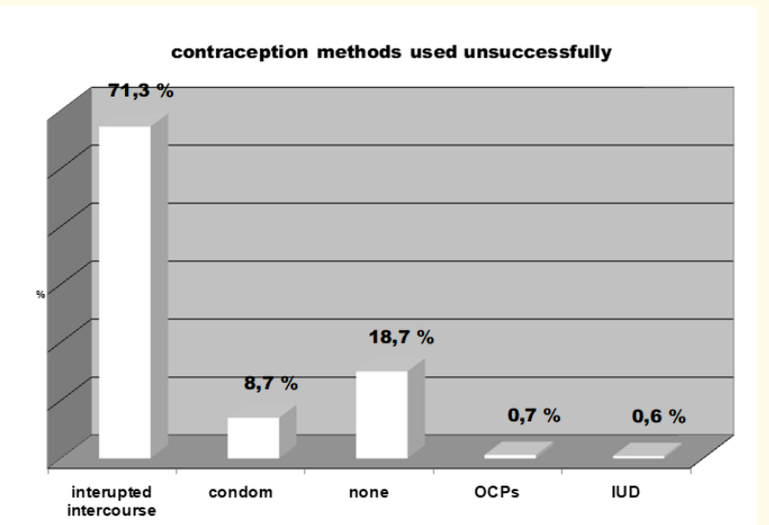

Figure 3

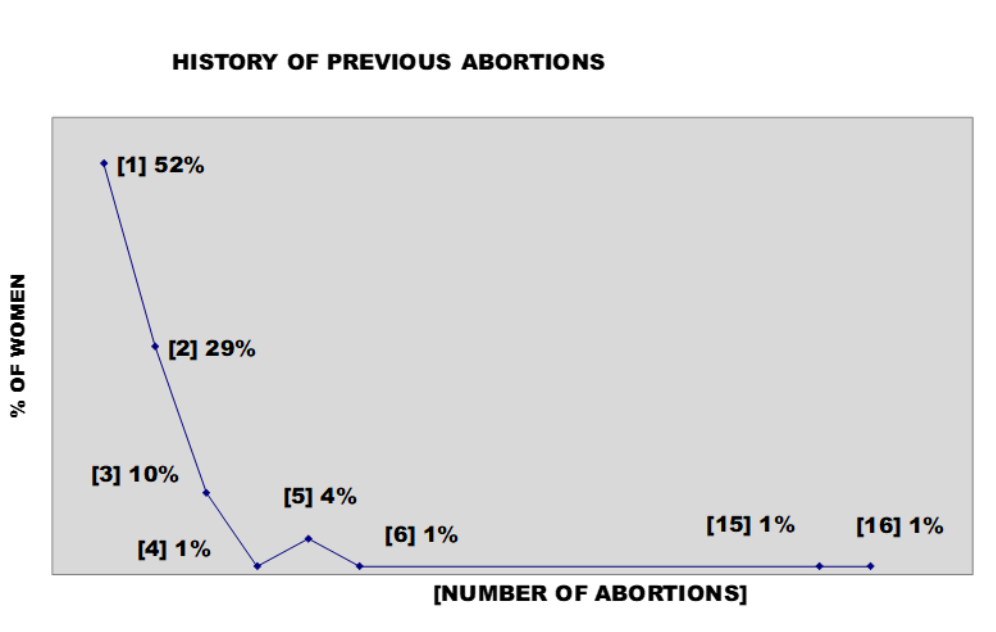

Figure 4

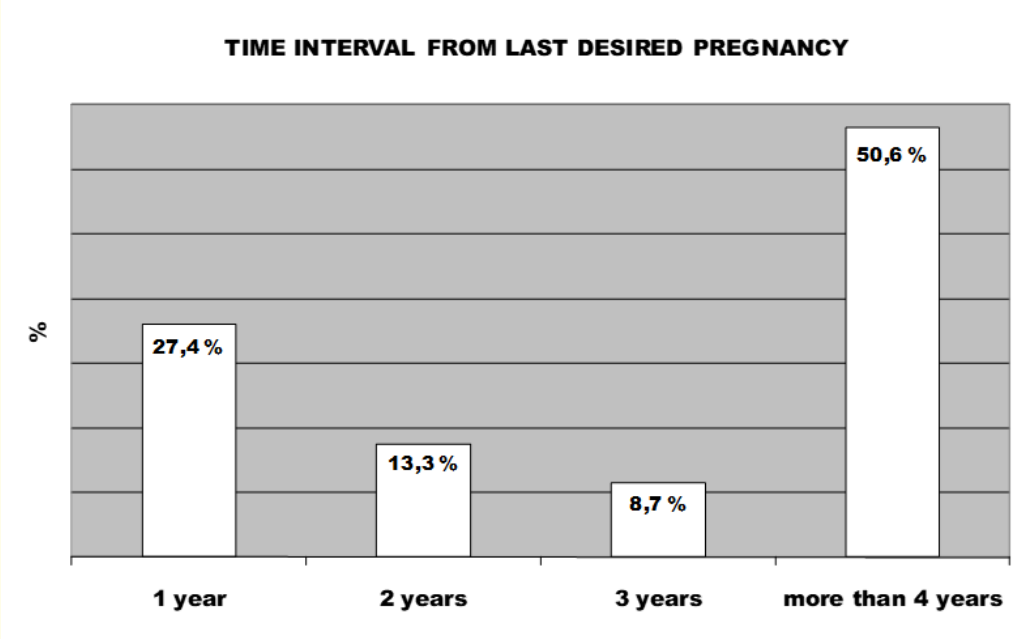

Figure 5

Women are offered the full extent of contraceptive and STI services: screening test for Chlamydia and advice of the results, testing for human immunodeficiency virus (HIV) and testing for gonorrhoea and syphilis. Personal data obtained are not further processed except for anonymous monitoring and reporting requirements of the center [25].

Conclusion

Reproductive 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 of all to make decisions concerning reproduction free of discrimination, coercion and violence [26].

The health impact of unsafe abortion is a major public health concern and reducing the recourse to abortion through expanded and improved family planning services is the aim. In circumstances where abortion is not against the law, such abortion should be safe [26,27]. Obstetrician gynecologists are seen as the experts in matters concerning sexual and reproductive health, including contraception, abortion and its complications. As such, there are greater responsibilities to be weighed alongside individual rights and an evidence-based approach is required in all cases. While access to comprehensive sexual education, information and modern methods of contraception that meet the needs of people will reduce the likelihood that women will be faced with unintended pregnancy, some women will continue to face the difficult decision not to continue a pregnancy at that point in their lives.

Early age at first intercourse is significantly associated with pregnancy under 18 years. Comprehensive sex education, which includes information about all contraceptive options and their optimal use, is essential. Services for young adolescents need to be confidential, youth friendly and culturally appropriate with time allocated for development of rapport and to address contraceptive, sexuality and broader health issues [28].

The evaluation of the conditions leading to undesired pregnancy termination helps forming family planning strategies. Contraceptive methods are differently accepted by specific groups and minorities. The number of abortions in reproductive life and the distance from the last successful pregnancy are indications of family planning maturity of the studied population. It must be acknowledged that to reduce the incidence of unwanted pregnancies and complications deriving from them, the community must invest in a combined approach, essentially focusing not only on abortion service provision, but also on preventive aspects, such as continuous education and access to appropriate form of contraceptives.

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Disclosure of Interest

The authors declare that they have no competing interest.

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