CASE REPORT

So near, yet so far: access to safe abortion services remains elusive for poor women in India

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SUMMARY

In this case study, we describe our experiences with a woman employed as a housemaid who sought unsafe abortion services from a private doctor. This was her sixth pregnancy, after previously giving birth to one son and two daughters and undergoing two induced abortions. Her husband remained opposed to the use of contraception. Initially, she had sought medical termination of pregnancy through a government hospital but was denied because of procedural delays, specifically the non-availability of an ultrasonography report consequent to a lack of proof of identity (ie, the AADHAAR card, a unique identification card for recording biometric and demographic data in India). She finally sought the services of an unqualified private physician and received oral abortifacient agents. Consequently, she was required to seek treatment for bleeding per vaginum from the dispensary staff at a government hospital. We note that many such incidents occur in our daily practice but remain unnoticed and undocumented. Although this patient was eligible for sterilisation (ie, tubectomy), her husband was uncooperative. This case illustrates the lack of decision-making power experienced by Indian women who have a low societal status.

INTRODUCTION

Each year, approximately 42 million women with unintended pregnancies undergo induced abortion worldwide, and nearly half of these abortion procedures are unsafe. As a result, approximately 68 000 women die of unsafe abortion annually. Unsafe abortion is therefore one of the leading causes of maternal mortality, accounting for 13% of events worldwide. In particular, India is faced with a considerably higher rate of overall maternal mortality, compared with developed countries (239 vs 12 per 100 000 live births). Furthermore, of the women who survive unsafe abortions, 5 million will suffer long-term health complications globally.¹

The finding that most women affected by unsafe abortion belong to underprivileged societal groups underscores the pressing nature of this public health issue.² Accordingly, in 1972, the government of India introduced the Medical Termination of Pregnancy (MTP) Act to improve the access of poor women to safe abortion services.³ Unfortunately, however, the effect of the MTP Act was overshadowed by the issue of female feticide, which arose in the 1970s. Specifically, a preference for sons, particularly in northern India, manifested in the

form of widespread requisitions of amniocentesis and ultrasonography (USG) for fetal sex determination, followed by the abortion of female fetuses. Inevitably, this mindset and related practices led to a decrease in the female-to-male ratio.⁴

To address the issue of female feticide, the government promulgated the Pre-Natal Diagnostic Techniques (PNDT) Act in 1994, which was later amended to the Pre-Conception PNDT (PC-PNDT) Act in 2002. This Act, which banned the use of USG for fetal sex determination,⁵ has led to the strict scrutiny of all requests for USG. Furthermore, physicians are required to maintain records and complete a proforma of all performed USG evaluations. The implementation of this Act led the health authorities to raid several USG clinics, leading to the penalisation and even imprisonment of many physicians for violations. Despite this strict regulation of USG clinics, National Health Mission (NHM) in 2005 recommended that all women undergo at least one USG during antenatal check-ups. Accordingly, this paradoxical situation has significantly increased the difficulty of USG examination for pregnant women.⁶

In 2010, the Unique Identification Authority of India unintentionally introduced a further complication to this issue: specifically, the Digital India Campaign made it compulsory for pregnant women undergoing USG to first present an AADHAAR (a unique identification card used to record biometric and demographic data) or other identification card.⁷ According to governmental law, any pregnant women undergoing USG at a government or private health facility must present valid proof of identity, and a photocopy must be deposited along with the USG requisition form. Furthermore, legal abortion has been restricted by the requirement for a husband's signature on the consent form, even though this restriction was not covered by the MTP Act.⁸ In this case study, we demonstrate how these bureaucratic procedures tend to obstruct, rather than facilitate, the access of poor women in India to safe abortion services.

STUDY SETTING

The School of Public Health (SPH) at the Postgraduate Institute of Medical Education and Research, Chandigarh, India, offers a 3-year MD Community Medicine course to junior resident (JR) physicians. During the training period, the JR physicians are posted in both rural and urban health posts of the SPH. The first and second authors of this report (SB and MAB, respectively) visited these health posts

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and examined patients on 6 days /week as part of their residency training.

CASE PRESENTATION

The family

An adult couple and their three children (9-year-old girl, 5-year-old boy, 1-year-old girl) lived in a one-room rented house in Chandigarh, India. The wife (ie, subject of the present case) had a history of two previous induced abortions for which she had been prescribed abortifacient drugs by a doctor at a primary health centre near her native village. Her husband, a daily wage earner with an alcohol addiction, did not approve of abortion or the use of any contraception and considered children to be 'God's gift'. However, annual pregnancies and childbirth were very difficult for the wife, who resorted to abortion when she became pregnant, without informing her husband. She considered it easier to obtain an abortion using abortifacient drugs in her native village than in Chandigarh, where the abortion rules were quite 'strict'.

First visit

Our patient, a 28-year-old woman, worked as a housemaid and had no formal education. She presented at our dispensary in an urban slum of Chandigarh unescorted, with a 2.5-month history of amenorrhoea. She detected her pregnancy by using a urine pregnancy kit 1 week earlier at home. She wished to abort the pregnancy, as her youngest child was only 1 year old, and asked us to prescribe an abortifacient. We referred her to a Gynaecologist for the same to the nearest Civil Hospital.

On examination

The patient had a thin frame and a body weight of only 45 kg. She exhibited moderate pallor but a normal blood pressure. During the abdominal examination, her uterus was not palpable. She was asked to undergo routine blood and urine testing at a local subdistrict-level hospital. A USG was prescribed to confirm pregnancy and assess the period of gestation at the Government Multi Speciality Hospital (GMSH), located 5 km away. The USG also sought to determine the fetal sex, with the aim of curbing female feticide.

Second visit

The patient returned 1 week later with her test results. Although her haemoglobin level was 9.1 g/dL (normal value in pregnancy is 11 g/dL), all other parameters were within normal limits. However, she was not able to undergo a USG evaluation at the GMSH, as she could not produce her AADHAR card or any other government-issued proof of identification in her name, which was required by the hospital staff. However, she and her family did not have these documents, as they had recently migrated to Chandigarh for employment opportunities. The subject told us that she had subsequently requested an abortifacient drug from a physician at the local Civil Hospital, but was refused because she did not have a USG report. She was advised to undergo USG at a private diagnostic centre but could not afford the expense; additionally, these private centres also requested valid proof of identity. Furthermore, the facilities required her husband's signature on the consent form for abortion, but as noted, her husband did not approve of abortion.

Third visit

Two weeks later, she presented at the dispensary with a 3-day history of spontaneous, profuse bleeding per vaginum, as well

as lower abdominal pain, extreme weakness and lethargy. Her pallor was severe, and she was found to have tachycardia and a blood pressure of 90/50 mm Hg. She reported that she had visited the Emergency OPD (outpatient department) at the local Civil Hospital on the previous day, but was refused admission because she was unaccompanied, and government regulations require an attendant for admission. The hospital had prescribed tranexamic acid to stop the bleeding, as well as iron and folic acid tablets.

We suspected that she had undergone an induced abortion, and further questioning led to her admission that after being refused abortion services at the government hospital, she had contacted an unqualified local clinician who prescribed abortifacient tablets. The profuse bleeding began on the following day and continued until she presented to our OPD. We immediately sent her with a nurse to the Civil Hospital for admission, where she was started on intravenous fluids. We also contacted her husband to inform him about her serious condition; he received counselling and requested to stay with her at the hospital. During a 3-day admission, the subject finally underwent a dilation and curettage procedure to remove the retained products of conceptus, which had caused the sustained bleeding and received 1 unit of transfused blood. The vaginal bleeding eventually stopped in the hospital.

GLOBAL HEALTH PROBLEM LIST

1. In India, the access of poor women to safe abortion services is hindered by many procedural delays.
2. The contradictions arising among the rules and regulations of the MTP Act, PC-PNDT Act, NHM mandate for antenatal care and Digital India Campaign have created difficulties for women seeking safe abortion.

DISCUSSION

Globally, India was the first country to launch a National Family Planning Programme in 1952, with an initial focus on promoting the use of condoms, Lippes loop and eventually the copper intra-uterine device as spacing methods. As noted earlier, the MTP Act was passed in 1972 with the aim of facilitating nationwide access to safe abortion services. However, the MTP was largely used as a substitute family planning measure.⁹ In the last decade, the desire for increased contraceptive options in India led to the introduction of another option for fertility control, oral abortifacient tablets.¹⁰ These popular agents, which are available over the counter or from local doctors, have enabled women to abort pregnancies without visiting a hospital. In other words, women can now privately manage this sensitive and personal issue. We note that although our subject also obtained these tablets through the private sector, current recommendations suggest the use of these tablets only under medical supervision, given the risk of profuse bleeding. This complication could have been fatal to our subject, who was fortunately able to receive timely surgical intervention at a government hospital. Despite this risk, however, these tablets remain available without prescription throughout India.

Women are often blamed for complications related to an abortion performed by a private and/or unqualified physician. In many instances, however, the inconvenience and difficulties imposed by government health providers lead women to seek treatment from private physicians. Our patient also initially sought safe abortion services from a government hospital, but was denied because of bureaucratic restrictions, including the requirement for proof of identity and her husband's signature

on certain proforma before she could even be registered as a patient. This case demonstrates how as far as poor people are concerned, the approach to safe abortion services in India can be described as 'one step forward and two steps backward'. Specifically, the government-backed Digital India Campaign aims to move systems forward, with good intentions. The issuance of an AADHAAR card with a unique identification number to every citizen of India is a measure of good governance, with the intent of increasing transparency in governance and providing services to a larger number of poor people. Similarly, the MTP Act of 1972 and the introduction of USG for pregnancy assessment under the NHM were good governmental initiatives. However, the simultaneous requirement that seekers of safe abortion services must provide an AADHAAR or any identification card represents a backward measure. In our present case, the patient was denied abortion services because she did not have an available identification card.

The patient in our case had a positive attitude towards government hospitals as providers of safe induced abortions. However, she was discouraged by the insistence of doctors on bureaucratic procedures (eg, requirement for proof of identity). Such incidents encourage a negative attitude towards government health services. Our patient's opinion of the health system would have been enhanced by her receipt of appropriate early treatment properly, and this situation might have even provided an image-building opportunity for government health facilities. Instead, this opportunity was missed because of the focus on procedural matters, and a user who would most benefit from these services was discouraged. In this situation, the desired outcome or solution was impossible to attain because of a set of inherently contradictory rules or conditions. On one hand, the MTP Act sought to empower women by relaxing the conditions surrounding access to safe abortion services. On the other hand, this access has been restricted by creating obstacles disguised as technical objections (ie, non-availability of the AADHAAR card). The present case, however, represents only the tip of the iceberg, as many such incidents occurring in daily practice remain unnoticed and undocumented.

Although further exploration is needed, the question of why women consider an abortion (ie, feticide), which is tedious, potentially fatal in many cases, and may lead to complications, more convenient than an easier option such as intrauterine devices, oral contraceptives, or condoms is moot and the answer is simple. In India, women lack social status and therefore lack of decision-making power. In the present case, the subject did not undergo sterilisation (ie, tubectomy), despite being a suitable and eligible candidate, and her husband was uncooperative in this matter.

CONCLUSION AND FURTHER DIRECTIONS

In India, procedural barriers are leading pregnant women with low socioeconomic status to seek abortion services from private/unqualified practitioners, with potentially serious health consequences. In light of the contradictions among the government endeavours backed by the USG, MTP, NHM and AADHAAR initiative, a compromise might involve the issuance of instructions to providers of safe abortion services indicating that abortion/USG services may not be denied to seekers who do not currently have an AADHAAR card. Furthermore, providers of MTP/USG services may consider issuing AADHAAR cards on site, based on priority. Suitable arrangements to accomplish these initiatives may be made directly at the USG centres, thus allowing the targets and objectives of all

government initiatives to be met and ultimately resulting in user satisfaction resulting from the reduced time required to obtain an AADHAAR card and to access MTP services.

Patient's perspective

The index case said:

- *'Itni jagah chakkar katwa diye hain. Abb Kaaghaz poore karen ya doctor ko dikhayen?'* ('They are asking us to go from this place to other to get the paper work done. Should we focus on that or on the consultation with the doctor?')
- *'Apne gaon mein to aasaan tha. Wahin ke daktar ko dikhaya tha. Ussne dawai di aur safaai ho gayi eik din mein. Yahan jhanjhat bahut hai!'* ('It was easier in my native village. We went to the local doctor. He gave me tablets and abortion was completed in a day. It is too cumbersome here!!')
- *'Abb kya Karen? Haar ke Private Daktar ko hi dikhana pada! Usi ne safai ki goli di. Na koi sawaal na kaghaz poochhe. Kaam ho gaya. Sarakaari mein rule kanoon hi bathere hain!!'* ('What to do? Ultimately we had to go to a private doctor. It was he who gave us tablets for abortion. He did not ask any question. No papers were insisted upon. It was a smooth job. In government set up there are too many formalities to be completed!')

Her husband said about abortion:

'Ye mera kaam nahin hai. Apne aap bhugtey! Aspataal jaye Daktar ko dikhaye. Jo marzi kaery. Main nahin jaoonga uske saath.' ('It's not my job. She has to suffer it alone. She is free to go to a hospital for consulting a doctor. She may do whatever she wants. I will not escort her!')

Learning points

- Paradoxically, the access of underprivileged women to safe abortion services has been reduced in India, despite societal modernisation and technological advances.
- There is an urgent need to remove the bureaucratic bottlenecks (procedural barriers) hindering the access of unfortunate women to safe abortion services.

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