

Unsafe Abortions in India: Removing the Bottlenecks

Mohammad Abu Bashar, Sudip Bhattacharya*, Amarjeet Singh

ABSTRACT

Unsafe abortions continue to cause maternal morbidity and mortality in developing countries. Much of this is avoidable. Many factors are responsible for occurrence of unsafe abortions even in 21st century. To rectify the situation, we need to have a relook at the circumstances involved. Here we present a case who suffered catastrophic consequences due to her forced decision to undergo an abortion by an unqualified doctor. The lady first tried to get aborted from government health facilities. But due to various barriers, she had to contact an incompetent medical practitioner for termination of her pregnancy. This case also represents the diverse system-related obstacles which often deny the underprivileged sections of society from obtaining quality health care. Unless and until these barriers are removed, the practice of unsafe abortions would continue to plague the developing nations like India.

Key words: Abortions, Barriers, Maternal mortality.

INTRODUCTION

A pregnant woman (G4P1L1A2 and LMP16-08-2017), 28 years old, literate but without any formal education, with a history of two previous abortions presented unescorted in our dispensary situated in an urban slum of Chandigarh, North India. She worked as a housemaid. She reported that she got her pregnancy detected around one week back by herself using the urine pregnancy kit at her home. She also told that she wanted to get it aborted as she didn't want the child because her younger son was only a year old. She asked the resident doctor at the dispensary for an oral abortifacient.

On examination, she was thin built and undernourished. She weighted only 45 Kgs and had a moderate degree of pallor. Her blood pressure was found to be normal. On per abdomen examination; uterus was not palpable implying pregnancy of fewer than 12 weeks of gestation. PV examination was not done. She was advised the routine blood, and urine tests during pregnancy and Ultrasonography (USG) for confirmation of pregnancy and period of gestation. She was asked to get these tests done in a nearby sub-district level hospital.

She returned after a week with blood tests and urine test done. Her haemoglobin was 9.1 gm/dl with normal blood sugar levels, and other parameters were also within normal limits. She could not get the USG done from district hospital as she didn't have any identification proof (ID proof) in her name. According to the government rules, any pregnant women undergoing ultrasonography at any health facility need to have a valid ID card, photocopy of which is deposited along with the requisition form. She told that she requested the doctor to the hospital to prescribe her

the abortion-inducing drug. But they refused she didn't have the USG report. She was advised by the doctor there to get the USG done from any private diagnostic centre. But she didn't have the money in the first place. Also, the private diagnostic centres too asked for any of her valid ID proof which they didn't have as they had recently migrated to Chandigarh from another state for job opportunities. She was finally advised by us to get an affidavit made for her identity and residential status as it could be used ID proof for getting the USG done. Public Health Nurses of the dispensary also told that his husband is a chronic alcoholic and that they were living in one room rented house in the locality with their three children.

After two weeks, she presented to us at the dispensary with profuse bleeding per vaginum for three days. She told that it started spontaneously with no history of any drug intake or injury. She was also having lower abdominal pain with extreme weakness and lethargy. On examination, she was found to be had tachycardia with severe pallor, and her Blood Pressure was found to be low. She also told that she had gone to the emergency outpatient department of the hospital, a day before but they refused admission as her husband did not accompany her and an attendant was required to get her admitted there. They had prescribed her Tablet Tranexamic acid to stop the bleeding along with Iron and folic acid tablets. We suspected induced abortion. On probing and enquiring further, she accepted that she had contacted an unqualified doctor who practised in the locality who prescribed her some tablets to induce abortion. She took these pills. She started to bleed from next day which was excessive and continued till date.

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A. What we did in the present case: (Individual level)

In this case, our staff escorted the index case to the higher health facility for the lifesaving treatment. We liaised with the higher health facility effectively in this case to remove some of the procedural hurdles. We also called her husband to our health centre so that emotional support component (to the wife) can be taken care of. She was admitted there for three days. She finally underwent dilation and curettage (D and C) to remove product of conceptus which was the cause of bleeding in her case. She was also transfused with three unit of blood during her stay. She was counselled for using Copper-T following the D and C.

B. Developing a mechanism to avoid future occurrence of such incidents in our field practice areas: (Community Level)

To tackle the issue, we have made a list of Standard Operative Procedures (SOPs) for our health centre team. The main components of SOPs were-

1. Facilitation of USG and MTP services for the abortion seekers, irrespective of submitting any Identification card.
2. We started tracking of every case who seek abortion services from us.
3. All the staff members have been instructed (verbally and in writing) to avoid future occurrence of such incidents in our field practice areas and help them to make ID cards if they want for the same.
4. We are taking care that the procedural bottlenecks (husbands signature and identification cards are no more mandatory for abortion services in our centre, we are in close contact with gynaecology and obstetrics department from the higher facility so that urgent consultation can take place in no time) about abortion services are removed.
5. We have conducted departmental (Community Medicine) meeting as well as city-level meeting with Director General Health Services, Chandigarh to seek their help and co-operation to remove the procedural barriers.

Our School of Public health has many training centres in rural and urban areas, where we have implemented these SOPs. Thus, some effort has been made by us to ensure easy access to abortion services for the needy population.

C. National level: Recently, in 2017, we have shared abortion and female feticide related research findings with the Advisor to our Honourable Union Health Minister, India for health policymaking. We suggested that procedural bottlenecks like the production of ID proof, husbands signature on MTP proforma for availing abortion / USG services should be removed.

DISCUSSION

According to the National Family Health Survey-3(2005-2006), nearly 21% of pregnancies are either unwanted or mistimed.¹ Unmet need for family planning (FP), which refers to the condition in which there is the desire to avoid or postpone childbearing, without the use of any means of contraception, ultimately leads to unwanted pregnancies. The concept points to the gap between some women's reproductive intentions and their contraceptive behaviour.² Globally, unmet need for contraception remains a problem.³ However, in developing countries like India decision to use family planning methods is determined mainly by the husband or the family rather than the women herself due to the low position of women in society.⁴ According to World Health Organization (WHO), unmet need is especially high among groups such as adolescents, migrants, urban slum dwellers, refugees and women in postpartum period.⁵

The burden of unsafe induced abortion is developing countries like India is too high.⁶ According to WHO, every eight minutes a woman die due to complications arising from unsafe abortions in developing countries making it leading cause of maternal mortality (13%).⁷ Because hazardous abortion is often done clandestinely by untrained individuals or by the pregnant women themselves, much of it goes undocumented; figures are therefore estimates.⁶ Worldwide, some 5 million women are hospitalised each year for treatment of abortion-related complications such as bleeding and sepsis, and abortion-related deaths leave 220,000 children motherless.^{8,9}

Poor quality of care and procedural barriers at government health facilities particularly for underprivileged sections of society is a significant problem in India as identified in our case.¹⁰ The woman was refused the abortifacient/abortion inducing drugs by the government doctors because her USG could not be done. Stringent Prenatal Diagnostic Techniques Act amended in the year 2003 and renamed as Pre-Conception, and Pre-Natal Diagnostic Techniques aims to prevent sex determination of the foetus by providing for penal action including imprisonment for both the service provider and the beneficiary in case of sex determination and sex-selective abortion. However, the Act is under criticism for issues in documentation and its inflexible nature.¹¹ It was identified as a significant barrier to access and receive quality care in the current case as it was on this ground that her USG could not be done as documentation requirement of Act necessitates that the pregnant women undergoing USG should have an Identity proof which she didn't have. Data indicate an association between unsafe abortion and restrictive abortion laws. Abortion-related deaths are more frequent in countries with more restrictive abortion laws (34 deaths per 100,000 childbirths) than in countries with less stringent laws (1 or fewer per 100,000 childbirths).⁷ In India, unsafe, illegal abortions persist despite India's passage of the Medical Termination of Pregnancy Act in the early 1970s. The Act was passed to remove legal hindrances to terminating pregnancies in the already underfunded public health care system, but women still turn to unqualified local providers for abortion as also evident in this case. The implications of the law never reached the population that require them most, i.e. the underprivileged section of the society.¹²⁻¹⁶

Public health problem lists:

- Unmet need for contraception and lack of family planning methods continuing in the 21st century
- Failure of government health facilities to provide timely quality abortion services to the underprivileged populations
- Getting safe abortion services is remain difficult for migrant females due to procedural barriers.

CONCLUSION

- Our patient represents one of the million women in India with unmet need of contraception who had to risk her life due to failure of government health system to provide quality care.
- Our patient could have been seriously harmed by her decision to contact a local practitioner, a quack, although the decision taken was a forced one due to frustration from the procedural barriers of the current health system.
- Public health facilities should be more accommodative, and there is need to remove unnecessary hindrances and obstacles to providing quality care to underprivileged population like slum dwellers and migrants.
- Unmet need of family which is more prevalent in disadvantaged sections was the triggering factor for the problems faced by the patient which has to be addressed.

Patients' perspective

"I always wanted to get the medicines for abortion from qualified doctors only, but as I could not get my ultrasound done, they refused to give me the medication. I had to take the medicines from a local doctor which I know is not qualified and is an unqualified doctor. I had to terminate my pregnancy because I don't want another child now. My husband is not ready to use any barrier methods, and I fear sterilisation operation.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ABBREVIATION USED

GPLA: Gravida, Parity, Live and Abortion; **LMP:** Last menstrual period; **USG:** Ultrasonography.

SUMMARY

Unsafe abortions continue to cause maternal morbidity and mortality in developing countries. Much of this is avoidable. Many factors are responsible for occurrence of unsafe abortions even in 21st century. To rectify the situation, we need to have a re-look at the circumstances involved. Here we present a case who suffered catastrophic consequences due to her forced decision to undergo an abortion by an unqualified doctor. The lady first tried to get aborted from government health facilities. But due to various barriers, she had to contact an incompetent medical practitioner for termination of her pregnancy. This case also represents the diverse system-related obstacles which often deny the underprivileged sections of society from obtaining quality health care. Unless and until these barriers are removed, the practice of unsafe abortions would continue to plague the developing nations like India.

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