Open Journal of Obstetrics and Gynecology, 2013, 3, 732-738 **OJOG**
http://dx.doi.org/10.4236/ojog.2013.310135 Published Online December 2013 (http://www.scirp.org/journal/ojog/)

Profile of abortion in Chile, with extremely restrictive law

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Received 10 November 2013; revised 8 December 2013; accepted 16 December 2013

ABSTRACT

Chile, together with El Salvador, Malta and Nicaragua has the most restrictive abortion laws. In these countries there is very little information on pregnancies that end in abortions. An analysis is made of official information regarding hospital discharges for abortion in Chile between 2001 and 2010, classified according to age and according to the WHO ICD 10. The Chilean Ministry of Health's Statistics Office (DEIS) collected the data. In 334,485 hospital discharges for abortion, Ectopic Abortion (O00), the Hydatidiform Mole (O01) and Other Abnormal Products of Conception (O02) corresponded to 37.2% of hospital discharges. Spontaneous Abortion (O03) reached 15% and Non Specified Abortion (O06) reached 35.5% and most probably included complications of induced abortions. 77% of hospital discharges corresponded to women between 20 and 34 years of age. Adolescents correspond to 11% of hospital discharges. In the annual average of 33,500 hospital discharges, Other Abnormal Products of Conception (O02), Other Abortions (O05), and Non Specified Abortions (O05) contribute to 72.7% of hospital discharges. This is explained by incomplete diagnoses, by means of the omission of induced abortion as this would mean jail for the woman and legal red-tape for the health personnel involved. Maternal mortality has not fallen. Abortion Mortality and Fatality rates do not change. There is a discrepancy between the law and hospital discharge diagnoses for abortion. The antiabortion law remains unheeded and obeys an ideological bias that brings damage and abuse to Chilean women. The aim of this study is to gain better information from a country that does not allow abortion under any circumstance, and its usefulness to countries in similar situations, together with its negative consequences on woman's health and rights.

Keywords: Abortion Discharges, Abortion Law, Unlawful Abortion

1. BACKGROUND

Chile together with El Salvador, Malta and Nicaragua has the most restrictive abortion laws [1-4]. Therapeutic abortion or an interrupted pregnancy is not allowed even in cases of risk of death or serious complications of pregnancy on maternal health. There is no information available, on the total female population, on what hap- pens in these countries as with pregnancies that are terminated by abortion, as it is very difficult to explore clandestine abortion and the information available is biased [5].

The World Health Organization defines abortion as the interruption of pregnancy with adequate procedures prior to fetal viability. This definition makes no mention of the fact that the fetus is alive or dead [6]. From a legal point of view, it has been interpreted as the interruption of the natural pregnancy process which produces the death of the fetus or product of conception. But there is no explicit explanation of this issue in Chilean legislation, only medico-legal or forensic interpretations [7]. Each country has definitions that vary in time and reforms in the legislation make it difficult to compare. From the point of view of obstetrics and gynecology, there is a variety of criteria for classifying abortion, but the one which is most frequently used is the WHO International Classification of Diseases (ICD 10) which permits an analysis according to age, gender, occurrence, prevalence,

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evolution in time and comparison among countries. Abortion appears in Chapter XV, heading O and has 9 categories (00 - 08) and 9 sub-categories [8].

Since 1931, therapeutic abortion in Chile has been contained in article 119 of the Health Code. Its text was repealed in 1989, towards the end of the dictatorship, and currently reads as follows: "No action may be taken which has the objective of provoking an abortion" [1].

The aim of this study is to provide the best official information available on abortion in Chile, to analyze its scope, limitations and to make it available to help other countries in similar situations, together with its eventual consequences on Women's Health.

2. METHOD

Official information has been obtained from hospital discharges for abortion cases in all the establishments in the country between 2001 and 2010, classified according to WHO ICD 10 and according to age. The records of discharge causes of hospitalized patients cover the whole country. The Ministry of Health's Department of Statistics (DEIS) collects this information through a special software application developed and placed at the disposal of all public and private establishments. The source is the National Hospital Discharge Statistics (IIEH), which is compulsory in the country. Diagnoses are recorded by physicians upon the patient's discharge from hospital and kept in the corresponding medical record [9]. These records are processed by specialized personnel in each hospital, and are validated by the Statistics Departments of each region. The DEIS finally validates, analyses, consolidates and publishes the information. In the case of this study, the DEIS provided a special analysis of the data base of hospital discharges for abortion in Chile, classified into five year age groups between 2001 and 2010.

The information analyzed is expressed in simple tables. Simple percentages and rates have been used with information on women of fertile age, live infants born provided by DEIS and INE (National Statistics Institute) [9,10]. The linear correlation coefficient uses the Pearson and Lee model.

3. RESULTS

Table 1 shows total annual discharges and WHO ICD 10 composition according to causes, remains stable over the decade. In a total of 334,485 discharges in 10 years, the highest proportion is 10.5% (2002), and the lowest 9.5% (2010), a difference that is not statistically significant. Discharges for ectopic pregnancies (O00) remain steady with variations of less than 2%. Hydatidiform Mole (O01) reached a maximum of 12.8% and a minimum of 8.5. Other abnormal products of conception (O02) also maintain similar proportions, varying from 10.8 to 8.9%, and corresponding to 37.2% of total discharges.

This group includes the interruption of embryonic development, Non hydatidiform Mole, retained abortion and other specified and unspecified abnormal products of conception. These are open categories that not always have histopathological studies to back them. Spontaneous abortion (O03) reaches 15%, which could be overnumbered.

Medical Abortion (O04), which includes legal abortion and therapeutic abortion are not recorded, as established by the current legislation. Non Specified Abortion (O06) is the second most frequent, with 34.7%. For the hospital discharge statistical staff, this category is invoked when reports contain insufficient information and therefore cannot be given a more specific classification. This category might possibly include complications caused by hemorrhages in illegal voluntary abortions. The last two categories Failure of Induced Abortion (O07) and Complications caused by Abortion, Ectopic Pregnancy and Hydatidiform Mole reach very low percentages.

Table 2 shows the age distribution of the total abortions recorded in the 10-year records.

41% of discharges correspond to women between 25 and 34 years of age, and 77% to women between 20 and 34 years of age. Adolescents corresponded to 11% of total hospital discharges.

Ectopic pregnancy increases with age until the age of 34. Mola pregnancies reach 1.7% in adolescents. The same proportions are maintained in the following five-year periods. Other abnormal products of conception increase progressively till the age of 34 and remain steady until age 39. Spontaneous abortion has a greater frequency than expected between ages 20 to 39. Other Abortions corresponds to 60% in the 20 to 34 year olds. Non Specified Abortion accumulates high rates of discharge at all ages. The last two rubrics (O07 and O08) show no great variations with age.

Table 3 shows abortion risks according to age and causes. Adolescents have been divided into two groups: under 14 years of age and 15 to 19 years of age, in order to compare the information on these two groups, of which there is very little. The risk of ectopic pregnancy increases progressively with age, coming to 27.3 per 1000 for women of over 40; nevertheless the risk is greater in the 10 to 14 year old age group than in 15 to 19 year olds. The rest shows the classical J curves described as fertility risks according to age. The criteria of this cause coding do not differ in the analysis of abortion risk per 1000 live births and by age groups.

The last column gives indication of interruption of abnormal pregnancies for reasons of health. described in all textbooks, as is the case of ectopic pregnancies, molar

Table 1. Hospital discharges for abortion cases. Chile 2001-2010, by year and WHO ICD.

ICD	O00		O01		O02		O03		O05		O06		O07		O08		Total	
Year	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N (*)	%
2001	3460	9.8	226	8.5	11065	8.9	6364	12.5	314	11.5	12667	10.9	40	11.3	249	13.9	34.385	**10.3**
2002	3694	10.4	280	10.5	11752	9.4	5527	10.9	282	10.4	13175	11.3	33	9.3	225	12.5	34.968	**10.5**
2003	3490	9.9	341	12.8	11702	9.4	5272	10.4	252	9.3	12162	10.5	57	16.1	221	12.3	33.497	**10.0**
2004	3265	9.2	262	9.9	12399	10.0	4800	9.4	309	11.3	12342	10.6	43	12.2	225	12.5	33.645	**10.1**
2005	3370	9.5	262	9.9	12231	9.8	4934	9.7	310	11.4	11813	10.2	70	19.8	194	10.8	33.184	**9.9**
2006	3573	10.1	235	8.8	12818	10.3	4698	9.2	234	8.6	11388	9.8	62	17.6	137	7.6	33.145	**9.9**
2007	3371	9.5	234	8.8	12542	10.1	4804	9.5	235	8.6	11169	9.6	43	12.2	134	7.5	32.532	**9.7**
2008	3543	10.0	260	9.8	13396	10.8	4780	9.4	222	8.1	11098	9.6	2	0.6	123	6.8	33.424	**10.0**
2009	3927	11.1	303	11.4	13925	11.2	4827	9.5	242	8.9	10422	9.0	3	0.8	123	6.8	33.772	**10.1**
2010	3702	10.5	255	9.6	12697	10.2	4818	9.5	324	11.9	9971	8.6	0	0.0	166	9.2	31.933	**9.5**
Total	35395		2658		124527		50824		2724		116207		353		1797		334485	
Mean	3540	100	266	100	12453	100	5082	100	272	100	11621	100	35	100	180	100	33449	**100**
%ICD	10.6		0.8		37.1		15.2		0.8		34.7		0.1		0.5		100.0	

O00: Ectopic pregnancy; O01: Hydatidiforme Mole; O02: Other abnormal products of conception; O03: Spontaneous abortion; O04: Medical Abortion; O05: Other Abortion; O06:Unspecified abortion; O07:Failed Attempted abortion; O08: Complications following abortion and ectopic pregnancy and molar pregnancy; (*) Total female population in fertile age (10 - 49 years old: 4, 820, 387 in 2001 and 5, 206, 810 in 2010, increasing 7,42%). Latin America and Caribbean population estimates and projections 1950 2050. 2004, Demographic Bulletin United Nation/CEPAL/ECLAC, Bulletin 73, [62].

Table 2. Abortion risk by age and ICD10 of WHO. Chile 2001-2010. Ratios by 1000 New Born.

ICD	O00		O01		O02		O03		O05		O06		O07		O08		Total	
Age	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
5 - 9	--		--		--		--		--		1	0.0	--		--		1	0.0
10 - 14	57	0.2	40	1.5	410	0.3	328	0.6	23	0.8	721	0.6	8	2.3	9	0.5	1596	0.5
15 - 19	1685	4.8	432	16.3	10500	8.4	6632	13.0	410	15.1	15840	13.6	61	17.3	226	12.6	35786	10,7
20 - 24	5139	14.5	486	18.3	18735	15.0	10221	20.1	580	21.3	23077	19.9	86	24.4	354	19.7	58678	17.5
25 - 29	8828	24.9	509	19.1	24757	19.9	10010	19.7	531	19.5	22372	19.3	73	20.7	408	22.7	67488	20,2
30 - 34	9943	28.1	425	16.0	27728	22.3	9320	18.3	491	18.0	21133	18.2	73	20.7	377	21.0	69490	20.8
35 - 39	7404	20.9	329	12.4	26209	21.0	8522	16.8	438	16.1	19676	16.9	34	9.6	276	15.4	62888	18.8
40 - 44	2091	5.9	235	8.8	14363	11.5	5060	10.0	224	8.2	11713	10.1	17	4.8	114	6.3	33817	10.1
45 - 54	248	0.7	202	7.6	1825	1.5	731	1.4	27	1.0	1674	1.4	1	0.3	33	1.8	4841	1.4
Total	35395	100.	2658	100.	124527	100	50824	100	2724	100	116207	100	353	100	1797	100	334485	100

O00: Ectopic pregnancy; O01: Hydatidiforme Mole; O02: Other abnormal products of conception; O03: Spontaneous abortion; O04: Medical Abortion; O05: Other Abortion; O06: Unspecified abortion; O07:Failed Attempted abortion; O08: Complications following abortion and ectopic pregnancy and molar pregnancy.

Table 3. Abortion risk by age and ICD10 of WHO. Chile 2001-2010. Ratios by 1000 New Born.

ICD 10	Abortion hospital discharges by group of age and Ratios										% of Abortions for medical reasons
	10 - 14	Ratios	15 - 19	Ratios	20 - 39	Ratios	40 - 54	Ratios	Total	Ratios	
O00	57	5.7	1.685	4.5	31.314	16.2	2.339	27.3	35.395	14.7	
O01	40	4.0	432	1.2	1.749	0.9	437	5.1	2.658	1.1	67.6 %
O02	410	40.7	10.500	28.3	97.429	50.3	16.188	188.7	124.527	51.8	
O03	328	32.5	6.632	17.9	38.073	19.7	5.791	67.5	50.824	21.2	
O05	23	2.3	410	1.1	2.040	1.1	251	2.9	2.724	1.1	
O06	721	71.5	15.840	42.7	86.258	44.6	13.387	156.0	116.206	48.4	
O07	8	0.8	61	0.2	266	0.1	18	0.20	353	0.1	0.9%
O08	9	0.9	226	0.6	1.415	0.7	147	1.7	1.797	0.7	
Total	1.597	158.3	35.786	96.5	258.544	133.6	38.558	449.4	334.484	139.3	68.5%
Total NB	10.085		370.772		1.935.243		85.798		2.401.898		

O00: Ectopic pregnancy; O01: Hydatidiforme Mole; O02: Other abnormal products of conception; O03: Spontaneous abortion; O04: Medical Abortion; O05: Other Abortion; O06: Unspecified abortion; O07: Failed Attempted abortion; O08: Complications following abortion and ectopic pregnancy and molar pregnancy.

pregnancy and abnormal products of conception, which include undeveloped pregnancies, non hydatidiform moles, and other embryonic development abnormalities [11]. It adds failed abortion attempts and complications caused by ectopic pregnancies, moles, and other abnormalities of conception, which gives 68.5% of total hospital discharges.

An important proportion of abortions classified as having no specific cause could correspond to hemorrhagic complications of voluntary pharmacologically induced abortions.

Table 4 shows the abortion rate recorded in hospital discharges is high between the ages of 25 and 34. Lower rates are seen in women under19 years of age. This information depends on the age distribution of the Chilean population, with high rates in girls of under 19 years of age. It is indispensible to compare reasons for abortions with live births, as this is the best way of measuring pregnancy risk, when ending in abortion.

Table 5 gives the impact of abortion on maternal death and in abortion fatality.

Maternal death rate per 100,000 LB over the 10 year period reaches 2.4 and does not express a trend, varying from 1.2 in 2009 to 3.0 in 2005 and 2006.

Overall maternal death is 19.9 over the 10 year period, varying from 12.8 in 2003 to 20.8 in 2005, and has a not significant tendency to increase owing to Direct or Indirect Maternal Death.

Abortion fatality rate over the 10 year period is 15.5 deaths per every 100,000 hospital discharges for abortion, fluctuating from 8.9 in 2009 to 21.1 in 2005 and 2006. There is no definite trend in its development, but there are enormous variations from year to year.

4. COMMENTS

With an average of 33,500 annual hospital discharges for abortion,the most frequent causes are: Other Abnormal Products of Conception (O02) Other Abortions (O05) and Non Specified Abortions (O06), which correspond to 72.7%. This leads us to suspect that this classification category has been overnumbered owing to incomplete diagnosis records on patients' discharge, where voluntary self induced abortions, or abortions caused by third parties, are omitted because in these cases the mother risks a jail sentence in addition to involving judicial red-tape for the health authorities. This is validated by a recent report of a qualitative research carried out by Universidad Diego Portales [12].

It is interesting to note that this classification does not show an important proportion of infectious or septic complications, which should be located in category (O08). This only reaches 0.5% and has tended to fall since 2001. This coincides with national data regarding the reduction of maternity ward beds destined to the treatment of septic complications of abortion [13].

The use of Misoprostol was introduced in Latin America 1984 for extremely specific medical use [14]. This prostaglandin is sold legally and illegally throughout the region and its emergence and use is associated to the fall in septic abortions throughout the Region [15].

Chile is no exception, and in spite of the fact that the drug is only available on a public and private institutional basis, the public can easily buy it through the internet and its sale also occurs in an informal parallel market which is unsafe, abusive, and even criminal because on many occasions false medications are given at very high prices that do not correspond the real market value of the product.

It is also interesting to see that although the market is easy to intervene, this has not occurred. The only explanation might be that the disappearance of this drug could result in the massive reappearance of abortion by means of abortions performed by non-qualified gynecologists, with the consequences known to us all [16]. Nevertheless, in order to ensure that there is no psychological pressure when obtaining data, the Chilean Ministry of Health has issued precise Guidelines to medical professionals on the use of Misoprostol in patients who request emergency treatment, or who are about to have an abortion, or have suffered the consequences of abortion [17].

Hospital discharges according to age show a profile similar to that described in various very old studies on abortion in Chile [18]. The larger proportion of hospital discharges for abortion in the categories, Other abnormal products of conception (O02) between the ages of 30 to 34 years and the items Other Abortions (O05) and Unspecified Abortions, with higher rates between the ages of 20 and 24, years leads us to suspect the existence of incomplete diagnoses at hospital discharge in the ages with a higher frequency of abortion. This confirms the

Table 4. Abortion rates by age. Chile 2001-2010 by 10,000 Female population.

Age	Female population At year 2005(*)	Mean of abortions in ten years(**)	Rates per 10,000 female population
10 - 14	731,237	160	2.2
15 - 19	719,637	3579	49.7
20 - 24	651,942	5868	90.0
25 - 29	580,621	6749	116.2
30 - 34	618,176	6949	112.4
35 - 39	620,390	6289	101.4
40 - 44	634,370	3382	53.3
45 - 54	987,607	474	4.8
Total	5,543,980	33,448	60.3

(*)National Chilean Population. Information from Chilean National Institute Statitics. One case of abortion: 5 - 9 years old was not included. (**) Annual mean Hospital abortion discharges (Total abortion in 10 years/10).

Table 5. Maternal Mortality Rates by 100,000 NB and Fatality Abortion Rates. by 100,000 abortionhospital discharges. Chile 2001-2010.

Year	N⁰	MATERNAL MORTALITY					NEW BORN (**)	N⁰Ab. Dischargesand Fatality Rates ***
	Rates (*)	O00-O08[a]	O10-O95[b]	O96-O97[c]	O98-O99[d]	Total		
2001	N⁰	4	29	1	11	45	246,116	34,385
	MmR	1.6	16.7			18.3		11.6
2002	N⁰	7	27	0	9	43	238,981	34,968
	MmR	2.9	15.1			18.0		20.0
2003	N⁰	5	18	0	7	30	234,486	33,497
	MmR	2.1	10.7			12.8		14.9
2004	N⁰	4	22	0	16	42	230,352	33,645
	MmR	1.7	16.5			18.2		11.9
2005	N⁰	7	21	3	17	48	230,831	33,184
	MmR	3.0	17.8			20.8		21.1
2006	N⁰	7	22	0	18	47	231,383	33,145
	MmR	3.0	17.3			20.3		21.1
2007	N⁰	4	26	2	12	44	240,569	32,532
	MmR	1.7	16.6			18.3		12.3
2008	N⁰	5	25	0	11	41	246,581	33,424
	MmR	2.0	14.6			16.6		15.0
2009	N⁰	3	28	0	19	50	252,240	33,772
	MmR	1.2	18.6			19.8		8.9
2010	N⁰	6	23	1	16	46	250,643	31,933
	MmR	2.4	16.0			18.4		18.8
C.C[e]		0.68	0.38	0.90	0.16	0.46		0.90
Total 10ys.	N⁰	60	264	10	148	482	2,195,182	334.485
	MmR	2.4	17.5			19.9		15.5

*Maternal Mortality Rate (MmR) per 100,000 NB (Report from Health Ministry). **Total Number of New Born per year (Report from Health Ministry). ***Fatality Rate: Abortion death per 100,000 hospitalized abortion cases per year. [a]Abortion maternal Rates, [b]Direct maternal Rates [c]Late maternal Rates [d]Indirect Maternal Rates; [e]Linear Pearson Correlation Cofficient (n/s).

fact that in situations of extreme penalization of voluntary abortion, these figures are increased artificially. The same happens with spontaneous abortion at all ages between 20 and 34, which reaches proportions that are much higher than the expected 10 to 15% [19].

In the item Risk per Live Births, age distribution shows the classical evolution of fertility risk according to age [20]. Nevertheless the highest rates are seen in the categories other Abnormal Products of Conception and Non-specified Abortions, which reaffirm the doubt regarding an over-dimensioning of these categories that cover up non septic complications of voluntary pharmaceutically induced abortions

Molar pregnancy reaches its highest levels at both extremes of reproductive life, as has been seen in other publications, and reaffirms the fact that very early or late pregnancies tend to present genetic malformations in humans [20,21]

With regard to the expression of abortion risk for Women of Fertile Age, abortions accumulate in the intermediate reproductive age (25 - 39 years). When abortion is expressed according to Live Birth risk and according to age, the two highest rates appear in the categories, Other Abnormal Products of Conception (O02) and Unspecified Abortions (O06). This profile is explained as a consequence of the Chilean legislation that covers up real diagnoses, as has been explained above.

Another extremely important fact is the high frequency of medical recommendations on the part of the specialty of Obstetrics and Gynecology for the interruption of pregnancy owing to Ectopic Pregnancy, Molar Pregnancy and almost the totality of the category Other Abnormal Products of Conception [11]. To these headings it is necessary to add failed abortion attempts, which is a specialized medical action and the complications mentioned in the first three items of the ICD 10. All this comes to 68% of hospital discharges. It is impossible to give an exact estimate of how many abortions have been caused by reasons of health, and which have been included in the categories Other Abortion and Non-Specified Abortions. It is expected that in this profile 7 of every 10 hospital discharges correspond to interrupted pregnancies owing to reasons of health, which places Chilean law in a situation of contradiction, and makes it

inapplicable, generating more risks than benefits and reveals the misinterpretation of a public policy based on laws that do not adjust to the reality of the normal evolution of human fertility and its consequences on maternal, fetal and perinatal morbidity

Chile has maintained one of the lowest maternal mortality rates in the Latin American Region, but this decade shows no great variations that indicate a falling trend. This occurs with Direct, Indirect and Total Maternal Mortality. It will possibly be necessary to implement additional measures in the areas of promotion and early detection of obstetric pathologies like hypertension, especially among youngsters of under 20 years of age inorder to change this rising trend. There is no change is specific abortion mortality.

The Abortion Fatality Rate per abortion varies amply with a tendency to remain as it is, which reflects the lack of impact of undesired pregnancy prevention measures or the non-application of a strategy aimed specifically at women with high Predictive Risks which had been successfully applied in the country [22]. For Chile, with extremely restrictive anti-abortion laws, it is impossible to gain more in-depth knowledge of what is really happening in the community. Furthermore, this restrictive law has no impact on the reduction of Maternal Mortality or on Abortion Fatality Rates.

Following the logic of a projection, this unchanged mortality should take into account the near-disappearance of septic complications which have been described as one of the great causes of maternal death by abortion. The CELADE (Latin American Centre for Demography) projection for Chile, based on an old study [23] calculated that for every woman hospitalized for abortion complications, there were 2 or 3 women in the community who aborted without complications, or who did not go to hospital, or whose complication was treated on an outpatient basis. Guttmacher has presented another series of projections for the countries of the Region [24], in which Chile has 3 women with illegal abortions who do not go to hospital for every hospital discharge for abortion.

This current profile of hospitaldischarges for abortion considers that the following categories should be taken as voluntary abortions: Other abortions (O05), Non-specified abortions (O06), Failed abortion attempt (O07) with an annual average of 11,800 abortions to which it would be necessary to add 50% of hospital discharges for Other abnormal products of conception (O02): 6300 and 10% of hospital discharges for spontaneous abortions, which totals 18,200 hospital discharges per annum for induced abortion. With the introduction of Misoprostol, this figure should be multiplied by 6, because it is estimated that for every hospital discharge for abortion, at least 6 women will have interrupted their pregnancy by means of abortion, without requiring hospital care. This gives us an estimated total of 109,200 induced abortions per annum in the country. This figure could vary between 72,800 and 145,600.

5. CONCLUSIONS

The situation in Chile is characterized by a profile of Maternal and Perinatal Health with fewer risks than other developing countries, but with a tendency for an increase of Direct and Indirect Maternity Risks, and a stabilization in abortion deaths expressed as maternal mortality and abortion fatality. The current legal framework of extreme penalization and restriction of abortion have not given the expected results in the welfare of the population; it violates the fundamental human rights of women and exposes them to violence, abuse, discrimination, damage to their physical and mental integrity. Other studies show that in countries where abortion is legal, abortion rates fell as a consequence of the implementation of services which, together with providing the possibility of a safe abortion, give proper counseling services and offer access to methods for preventing new unwanted abortions [25].

In Chile, it has been shown that good quality contraception, including good quality service, and an ample availability of contraceptive methods prescribed by physicians and midwives, significantly prevent unwanted pregnancies in women with high predictive abortion risk [22]. These simple measures have not been applied.

The profile of hospital discharges for abortion in Chile shows a serious discrepancy between the abortion law and the daily practice of medicine in Health Services of the Public and Private Health Systems. Health professionals and workers are exposed daily to ethical conflicts, and tensions are created that contribute to hiding and giving misinformation on the grave problem of abortion and its consequences, seriously affecting reliable epidemiclogical information leading to making decisions on this issue.

This reality, which applies to various countries in the region, has received an international recommendation to "Consider the possibility of amending the laws regulations, strategies, and public policies on the voluntary interruption of pregnancy in order to protect the lives and health of women and adolescents, improving their quality of life and reducing the number of abortions" [26]. This study once again reaffirms the urgency with which our country must obey this recommendation.

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