ACCEPTANCE OF INDUCED ABORTIONS IN RURAL SOCIETY & SCOPE OF FAMILY WELFARE SERVICES

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SUMMARY

A prospective random survey was carried out at primary Health center two adjoining villages with 250 females of whom 150 had one or more abortions. Illegal abortions, (often adopted to keep secrecy) as well as, legal abortions, are fraught with complications, the severity and frequency being more in the former. The reasons for acceptance of induced abortions are mainly of three categories i.e.

(a) UNPLANNED PREGNANCIES, FINANCIAL/UNEMPLOYMENT PROBLEMS and PRESSURIZATION BY HUSBAND (39.8%);

(b) FAILED CONTRACEPTION &ABORTION ALONG WITH STERILIZATION (22.6%); and

(c) CONCEPTIONS IN SINGLE/DIVORCED FEMALES and ABORTIONS AS ALTERNATIVE TO STERILIZATION (RELIGIOUS/SOCIAL PREJUDICE & PRESSURIZATION) (37.6%).

Widespread publicity and motivation, both in the community as well as during termination of pregnancies, for acceptance of contraceptives and sterilization will not only boost up ongoing family welfare services, but also minimise unplanned and avoidable conceptions & consequent abortions with added complications in (a) (39.8%) and somewhat in (b) (22.6%). Long term multifaceted planning is needed for (c) (37.6%).

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INTRODUCTION

Almost 18 years have passed since enforcement of the "MTP ACT" of India. Rural people, which comprise almost 80% of Indian population, have demands for induced abortions with adequate legal reasons but sometimes resort to illegal terminations with complications which lead to serious morbidity, and at times mortality. This study was carried out with the aims and objectives as follows:-

(a) to study (i) the reasons for demands of induced abortions and the influence of the rural socio-cultural and obstetric background, (ii) the reasons for resorting to illegal abortions (even though having justifiable reasons to claim M.T.P.) and complications thereof;

(b) to study the scope for increasing contraceptive and sterilization acceptance, based on the existing infrastructure, thus to boost up ongoing family welfare services, as well as to reduce needs & demands of legal & illegal abortions.

MATERIALS & METHODS

A random prospective survey was carried out at BADURIA PRIMARY HEALTH CENTRE & two adjoining villages from January, 1989 to October, 1989, with 250 females. This study included cases considered under ACCEPTOR group who underwent induced abortions either in the P.H.C. or elsewhere and NON-ACCEPTOR group who never any termination. Socio-cultural and obstetric histories were taken and history of induced abortions and contraceptive practice studied in details.

RESULTS & DISCUSSIONS

Of the total 250 females 150 had one or more induced abortions (Group A) and 100 never had terminations (Group B) In the total o73 study 40.8% were Hindus, 56%

Muslims, 2.4% Santhals and 0.8% Marwaris. Amongst the acceptors, there were 16 single and 4 divorced (10.6% and 2.6% of acceptors) and the rest leading conjugal life.

Of the acceptors, 25.4%, 61.3% and 13.3% were in the age groups of <20 yrs., 21-30 years and >30 yrs. respectively. 49.2% of females & 66.7% of husbands were literate.

Sixty six out of 102 i.e. 64.7% of Hindus & 82/140 i.e. 58.6% of Muslims had induced abortions, showing no significant difference on acceptance religionwise.

Acceptance was more amongst females whose husbands were health workers, service holders, technical, personnel & unemployed, compared to manual workers like farmers & van-peddlars (acceptance 71.0% - vs. - 48.0%).

Females belonging to higher socio-economic status more often resorted to induced abortions (80%, 70.9% & 48.5% of acceptance with S.E. grades II, III & IV + V respectively). Similar was the finding with better educated females. This observation is similar to that of Bhojwani and Arora (1981) but contrasts with that of Sanyal et al (1989).

Early age at marriage, higher parity and more preventible fetal & child deaths were more often encountered in females who never had induced abortion. Early child birth, spacing <2 years but less number of term deliveries were encountered in ACCEPTOR group (Tables I & VI). This was partly responsible for more induced abortions in ACCEPTORS.

10.7% of all induced abortions were done in unmarried females. Of the married, 17.9% & 62.6% of induced abortions were done before first term delivery and <2 term

TABLE I

Obstetric patterns of acceptors (A) and non-acceptors (B)

	Points	Observations (A - Vs. - B)	Comments
1.	Age at marriage	<18 years - 74.6% Vs. 94%	Early - B
2.	1st child birth	< 2 years - 89.1% Vs. 70%	Early - A
3.	Spacing	<2 years - 70.9% Vs. 50%	
		< e years - 90.9% Vs. 94%	Spacing - A
$.	Preventible Fetal/child death	1/10th - Vs. - 1/3rd.	B

TABLE II

Number of term deliveries & induced abortions in married females

No. of term Deliveries	Percentage (%) of total abortions
0	17.9
1	13.4
2	31.3
3	11.9
4	11.9
>5	13.6

TABLE III

Profile of induced abortions (186 abortions in 150 females)

	Points	No. of abortions		Points	No. of abortions
I.	Months Pregnancies		III.	Places of abortions	
	11/2	2		Chambers (Quacks + M.B.B.S.	38
	2	78			
	21/2	76		Nursing Home	4
	>3	8		P.H.C.	122

Points	No. of abortions	Points	No. of abortions
II. Methods		IV. Performers	
D&E	164	Quacks	12
Suct. Evac.	20	Paramedical	2
Ethacridine Lact.	2	M.B.B.S.	58
Ethacridine Lact.	2	Specialists	114

deliveries respectively (Table II), pointing to the incidence of avoidable and unwanted pregnancies and need for effective family welfare services.

One, two & three induced abortions were done in 122, 20 and 8 women respectively. (Table III) summarises some details of induced abortions. The complications of abortions in this series (Table IV) are more than that of Sanyal et al (1989),partly due to increased incidence of complications of abortions done at chambers of M.B.B.S. Practitioners, possibly due to improper training and inadequate asepsis and lack of meticulous precautions. All the 14 cases of illegal abortions had complications (table IV).

The reasons for demanding induced abortions (Legal & illegal) are categorized in table V. Illegal abortions, done by quacks and paramedical persons in 14 cases in the study, were adopted, primarily to keep secrecy. The secondary reasons attributed were (i) Publicity by quacks - 8 cases (ii) Easy availability - 4 cases, (iii) Financial Problems, lady performer & known persons - 2 cases each. Awareness of the public about the dangers of illegal abortions & motivation for contraceptives & sterilization are needed to minimise uptake of illegal abortion. Increased acceptance and proper use of contraceptives and sterilization at reasonable parity will minimise avoidable and unplanned pregnancies and need for induced abortions in (a) and somewhat in (b). Long term planning with socio-

TABLE IV

Complications of induced abortion

Complications	Abortions	
	Legal (172)	Illegal (14)
1. Incomplete	18 (10.5%)	4 (28.6%)
2. Infection	8 + 2 (4.6)	2 + 8 (14.3)
(Mild + Severe)*	+ 1.1%)	+ (57.1%)
3. Perforation	4 (2.3%)	-
4. Cervical incompetence*	2 (1.1%)	-
5. Asherman's Syndrome*	2 (1.1%)	-
	36 (20.9%)	14 (100%)

*Done by M.B.B.S. - Pvt. Practitioners.

TABLE V

Reasons for acceptance of induced abortions

Reasons		No. of Cases	Total (%)
(a)	Financial/Family Welfare	16	
	Unplanned Preg.	48	74 (39.8%)
	Forced by husband	4	
	Unemployed husband	6	
(b)	Failed contraception	12	42 (22.6%)
	(Cond. 6; IUCD -4; o.c.-2)		
	Alongwith Sterilization	30	
(c)	Single	16	
	Divorced	4	
	Alternative to sterilization		
	(Religious/social pressurization	50	70 (37.6%)

economic uplift is prerequisite to tackle problems in (c) (Table V).

Contraceptive acceptance amongst acceptors of induced abortions o73 are significantly higher than non-acceptors. Motivation during induced abortions increased acceptance in 43.2% (Table VI). Though ultimate acceptance of sterilization amongst group (B) are more than (A), late acceptance at higher parity are significantly noticeable in (B). (Table VI). Motivation in the community is needed to counteract this non-acceptance of contraceptive and late acceptance of sterilization in 'B'.

CONCLUSIONS

(i) Illegal abortions often adopted to keep secrecy, are endangered with severe complications.

(ii) Legally performed abortions are sometimes fraught with complication.

(iii) Demands for termination of pregnancies are mainly of three categories i.e. (a) those sought for unplanned pregnancies/unemployment problems & pressurization by husband (39.8), (b) those failed contraception and those alongwith sterilization (22.6%), and (c) those for single/divorced females and for religious and social objection to sterilization (37.6%).Unplanned pregnancies and consequent abortion can be minimised in (a) and somewhat in (b) by proper use of contraceptive and adoption of sterilization at proper party. (c) will need long term planning.

TABLE VI

Contraceptive and sterilization acceptance amongst - acceptors (A) and Non-acceptors (B) of abortions

Contraceptive Acceptance				Sterilization Acceptance		
Methods	A	B	I.	Methods	A	B
Withdrawal	2	2		Vasectomy	2	-
Safe period	-	2		Minilap	12	12
Condoms	30+14	6		Laparoscopy	20	42
I.U.C.D.	4+16	4		Others (Caese, lign H. and L)	6	-
					40	66
	56+581*	20*2	II.	At parity	>2 - 27.3%	18.4%
					>2 - 18.1%	48.9%
					45.4%	67.3%

*1 On Motivation during induced abortions; 43.2% increased acceptance.

*2 Reflects spontaneous acceptance/motication in the community.

(iv) Increased motivation & awareness of people in the community are very much needed. During induced abortion also should try motivate couples as acceptance of contraceptive (+43.2% in the study) and sterilization increases appreciably. These will help reduce avoidable and unplanned pregnancies, lead to less demand for M.T.P.and illegal abortions with consequent complications, as well as boost up ongoing family welfare services.

REFERENCES

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