Offering contraceptive choices post abortion: The ignored link by service providers

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Abstract: *An overwhelmingly large number of induced abortions in India are carried out due to unwanted pregnancies. Offering contraceptive choices to a woman /couple immediately after abortion can help prevent unwanted pregnancies and maternal morbidities. Yet, in an astoundingly large number of cases, abortion providers do not offer such contraceptive choices. The present paper seeks to explore this aspect in different contexts. The data presented in the study chiefly draws from a large-scale community based study conducted across the entire state of Maharashtra by CEHAT to enquire into abortion rate, care and cost. Based upon this data, the authors seek to draw attention to the larger issues emerging therein.*

The paper examines whether the nature of provider (public/ private), the setting (rural/urban), or the personal history of the woman (age; standard of living; parity; history of repeated induced abortions, etc) had a bearing on the offer of contraceptive choices by the abortion provider to the woman. Consistently however, such offer of contraceptive choices was not provided in a very high number of the episodes. Considering that the family planning related counseling services by the health care system, both public and private, is highly deficient, such abortion providers are a crucial, and often the only institutional link to offer contraceptive choices to the woman / her partner. A systematic offering of contraceptive choices by the abortion provider would not only help a couple prevent unwanted pregnancies, it shall engender the reproductive health of a woman as also help secure a semblance of reproductive rights for her.

INTRODUCTION

Abortion has been a sensitive issue in most countries of the world, and has recently received international attention as a public health issue. In India, Medical Termination of Pregnancy (MTP) is permitted under specific conditions. The MTP Act of 1971 and the MTP Rules and Regulations of 1975 lay down the legal and medical framework for abortion services. But merely the fact that abortion is legal does not guarantee women to safe and legal abortion. For each legal abortion there are around 10-11 illegal abortions in India (I). Studies have indicated that over the years, numbers of induced abortions are on the rise. Evidence show that abortion is used as a method of contraception. It has been commented that, abortion as a method of contraception is advocated openly by government authorities, though on paper it is not a part of the Family Planning Programme(II). What is equally disturbing is the fact that the proportion of currently married women using the officially sponsored spacing methods increased only by one percent (from 6 percent to 7 percent) between the two NFHS surveys (III), whereas the family size has decreased over the years[1]. Therefore it is not surprising to see that an

[1] Though a very marginal rise between the 2 NFHS surveys.

overwhelmingly large number of induced abortions in India are carried out due to unwanted pregnancies. Offering contraceptive choices to a woman /couple immediately after abortion can help prevent these unwanted pregnancies and resultant morbidities.

THE METHODOLOGY

The study, data from which has been chiefly drawn for the present paper, was a large scale community based study carried out in the state of Maharashtra in western India between 2000-2001. Broadly the study was aimed to analytically understand patterns of abortion incidence and related issues, abortion care seeking behaviour, reasons for seeing abortion and to analyse the changing patterns across time and costs of abortion care. For the purpose of this paper, we would restrict our findings only to the rate and purpose of induced abortions and subsequent contraceptive advice given by providers.

The sample size was fixed at 5000 households and was drawn in such a way that it would enable estimates for abortion incidence for the entire state of Maharashtra in India, and also independently for urban and rural areas. The sample was distributed proportionately over rural and urban areas of the state. The primary sampling units (PSUs) were villages in case of rural areas and census enumeration blocks (CEBs) in case of urban areas. The secondary sampling units were households. For selecting rural PSUs two stage and for urban areas three stage stratified sampling procedure were adopted. The households to be interviewed were selected with equal probability in each selected enumeration area using systematic random sampling. From the selected sampled households, all ever-married women in the age group of 15-54 were eligible for this study.

Three types of pre-tested tools for data collection were used– Area Profile Recorder, Household interview schedule and Woman's interview schedule. The woman obtained detailed information about their pregnancy outcomes during a woman's entire reproductive life, along with other relevant information like sex, current age of the surviving children, age of women at each of the recognized pregnancy outcomes, and the calendar year and month for the same. Special probes were used when the spacing between subsequent births were not explained with contraception usage, including abstinence Details about reasons, care and cost aspect of all pregnancy loss was gathered for the period 1996-2000[2].

RESULTS AND DISCUSSION

[2] The reference period of the survey was post 1996. Most of the details about pregnancy outcomes were gathered only for the period after 1996, in order to avoid problems in recall for episodes in earlier years.

The data was collected from 5712 women from 5405 households. The household response rate is 97.4 per cent and for eligible women it is 90.4 per cent. The study found that for every 100 recognised pregnancies for the 5-year period prior to survey (1996-2000), 89.5 percent of pregnancies ended in live birth, 1 percent in still birth, 4 percent in spontaneous abortion and 4.5 percent in induced abortion. In the case of induced abortions, both rate and ratio is about 2 times more in urban areas than in rural areas, a substantial change over the earlier period when it was over 4.5 times indicating improved access for abortion services in recent years in rural areas, as well as indicative of an increased demand for sex-selective abortions. Rate of pregnancy loss, both spontaneous and induced are much higher in Mumbai than urban areas of the rest of the state.

Incidence of induced abortion in urban areas shot up quite dramatically from 3.7 percent between 1986-90 to 7 percent of reported pregnancy outcomes in 1991-95. This may be due to the fact that sonography centres and also MTP centres became more accessible to people in urban areas and hence a substantial part of the increase may be due to sex-selective abortions. For rural areas, this spurt in induced abortion rate occurred in the later period i.e. 1996-2000. This may be due to the fact that abortion services became comparatively more accessible to the rural population in the latter half of the last decade. There is not much of a difference in terms of proportion of women experiencing natural losses across standard of living groups, but in case of induced abortion there is considerable difference among lower and higher standard of living. Proportion of women from higher standard of living experiencing induced abortion is 8.7 times higher than of women from lower standard of living.

As mentioned earlier, the study also asked the woman about the possible reasons for undergoing induced abortion. Of the 141 abortions recorded in the 5-year period (1996-2000) prior to survey, only 19 percent of the abortions were terminated within the framework of the MTP act. For vast majority of abortions (117 out of 141), unwanted status of the pregnancy was the main reason for termination. This high percentage of unwanted pregnancy brings the issue of access and demand for contraceptives, especially spacing methods, into focus. Yet, in an astoundingly large number of cases, abortion providers did not offer such contraceptive choices. Another 7 percent of the pregnancies ended in abortion due to unwanted sex of the fetus. This is an increase of 4 percent from the earlier 20-year period (1976-1995). The following table (Table 1) gives the breakup of reasons for resorting to induced abortions for the reference period, 1996-2000.

Table 1: Reasons for undergoing induced abortions

Sr.no	**Reason for induced abortions**	**% of responses**
1	Unwanted pregnancy	70.0
2	Unwanted sex of the	7.6

	foetus	
3	Contraceptive failure	2.4
4	Biological problem	16.7
5	Other reasons	3.3
Total		**100.0**

Offer of contraceptive choices in the event of induced abortion due to unwanted pregnancy: Different contexts

For the purposes of this paper, a major line of enquiry was to find out whether contraceptive choices were advised to the woman (abortion seeker) by the provider, in the event of an induced abortion due to unwanted pregnancy. As we shall presently see (Table 2), contraceptive choices were not advised by the service provider in a large percentage of the cases. This is true in a variety of contexts and is elaborated as follows. The public sector was a marginal player in the provision of abortion related services in the present study, and the private sector was, by far, more accessed. However, neither sector advised contraceptive choices to the woman in all episodes of induced abortions due to unwanted pregnancies. Similarly, irrespective of the rural or urban place of residence of the woman (and where she had accessed the health care facilities for abortion related services), a very high percentage of abortion seekers were not advised post abortion contraceptive choices. In the city of Mumbai, however, the situation was slightly different with a majority of the service providers offering such advice, unlike cases from rest of the urban areas where in the majority of the cases, such advice was not given.

Table 2: Offer of contraceptive choices by the provider according to place of residence

Context	**Contraceptive choices offered (%)**		**Number of abortions**
	Yes	**No**	
Rural	56.4	43.6	55
Urban	56.5	43.5	62
Mumbai	73.1	26.9	26
Rest Urban	44.4	55.6	36
Total	**56.4 (66)**	**43.6 (51)**	**100.0 (117)**

Figures in parenthesis denote number of abortions

We also examined the data to see whether the personal history of a woman had a bearing on the advice of contraceptive choices offered by the abortion service provider. Table 3 cross-tabulates the data against three such variables, viz., the number of pregnancies of the woman, her standard of living (SLI) and her age at abortion. Again, consistently, in a high percentage of the cases, contraceptive choice

was not advised to women irrespective of their personal histories. In fact, for women with the highest parity as present in the data (5+ children), a category one would presume would be in greater need of such advice, a majority of them were not offered such advice. Similarly, among the three categories of standard of living (SLI), such advice is not given in a large percentage of the cases for those belonging to the middle and high SLI, and the picture is even worse for those in the low SLI, where such advice is not given in a majority of the cases. If we see such data cross-tabulated against the age of the woman at abortion, again, such advice is not offered in a high percentage of the cases.

Table 3: Personal history of the abortion seeker and offer of contraceptive choices by the provider

Sr. no.	Personal history of the abortion seeker	Whether contraceptive choices were offered		Number of abortions
		Yes	No	
1.	**Number of pregnancies**			
	2	58.8	41.2	34
	3-4	59.7	40.3	62
	5+	42.9	57.1	21
2.	**Standard of living**			
	Low	22.2	77.8	9
	Medium	54.0	46.0	50
	High	63.8	36.2	58
3.	**Age of the woman at abortion**			
	Less than 19	44.4	55.6	9
	20-24	63.6	36.4	44
	25-29	55.6	44.4	45
	30+	47.4	52.6	19
	Total	**56.4 (66)**	**43.6 (51)**	**100.0 (117)**

Figures in parenthesis denoted number of abortions

The foregoing tables show that the service provider did not advise contraceptive choice to a very high percentage of abortion seekers. In cases where contraceptive advice was given, we sought to analyse the data further by looking into the type of contraceptive method advised. On the whole, non-terminal methods were given preference over terminal method (sterilization) by service providers in cases where they did offer contraceptive advice. This is a heartening feature as it augurs that a woman/couple is offered a choice with respect to whether she/they wants to limit the family size at that point of time or not. However, it has to be ensured that the entire range of contraceptive choices have to be offered to the woman and their possible health implications be made known to her. Information should also be

made available to the woman with regards to the health care facility(ies) she can access in the event of any morbidities arising out of the abortion as also the use of contraceptive. It is only when such informed choice is proffered to the woman that a semblance of reproductive rights can be secured for her. The high percentages of female specific contraceptive practices being offered by the service providers, however, betray the gender bias in the offer of contraceptive choices. If the range of contraceptive choices offered has to be more gender neutral and involve male participation, then the range has to widen to that effect.

Table 4: Type of contraceptive choices advised

Type of contraceptive advised (in %)					
Pills	**IUD**	**Condoms**	**Abstinence**	**Sterilisation**	**Others**
27.7	31.3	15.7	12.0	12.0	1.2

We further looked into the data to see whether different patterns in the type of contraceptive method advised were emerging with respect to the type of provider, as also the parity of the woman. Though the cell counts are very less to make generalizations on the basis of the data, however, the data is suggestive of the fact that sterilization and IUD insertions are, by far, the preferred methods advised by the public providers, whereas the private providers advise contraceptive pills and condoms in addition to IUD. With respect to the parity of the woman, cross-tabulated against the type of contraceptive method advised, the data suggests that non terminal methods like IUD insertion, contraceptive pills and, to some extent, condoms are the dominant methods advised by the providers, irrespective of the parity of the woman.

Abortion as a method of contraception

India's MTP Act allows abortions for the indication 'failure of contraceptive' and is silent about use of abortion as a spacing method. Empirical studies have shown that majority of the women have knowledge about contraceptive methods – yet this knowledge does not translate into practice. A community-based study conducted in Maharashtra in the late nineties recorded a whooping 74.1 per cent of abortion either because desired family size was achieved or because pregnancy was mistimed (IV). This study found that around 67 percent of pregnancies were terminated due to "unwanted status" of the pregnancy, 4 percent was terminated due to economic problems and another 4 percent due to contraceptive failure. The present study also confirm earlier evidences that women have resorted to repeat abortion either to limit their family or as a spacing method. A total of forty-three women underwent repeat abortions (two times or more), due to unwanted pregnancies alone. It is to be noted that such repeat abortions are due to reasons of unwanted pregnancies alone, and that a woman might have resorted to abortions for other reasons too, which have not been covered in the present paper. In fact there are instance of women where women

had as many as 4 abortions in order to limit their family, but surprisingly in most of these cases, any type of contraceptive method was not advised by the provider, which in most of the cases are private providers.

It is distressing that women have had to take recourse to abortions repeatedly in the event of unwanted pregnancies. Such recourse to induced abortions to terminate unwanted pregnancies is not only indicative of the poor contraceptive outreach services available in the state of Maharashtra, but also indicates poor post abortion counseling services being provided by the abortion service providers, thereby making a woman vulnerable to repeat pregnancies and consequently, repeat abortions to terminate such pregnancies. An elaboration of the background characteristics of women undergoing repeat abortions due to unwanted pregnancies are pointers to the socio-economic milieu to which such women belong. The following table (Table 5) shows the place of residence, caste of the head of the household, occupation of the woman and years of schooling of the woman. The table throws up certain important findings. Cases of repeat abortions due to unwanted pregnancies are as much prevalent in urban areas (including, significantly, in the city of Mumbai) as they are in rural areas, thereby necessitating the strengthening of the outreach services in both the rural as well as urban areas, as also sensitization of abortion providers in both rural and urban settings. Non-working women constitute the single largest category of women undergoing repeat abortions due to unwanted pregnancies (26 out of the 43 cases), and this might be indicative of their poor negotiating powers within the household. However, it is to be noted that women of different occupational backgrounds (including those in professional jobs as well as women agricultural labourers) report cases of repeat abortions due to unwanted pregnancies also. Hence, it is important to devise strategies that disseminate contraceptive related information to women (both non-working and working, and reaching out to women of different occupational backgrounds), as also to drive home the fact to abortion providers that all women, irrespective of their occupational backgrounds are in need of post abortion contraception counseling. Similarly, the data does not show conclusively that the higher caste status or more years of schooling of a woman is a defense against repeat unwanted pregnancies, thereby underscoring the need for reaching out to all women with contraceptive related information, and sensitizing abortion providers on the importance of post abortion counseling on contraceptive choices.

Table 5: Background characteristics of women with repeat abortions due to unwanted pregnancies

Sr.no.	**Background characteristic**	**No of women**
1.	**Place of residence**	
	Rural	18
	Urban	25
	Mumbai	15

2.	**Occupation of the woman**	
	Professional	5
	Clerical	1
	Skilled work	3
	Cultivator	2
	Agricultural Labourer	6
	Not working	26
3.	**Caste of the head of the household**	
	Upper caste	9
	Dominant Peasant Proprietor	8
	OBC	13
	Scheduled Castes	4
	Scheduled Tribes	1
	Non Hindus	8
4.	**Years of schooling of the woman**	
	No schooling	5
	1-4 years	3
	5-7 years	10
	8-10 years	11
	11-12 years	7
	13-15 years	6
	16-17 years	1
	Total	**43**

What is disturbing about the finding is that non-use of contraception, rather than contraceptive failure, which was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. These data thus indicate that women do resort to abortion as a spacing method, reflecting its inevitability in absence of guaranteed access to safe and sure contraceptives. These data suggest that (a) there is an increase in resorting to abortion for the reasons of spacing and (b) abortions are not denied when sought for as a spacing method.

Role of provider in contraceptive provision

Providers have a significant role to play in the sphere of contraceptive provision, as they have the necessary knowledge and potential opportunities to interact with the woman/couple on this, and are often the only institutional link to offer contraceptive choices to the woman / couple. Also, importantly, people's trust with the medical community could be utilised for this. But unfortunately, as evident, contraceptive choices were not offered in a very high number of episodes.

A study of abortion providers in two districts of Maharashtra show that only a few providers felt that women's lack of decision making power was responsible for their unwanted or unplanned pregnancies. Some providers were of the opinion that they did not think it was their job to prevent unwanted pregnancies and therefore, they did not counsel for post-abortion contraception. Moreover, women's repeat abortions because of non-use of contraception for spacing had earned abortion providers their business. They argued that by charging a higher fee from women of rural rich households who did not care for family planning, they would be able to provide abortions at subsidised costs to poorer women (V). Such mindset may lead to pushing women to face repeat abortions by keeping them away from knowledge about contraceptives. If providers are made to understand the situations in which women seek abortion, their concern for women's health and well being, shall have the potential to reflect in the abortion service provision by way of contraceptive counseling.

POLICY IMPLICATIONS

Research have shown that the reason women seek abortion is not their preference for abortion over contraception, but rather the shortage of contraceptives and contraceptive failure (VI). It is widely accepted that increased successful post abortion contraceptive service are effective in preventing unwanted pregnancies and, consequently, morbidity and mortality due to repeated abortions. Provision of contraceptive information and services should be made an integral part of abortion care. Equally important is the fact that contraceptive acceptance should never be a precondition for provision of abortion services. Women/couple should be given proper advice about available methods of contraception along with their health implications as also the health care facilities where they could access such services. We would like to emphasize here that making contraceptive acceptance a pre-condition for providing abortion service would not reduce abortion, instead it would lead to increase in clandestine and unsafe abortions. Service providers should be sensitized to the contraceptive needs of a woman and the reproductive rights framework in which such needs are to be addressed. The private sector, being a large player, should also be regulated for its quality and affordability. Also any expansion of contraceptive methods should take into account the social and cultural context of the dynamics of contraceptive usage. A systematic offering of contraceptive choices by the abortion provider would not only help a couple prevent unwanted pregnancies, it shall engender the reproductive health of a woman as also help secure a semblance of reproductive rights for her. We hope that the present study would stimulate policy makers to pay increased attention to the complex determinants that explain sexual and reproductive behaviour and specific contraceptive usage, including abortion.

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