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Guest Article

Induced Abortions by Qualified People – How Safe?

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Summary

WHO defines unsafe abortions as not provided through approved facilities and/or person. We suggest any induced abortion which impairs reproductive health should be considered unsafe irrespective whether it is performed legally or illegally. Scan of Indian data shows that induced abortions performed by qualified but untrained persons have more complications though they are safer than child birth. Suggestions are given to make induced abortions safer.

What is unsafe abortion?

There is no clear definition of unsafe abortion. However, definition approved by World Health Organization (WHO 1992) is generally accepted. It defines unsafe abortion as not provided through approved facilities and or person. WHO has not clarified as to what constitutes approved facility or person because it may vary from country to country. WHO definition gives an impression that induced abortion provided through approved facility/person would be safe. We know that it is not always so. We suggest following definition of unsafe abortion which may be more appropriate. Any induced abortion which impairs reproductive health should be considered unsafe abortion irrespective whether it is performed legally or illegally. This raises important question. Are all abortions performed without legal sanction always unsafe? Are abortions performed with legal sanction, always safe? Physicians in Taiwan Greece, Netherlands do provide abortion service though abortion is not legal in these countries. In India inspite of the MTP act, many obstetricians do perform abortion even though they are not approved by government because of redtapism and usual administrative delay. However, abortions performed by physicians though technically illegal are reasonably safe. Many FOGSI members applied for registration for approval to perform MTP procedures. Because of the unacceptable delay on the part of the government to approve these doctors, they continued to perform these procedures under safe and hygienic conditions. Though technically illegal it would be ridiculous to consider them as unsafe. Fortunately after repeated appeals and representations by FOGSI and IMA, government administration is streamlining its servicing for approval of the private doctors and their nursing homes. When abortion is legalized, it does provide legitimacy to the procedure but does not guarantee that safe abortion services will be available. In India though MTP act came into force in 1972 there were not enough trained doctors to perform abortion. MTP services were not accessible to rural area. Many qualified and unqualified, trained and untrained persons started offering MTP services. The ICMR Report (1989) states that MTP is performed by many unqualified agencies such as dias, practitioners of indigenous system

of medicine, chemists, relatives etc. In 1972 teachers of Ob. Gyn. and other senior specialists had no official training to perform MTP. Sixty teachers from medical colleges were sent for training in Sweden, Yugoslavia and UK. These doctors after their return trained other doctors to perform MTP. Some PHC doctors were trained to perform MTP procedures. The ICMR Report further states that services in PHC were underutilized for following reason.

1. There is no proper care at PHC. No followup care provided.
2. PHC does not maintain secrecy of the clients
3. PHC doctors charge too much money
4. PHC is far off

In India, when MTP act was passed, it was assumed that unsafe abortions would disappear and so morbidity/mortality associated with unsafe abortions would be prevented. Reports say that number of illegal abortions have not reduced in India. Studies (Bates and Zawadzki, 1964) from East European countries like Bulgaria, Hungary, Rumania, Poland etc. show that though there was increase in number of legal abortions, there was no corresponding decrease in the number of illegal abortions. The report further states that in Denmark, with liberal abortion law, there were 4000 legal and 12000-15000 illegal abortions in 1964. It is likely that clients who resort to illegal abortion are different from those who resort to legal abortion.

Bates & Zawadski (1973) described five categories of persons providing abortion services. These categories were described when abortion was illegal in most countries.

1. The Physician abortionist
2. Abortionist with some medical training.
3. The Quack doctor/unlicenced practitioner
4. The amature with no background or training
5. The self abortionist

It would be logical to assume that once abortion is legalized, only trained and qualified physicians would perform the abortion. Unfortunately, in India, all above mentioned five categories exist three decades after the MTP act. Reports from Bhatt and Soni (1973), Maitra (1999) Government of India (1990) shows that 4-6 million illegal abortions take place.

How safe are induced abortions by qualified people?
It is true that illegal abortions performed by unqualified and untrained persons are unsafe. It is logical to believe that legal abortions performed by qualified persons should be safe. Let us analyze the data to find out how safe are legal abortions by qualified people.

ICMR (1981) studied the sequelae of induced abortions in 13 postgraduate centers in India in 1976 77. The study showed that minor complications after induced abortions were 31.3 per 1000 procedures and major complications were 2.1 per 1000 procedures. Abortion mortality was 68/100,000. Similar study was carried out in UK two years after abortion was legalized in 1967. The report of Royal College of Obstetrician and Gynaecologists (RCOG, 1972), shows that abortion mortality was 30/100,000. When any new procedure or technique is introduced, the complication rate is high all over the world. There is a learning curve for mastering a new procedure. The safety of the procedure increases as the expertise develops and safe techniques are developed. We would expect the MTP procedure to be safe in India as it is in other parts of the world. Unfortunately, Indian data does not support that MTP is safe in India.

It must be admitted that though mortality after MTP is high, it is no doubt lower than mortality due to child birth which varies from 400-500 per 100,000 live births. In other words MTP in trained hands is safer than child birth.

Bhatt (1997) studied maternal mortality in India (WHO-FOGSI study) and found that 1.5 percent of maternal deaths were due to MTP performed in medical college hospitals. Sinha et al (2001) state that in 1997-98 there were 8 deaths due to MTP in RCM Hospital, Ranchi and six of these were performed by medical persons. Sinha further states that these patients were transferred 10-15 days after the procedure. Bedi (2001) conducted a multicentric ICMR study in 31 teaching hospitals in 16 states in 1993-94. There were 119 induced abortion complications admitted in these teaching hospitals. Large majority of these MTPs were performed in private clinics or private nursing homes. Registered Medical Practitioners (RMP) were involved in 40.5 percent of these cases. Though death after MTP is notifiable, it is difficult to get correct data. Many deaths may occur in surgical wards and renal units and cause of death may be given as peritonitis or renal failure. There may be no mention of MTP. It is true that untrained, partially trained or self trained qualified doctors are responsible for most of the morbidity/mortality due to MTP. Training is more important than qualifications for safety of induced abortion. Safe abortion can be made unsafe if performed by untrained or partially trained qualified person. Even qualified and trained persons can make abortion unsafe if they fail to recognize 'high risk' abortion. Indian data shows that more unsafe abortions are performed in private sector. Private sector consists of doctors with

variable qualifications, experience and training. At the top we have a well trained and experienced consultant with postgraduate qualification and at the bottom we have MBBS doctor who is self trained or partially trained. In rural areas, unqualified doctors also perform MTP.

Induced abortions must be classified as 'low risk and high risk' abortions just as pregnancies are classified as 'low risk' and 'high risk' pregnancies. We suggest that trained MBBS doctor should be authorized to perform low risk MTPs only. All high risk MTPs should be sent to those centers who have the equipment and expertise. Normal healthy women with pregnancy upto 8 weeks and without any uterine scar, anomaly or tumor can be dealt with by MBBS doctor.

High risk abortions are also called 'challenging abortions'. Presence of these risk factors suggest that more expertise is needed to deal with these cases. The challenging abortions could be following conditions.

1. Adolescent girls	many adolescents have very tight internal os. Incomplete abortion may result or develop cervical tear.
2. Bad Obst. History	Previous uterine scar, previous MRP
3. Genital malformation	Bicornuate uterus, septate uterus, extreme flexion of uterus
4. Uterine fibroids	They may distort uterine cavity
5. Medical diseases	Severe anemia, heart disease, genital infection & other complicated medical diseases
6. Physical handicap	When lithotomy position cannot be given

It is true all high risk factors may not be detected in advance. Uterine anomaly may not be diagnosed till the procedure is performed or even later. However, many of these high risk factors may need ultra-sound facilities and special instruments and techniques.

How to make induced abortions safe?

Though MTP is a part of training in all postgraduate courses in obstetrics and gynaecology after 1972, there are many practicing gynaecologists who passed before 1972 who have not received formal training in MTP. Many of them are self trained. Newer techniques of MTP are introduced. In USA and in many other countries, second trimester abortions are performed by dilatation and evacuation (D&E) technique. Special instruments are devised to extract the fetus. In experienced and trained hands, it is a good technique. However, if persons not trained in this technique, perform D&E in second trimesters, then the complications would be high. The entire emphasis should be on training. Greater the experience of the operating surgeon and earlier in pregnancy the termination is carried out, fewer will be the complications. Suction evacuation is the safe and effective method for first trimester termination. Unfortunately because of erratic power supply, the electric suction apparatus do not work and doctor has to resort to D&C procedure. The risk of incomplete abortion is high with D&C method.

Retained products may encourage infection and haemorrhage. Medical methods of early pregnancy termination (RU-486 Mifepristone) are likely to be available in future. If judiciously used, it can make safe abortion in early weeks. Newer Manual Vacuum Aspiration (MVA) syringes are now available and it would certainly help in areas with no power supply or erratic supply. Challenging abortions should be performed at those centers where backup service is available in case of complications or failure to terminate pregnancy. The most important strategy to make abortions safe is to increase the number of trained persons who can do the job. In some government facilities, doctors refuse to perform MTP unless the woman accepts some method of contraception. This ideology forces the woman to go to quacks and have unsafe abortion or if she is affording, go to private clinics. I feel that every woman coming for MTP must be counseled to adopt some method of contraception but to make it a precondition, it would be counter productive. The need for providing safe abortion services in rural areas is very urgent and it is heartening to note that the New Population Policy 2000 announced by the government has made provision for more training centers. If we consider the demand for MTP at 6 million per year and we have about 15000 FOGSI members, each FOGSI member shall have to perform 400 procedures per year. It may be difficult if not impossible for obstetricians to accept this load of work especially in rural areas. Therefore, we must plan for MBBS doctors with good training to perform the procedure in pregnancies up to 8 weeks.

The number of second trimester abortions significantly declined all over the world. There is no doubt that early termination of pregnancy is much safer than late termination. Tietze (1981) opined that rate of complication increases by 20% for each additional week of gestation beyond 8 weeks. Incidence of second trimester abortion is less than 5 percent. It is not possible to prevent second trimester abortions because of following conditions.

1. Teenagers, unmarried women, widows delay in seeking help. Proper counseling and education may encourage them to seek early help.
2. Late detection of fetal anomalies
3. Intrauterine fetal death
4. Clients staying far away from abortion services

Unfortunately many second trimester abortions are carried out in India after sex determination tests. Sex determination tests solely for selective female feticide are banned in India since 1996. FOGSI has also resolved that SD tests should not be encouraged for selective female feticide. However, it is common knowledge that ultra sound is liberally used for determination of sex between 13-16 weeks. This is responsible for increase in second trimester MTPs. Obstetricians and Sonologists have to do introspection if this trend should be encouraged for commercial gains. Complications of late abortions are 10 times higher than early pregnancy termination. FOGSI must continue to discourage MTP after SD tests.

Role of FOGSI in promoting safe abortions

FOGSI is a powerful National organization with large membership. It can play a very vital role in promoting safe abortion concept. Our president has set the ball rolling by giving the slogan, 'safe abortion saves lives.' We suggest following steps may help in reducing the incidence of unsafe abortion. It can advise the teachers at medical colleges to teach and effectively train the undergraduate and postgraduate students in various techniques for MTP. Teachers can devise the National guidelines for selection of cases, techniques to use and other "Dos & Don'ts" for MTP procedures. MTP committee has published a book on similar lines. It can participate in training program for doctors in rural areas. There is need to quantify the guidelines, supervised training in their clinic setup is essential. It can define challenging abortions or high risk abortions and inform the members how to tackle them effectively. It can devise guidelines to deal with complicated cases after illegal abortions performed by unqualified and untrained people. It can advise their members not to increase second trimester MTPs done after SD tests. MTP committee of FOGSI is doing a very constructive role in promoting safe abortions. We suggest MTP committee try to establish a National Registry of unsafe abortions admitted/treated by FOGSI members. This would be an excellent document which may help in taking steps to reduce unsafe abortions in India.

Prevention of unwanted pregnancies is the best prophylaxis for unsafe abortions. Therefore there is a need to promote safe and effective methods of contraception. Unprotected intercourse or contraceptive accidents do occur all over the world. There is an urgent need to promote emergency contraception in the country. Judicious use of emergency contraception may reduce the need for abortion in many cases and save impairment of reproductive health in women.

In conclusion, induced abortions by qualified and trained doctors are reasonably safe. Efforts must be made to make them SAFER.

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