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Making Abortion Safer

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Introduction

Abortion is one of the leading causes of maternal mortality and contributes significantly to maternal morbidity. Accessibility to safe and legal abortion is important for women's survival and reproductive health and is considered as a reproductive right of every woman and, therefore, a human right. The provision of safe and legal abortions was one of the key issues discussed at the International Conference on Population and Development in Cairo in September 1994. India was one of the countries who joined the consensus on the Program of Action framed by the Cairo conference that supports safe and legal abortion as a key intervention for improving women's survival and health.

Background

Abortion has been legalized in India since 1971 through the Medical Termination of Pregnancy (MTP) Act [1].

The Act gives women the right to an abortion in specific situations - if the pregnancy is a risk to the life of the woman, or is likely to cause grave injury to her physical or mental health, or is likely to result in the birth of a child suffering from serious physical or mental abnormalities. The Act also permits termination of a pregnancy caused by rape or from failure of any contraceptive method used either by the woman or her husband for limiting the number of children. In determining whether the continuance of the pregnancy would involve such, risks to the health of the mother, the law allows the 'registered medical practitioner' to take into account the woman's actual or reasonable foreseeable environment (a registered medical practitioner is a practitioner who possesses a medical qualification that is recognized by the Indian Medical Council).

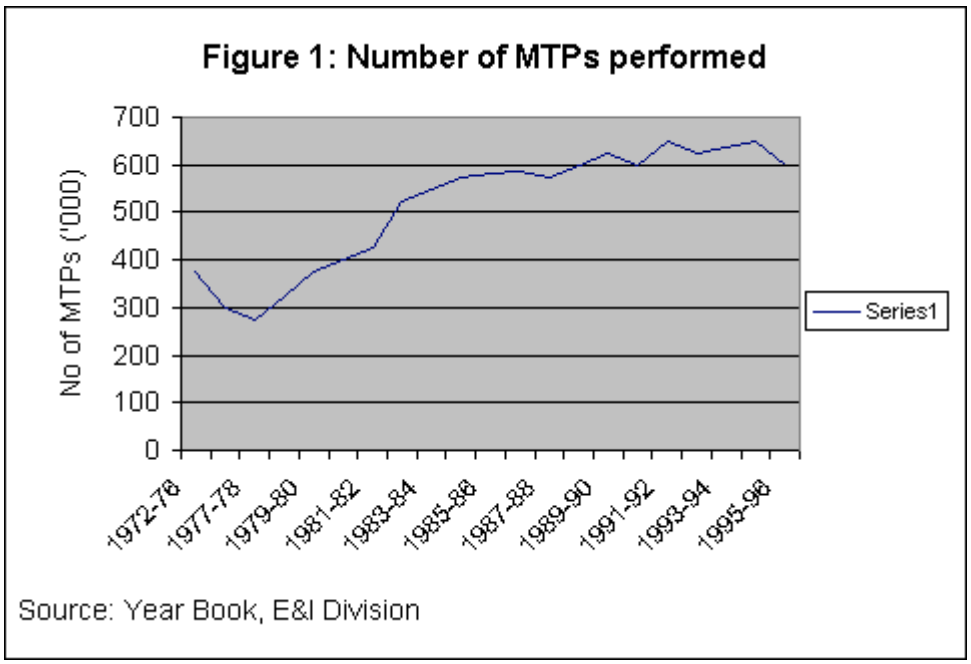
A pregnancy may be terminated by a registered medical practitioner where the length of the pregnancy does not exceed twelve weeks. If it exceeds twelve weeks, but does not exceed twenty weeks, the opinions of two registered medical practitioners are essential, unless a medical emergency exists. Termination of pregnancy by any person other than a registered medical practitioner is a punishable offence [1].

The Act further specifies that the MTP procedure shall not be performed in any place other than a hospital established or maintained by the Government or a place for the time-being approved by the Government for the purposes of the Act. The consent of the woman or the written consent of the guardian in the case of a minor (below 18 years) or in case of a mentally retarded woman is required before terminating the pregnancy. Further, the MTP is to be performed free of charge if it is done in a Government hospital, but can be charged if it is performed in a non-governmental facility recognized under the Act. Although the Act did not extend to Jammu and Kashmir at first, it has now been extended to almost all the states; though it has not been implemented in Sikkim as yet [2]. The MTP rules and regulations made by the Department of Health and Family Welfare also emphasize complete confidentiality [3].

Status of Legal Abortion Since The MTP Act

In their review of abortion, Chhabra and Nuna [4] estimated the annual number of abortions in India is to be over 11.2 million, of which 6.7 million are expected to be induced. They showed that the highest number of induced abortions are expected in Uttar Pradesh followed by Bihar, Maharashtra, West Bengal, Andhra Pradesh, Madhya Pradesh, Tamil Nadu and Karnataka. However, a comparison of reported abortions per 1,000 births showed that Goa had the highest number followed by Kerala and Nagaland; Madhya Pradesh reported the lowest rate.

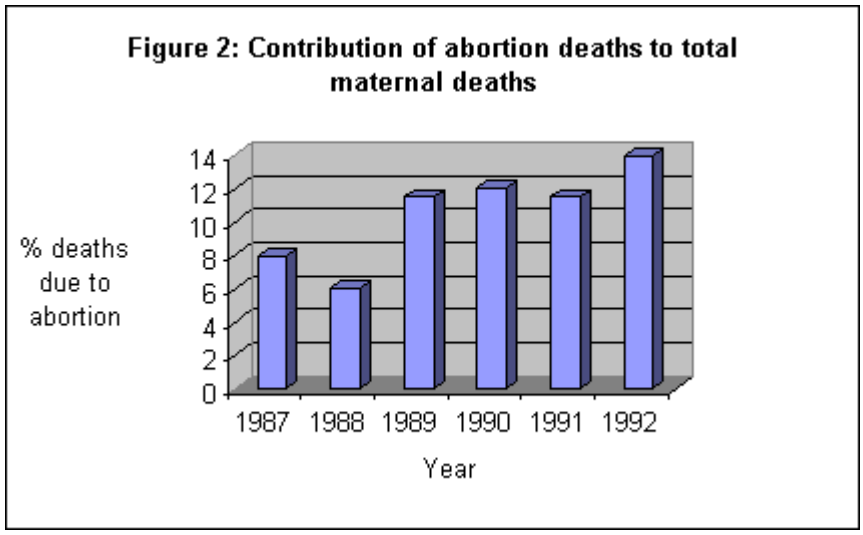
The reported MTP figures show a rise in the utilization of the service B [2], [5] since its inception as seen from (Figure 1). It is interesting that since 1981-82, there has not been much change in the number of MTPs in spite of the increase in the number of MTP centers. Underreporting could be one reason for this finding. Studies have also shown that the majority of MTP seekers were married, multifarious and above 25 years of age [4], [6]. Most abortions were first trimester abortions, and the commonest reason given for the abortion was 'failure of contraception'. The number of deaths reported as a result of complications of complications of MTP was negligible. This could be due to the fact that majority of abortion seekers belonged to 'low risk' categories (in terms of age, duration of pregnancy etc.) and that the providers were skilled.



Although there is no definite evidence, the number of second trimester abortions D have been reported to be on the rise. This has been attributed to two factors: first, an increase in out of wedlock pregnancies among adolescents cases that are likely to seek abortion services late. And second, a reported increase in the number of sex determination tests done in the second trimester (using the ultrasound) followed by selective abortion of female foetuses.

Has Legalization Made Abortion Easily Accessible and Safe?

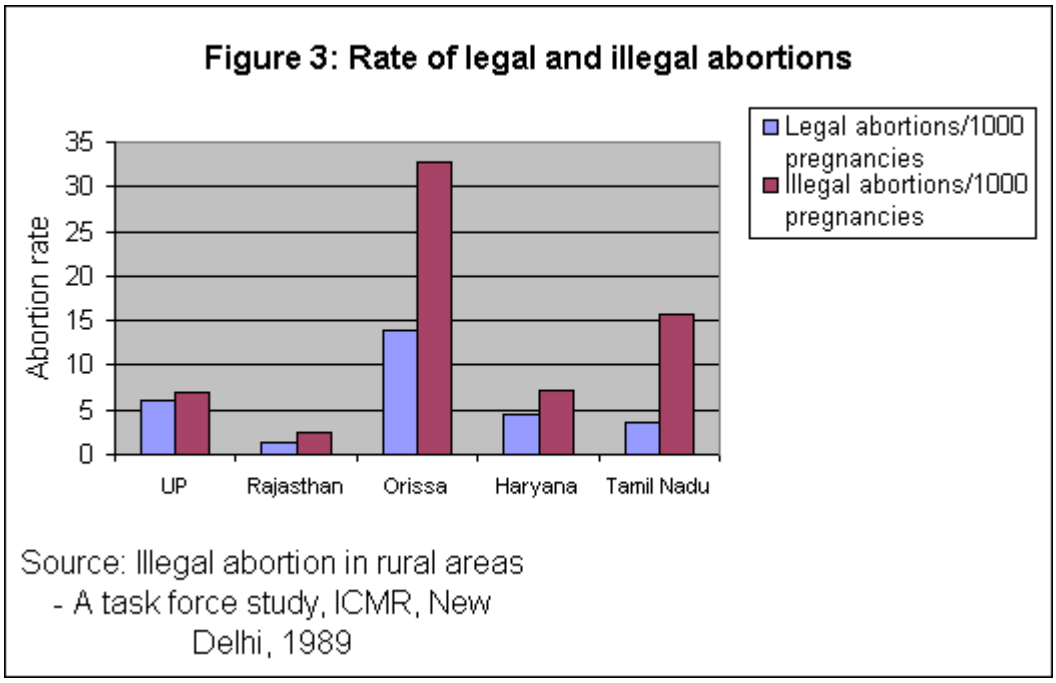
It is assumed that legality makes abortion safe. But the Indian experience dearly shows us otherwise. Although the MTP Act was enacted with the intention of reducing the incidence of illegal abortions and consequent maternal mortality and morbidity, the facts given below clearly show that it has not made a significant impact in reducing abortion-related mortality. It is evident from (Figure 2) that the percentage of maternal deaths due to abortions has not decreased [7].



There is further evidence to show that deaths due to complications of abortion have not decreased significantly from a study on maternal mortality (institution-based) conducted by the Indian Council of Medical Research (ICMR) in the eighties [8] wherein 18 per cent of maternal deaths were found to be due to abortion. The ICMR report compared this with the findings of a similar institution-based study conducted by the Federation of Obstetrical and Gynecological Societies of India (FOGSI) [9] in the seventies and concluded that although the total number of maternal deaths had decreased, the contribution of deaths due to abortion (20 per cent) remained the same as that reported by the FOGSI study. The ICMR study also observed that the majority of abortion-related deaths were due to sepsis caused as a result of illegal abortions.

It was interesting to note that a comparison of age specific mortality related to abortions from the Surveys of Causes of Death for the years 1991-94 [7], showed a rise in mortality in the 20-24 age group, the highest among the different age groups. There could be two reasons for this trend: a rise in the number of unwanted pregnancies due to the unmet need for contraception, and the reported rise in abortions after sex determination tests. Deaths related to abortion have been reported among women aged 15-19 years during 1993 and 1994, probably a result of the reported increase in abortions among adolescents in recent years.

A study of illegal abortions carried out by the ICMR [6] reported that the rate of legal abortions was 6.1 per 1,000 pregnancies as compared to the rate of illegal abortions which was 13.3 per 1,000 pregnancies (Figure 3).



Chhabra and Nuna [4] have also reported an increase in illegal abortions based on findings from various studies.

As stated earlier, there was a negligible number of deaths as a result of the MTPs. Therefore, one can safely assume that deaths due to abortion are largely a result of illegal abortion procedures.

Legislation is only the First Step in making Abortions Safe

The MTP Act was formulated on the basis of a consensus among medical professionals, legal professionals, social activists and politicians keeping in focus the interest of women's well-being. However, in spite of the fact that the Act was effected to make safe abortion services available to all women who need them, it has not been translated into reality for many women across the country. There have been major gaps in its implementation and therefore it is very clear that the legislation liberalizing abortions is only the first step in making abortions safe. Some of the gaps in the implementation of the Act are discussed below.

While the number of MTP procedures and facilities recognized for providing MTP services have increased, the increase in the number of the facilities does not correspond with the increase in the demand for abortions. One reason is the uneven geographical distribution MTP facilities. Thus, statewise MTP figures show that Maharashtra with 9.3 per cent of the country's population accounted for the maximum number of MTPs (20 percent) while Uttar Pradesh with 16.4 per cent of the population accounted for 19.5 percent of all MTPS. In a situational analysis of MTPs done in Gujarat, Maharashtra, Tamil Nadu and Uttar Pradesh conducted by the Center for Operations Research and Training (CORT) [10] in both the private and public sectors, it was interesting to note that Maharashtra

has 23 MTP centers per million population while Uttar Pradesh has only 3.4. Further, Gujarat with only 4.9 per cent of India's population had 213 MTP centers per million population while Tamil Nadu with 6.7 per cent of the countries population had only 11.2 Chhabra and Nuna [5] observed that Bihar had the worst MTP institution-to-couple ratio. They also found that most of the MTP facilities were located in urban areas.

The CORT situational analysis further showed that on an average only 30 per cent of the PHCs/block PHCs approved for providing MTPs in Gujarat, Maharashtra and Uttar Pradesh were actually providing such services. However in Tamil Nadu, 68 per cent of the block PHCs were providing services, most of them at camps. This gives an indication of the extent of availability of services in rural areas and further corroborates the statement about MTP facilities being by and large urban based.

The lack of trained doctors, equipment and facilities have been mentioned as other reasons for the gaps in implementation's [10]. However, at the next level, the percentage of CHCs, rural hospitals and subdistrict hospitals providing MTP services was much higher.

Chhabra and Nuna reported that the MTP recognized institutions were performing fewer abortions than they were expected to. The ICMR F study on illegal abortions showed that most women preferred to use the services of a qualified doctor in Government (63.1 per cent) or private allopathic (18.5 per cent) clinics as they felt that the quality, of services was better and there was less risk. There is evidence to show that the number of training facilities may not be adequate to train the required number of doctors. For example, the CORT study revealed that the number of doctors trained in institutions recognized for MTP is much less than the potential capacity. Further, of those trained, quite a significant number were not performing MTPs due to a variety of reasons. The percentage of doctors not performing MTPs was higher in the PHCs and ranged from 19 to 37 per cent. Besides lack of essential equipment and facilities, lack of confidence was reported as a reason though the training in most cases had met the standards laid down under the MTP rules and regulations. Even in places where Government doctors were performing MTPs, very few MTPs were being performed. Chhabra and Nuna estimated that each institution performs only one MTP in three working days as compared to the Committee's expectation of 3-4 per institution.

Funding constraints have been one of the reasons which has affected the availability of equipment. To add to the problem, the Department of Family Welfare had issued a circular to switch over to the suction curettage technique; the switch over is not mandatory for the private/non-government sector.

Replacement of equipment and the expansion of its availability is delayed due to financial problems as well as the insistence on ISI certification of the equipment by the Central Government. As per state Government rules, the purchase is to be made from the lowest bidder who may not have the ISI certification.

In the non-governmental sector and private sector, the cumbersome licensing and reporting procedures have been a major deterrent in getting MTP facilities registered. However, many private institutions are providing these services safely, but illegally. With the Consumer Protection Act being implemented seriously in many states, the access to these safe but illegal abortion facilities is going to decrease, and may contribute to a further rise in unsafe and illegal abortions.

It is thus clear that the implementation of the MTP services has not been satisfactory to date, and where facilities are available, they are not being, used optimally.

The ICMR study [6] also observed that about 38 per cent of the women in the five states where the study was undertaken were unaware of the MTP Act. Similar findings have been reported by others [11]. For example, only 15.4 per cent reported to have heard about the Act from Government staff, and about 47 per cent knew that MTP facilities were available in PHCs. Private doctors/registered medical practitioners, trained and untrained dais and others were reported as providers of MTP beyond the fourth month of pregnancy. While a good proportion of women were aware that MTPs could be obtained free of cost in Government facilities, a small percentage reported that they charged a fee. The CORT study also revealed that fees were charged by Government doctors. Further, the majority of the women considered three months or less of pregnancy as safe for performing an abortion.

Quality of services (defined by women as 'experienced doctor' with 'no complications', 'doctor talks well' etc.) was a major concern in the choice of a provider in case of MTP services as is evident from some of the recent studies conducted in Maharashtra [11], [12] and from the CORT study [10]. A definite preference for Government PHC doctors was reported; the most important reasons being efficiency, experience and good treatment though in practice, the majority used private sector providers (both allopathic and others) [6], [11]. Cost did not seen to be such a significant factor in the decision about a provider. Another important concern expressed by women from Maharashtra was the insistence on adopting a family planning method after an abortion practiced in Government institutions. Privacy and confidentiality were other major reasons for using the services of a private provider particularly in the case of pregnancies out of wedlock.

Ignorance about the MTP Act and the right to safe abortion has been a major contributory factor to the continuing high rate of illegal abortions in spite of the legalization of abortion 25 years ago. Deaths due to complications of abortion continue to be a major cause of maternal deaths. Accessibility to good quality abortion services has been another important factor in the continuing high rate of illegal abortions. It is very clear then that merely passing a law making abortions legal is not enough.

Making Abortion Safe and Accessible

The need for safe abortion services is well established. Besides the need for services in case of induced abortion, there is also a need to provide care to the women who undergo spontaneous abortion. The ICMR study [8] on maternal mortality showed that 9.5 per cent of all pregnancies ended in spontaneous abortions and the study on illegal abortions [6] showed a spontaneous abortion rate of 42 per thousand pregnancies (4.2 per cent). These cases of spontaneous abortion also need care. Approximately 25 per cent of the total abortion services provided under the All India Hospitals Postpartum Program were for spontaneous abortions [2].

Strategies for Making Abortion Safe and Accessible

Community Education

1. The education of women in the community about the importance of safe and legal abortion to women's health and survival, and the provision of MTP services under the Act is important. The safe period for performing a MTP and which facility or provider is recognized for providing MTPs are other important pieces of information that should be shared. It is just as important to stress that repeated abortions are dangerous. The use of family planning methods to avoid pregnancies should become part of the educational campaign.

Since abortion is a sensitive topic, it is important that the educational sessions are planned in a sensitive manner taking into consideration the social environment. Women's groups should be made responsible for this activity. 'Swasthya Sanghs', where available, could be used as a channel for communicating the message about safe and legal abortions to the women in the community. Besides creating an awareness about safe and legal abortions, women can play a role in monitoring the quality of services and in reporting irregularities in the provision of services. Involvement of women in performing the 'watchdog role' will definitely contribute to improving MTP service quality and thereby contribute to

a reduction in the number of lives lost and the needless suffering caused by complications resulting from unsafe and illegal abortions.

2. With the rise in the age at marriage, a decrease in the number of pregnancies among married adolescents has been reported though a rise in out-of-wedlock pregnancies among adolescents has also been reported. To prevent an increase in abortions for out-of-wedlock pregnancies among adolescents, it is important to organize educational sessions on sexuality and contraception for adolescent girls. Such programs should also include the topic of abortion - when and where to go for a MTP, as also the hazards of repeated abortion. In recent years, such educational programs for adolescent girls are being taken up but mostly in schools and urban slums.

3. Studies on abortion have shown that husbands play a major role in decision making with regard to whether to go for an abortion, when to go and where to go. Therefore, it is important that men in the community should also be given information about the MTP Act. The importance of using contraceptives to prevent unwanted pregnancies should be a key component of such sessions. Men should be made aware of the dangers of repeated abortion.

4. Community leaders particularly women Panchayat leaders should be made aware of the MTP Act, safety of MTP and the dangers associated with unsafe and illegal abortions. These women leaders could then be made responsible for ensuring that women seek safe legal abortions and for monitoring illegal abortions in the community. Again, the importance of using contraceptives to prevent pregnancies should be stressed.

Improving Access to Safe and Legal

Abortion

1. Training: The criteria for certifying a practitioner competent to conduct MTPs should be modified as suggested under the section on training which follows.

- Licensing procedures: Mechanisms should be developed to speed up the existing licensing procedures. Undue delays in getting licenses to perform MTPs have been a major problem faced by the private and non-governmental sectors. The Rules and Regulations of the Act do not include relicensing. A review of the approved institutions every five years and relicensing should be made mandatory. The renewed license should be displayed. Besides the availability of equipment, facilities and trained staff, the quality of services, maintenance of records of MTP cases and regular reporting should be the criteria for relicensing.

2. Providing safe abortion services: Poor access to qualified service providers has been pointed out as one of the reasons for the continuing high rates of illegal abortion and related mortality. Financial and procedural constraints in equipping MTP centers have also been pointed out. To overcome this problem, it is important to provide different levels of service in different institutions.

- Equipment As stated earlier, due to funding constraints, it may not be possible for state governments supply electrical vacuum suction equipment for MTP to all the PHCs. Alternatives should be pursued to make it possible for women to have easy access to safe abortion. It is recommended that all PHCs, where no equipment for suction curettage is available, should be supplied with special 50 ml plastic syringe and cannula with an adaptor to build a vacuum. Efforts should be made to supply all CHCs/sub-district level PHCs with electrical vacuum suction machines. The total number of these institutions is only about 5,000. As a preliminary step, electrical vacuum suction machines from PHCs where the doctor is not trained, could be shifted to CHCs or sub-district PPCs.

- Training:

- PHC doctors: All PHC doctors should be provided training in manual vacuum aspiration of the contents of the 6-8 weeks pregnant uterus using the special 50 ml plastic syringe and cannula.

- CHC/PPC doctors: All CHC/PPC doctors should be trained in manual vacuum aspiration using the plastic syringe and cannula. In addition, they should have competence in evacuating the contents of the uterus using the suction curettage technique in cases of pregnancy up to 12 weeks.

- Vacuum suction is also useful in dealing with management of incomplete abortions.

- The criteria for certifying a doctor competent to do MTPs should be modified as follows:

a) Competency in safe termination of pregnancy: The doctor should be competent in:

i. assessing duration (weeks) of pregnancy

ii. evacuating the uterus using the technique/techniques (as appropriate) listed above.

iii. recognizing when the uterus is empty while doing the suction.

iv. recognizing complications early and referring them.

b) Skill in pre and post abortion counseling

The training should be provided at sites other than medical colleges where a qualified trainer is available and where the caseload for MTPs is adequate to provide enough client experience. District level hospitals and Postpartum Centers where the case load is adequate should be considered as potential sites for training. This strategy not only increase the number of training sites, but also provide experience to the doctors in handling complications in situations with minimum facilities.

A similar training strategy needs to be developed for the private sector too. Doctors working in private health facilities with no in-patient facilities or in nursing homes with no operation theatre facility should be trained like the PHC doctors while in nursing homes with in-patient facilities and beds, the doctors should be provided training similar to that of CHC doctors.

FOGSI members should be encouraged to play an active role in training practitioners in the private sector. They also should participate in the training of doctors in the government sector.

Monitoring Quality of Abortion Services

FOGSI should play a lead role in monitoring quality of abortion services in the public and private sectors.

A committee should be formed at the district level that will include the Chief Medical Officer of the district, a senior obstetrician from the district hospital and a member of the FOGSI to monitor the quality of abortion services. The committee should also be made responsible for issuing licenses for providing MTP services as well as for derecognising facilities providing poor quality of abortion services. This approach will greatly decentralize the licensing procedure as well as monitor the quality of abortion services.

Operations Research

The ICMR is undertaking clinical trials in medical colleges to asses the safety and efficacy of RU-486 with prostaglandins for non-surgical MTP early in the first trimester. The results of the ICMR studies have shown a high success rate with the method, particularly in the first two weeks of missing the period. However, there have been some difficulties in the enrolment of women for clinical trials with RU-486 as it involves repeated visits to the hospital. The situation in rural areas, however might be quite different. Vacuum suction may not be readily available and it may be easier for the PHC doctor to assess the gestational age and provide RU-486 with prostaglandin. Follow-up visits may not be a major problem in rural areas. Operations research should be extended to district hospitals to study the use and effectiveness of RU-486 in rural areas. If found useful, this method should be made available in all the PHCs in the country and will provide a safe medical alternative to surgical interventions in the first trimester of pregnancy.

Studies on the Incidence of Abortions

There is no data available on the Incidence of abortions in the country. Such information is useful not only in assessing the impact of the legislation on abortion services, but also for keeping track of illegal abortions. Thus, it is clear that making abortion services safe and accessible goes beyond legislative measures. In the context of the new Reproductive and Child Health Program and the target free approach of the Government of India, the provision of safe and easily accessible abortion services is a high priority.

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According to the Demographic and Health Surveys:

- in 13 counties, more than half the women of reproductive age have no education;

- in 14 countries, at least half of the women marry before age 18;

- in 18 countries, women receive medical assistance at delivery for fewer than half of births;

- in 10 countries, fewer than half of married women know where to obtain a modern contraceptives;

- in 22 countries; more than a quarter of married women have an "unmet need" for contraception;

- in 30 countries; at least one out of every four women has experienced the death of a young child.

Source: Safe Motherhood Newsletter, Issue 17, March-June 1995.