Can India transition from informal abortion provision to safe and formal services?

The past three decades brought important developments to the area of women’s access to abortion, especially with the advent of medical abortion methods. However, the rate of unsafe abortion worldwide remained unchanged between 1995 and 2008. Although abortion was legalised in India in 1972, several barriers continue to prevent women from accessing safe abortion services, especially in rural areas. They include skewed distribution of urban and rural abortion facilities, high costs, and provider barriers including denial of choice between medical and surgical methods and insistence on husband’s consent.

A facility survey from 2003 reported that only 15% of primary health centres provided abortion services. Another study from Rajasthan state revealed that nine districts included 83% of all facilities whereas the remaining 22 districts included only 17%. Within districts too, abortion facilities tend to cluster in urban areas.

For the average rural Indian woman, getting a safe abortion means finding someone to accompany her to an unfamiliar town or city, arranging for childcare and money for transport and services, and spending an entire day on travel. This absence in turn attracts the attention of family members and neighbours, reducing confidentiality. Data from rural Rajasthan, on follow-up of women referred for late abortions, showed that 80% did not visit the urban referral facility, but instead continued the pregnancy or visited an unlicensed provider.

Even when formal abortion providers are available, women might not seek care from them. Although women have shown overwhelming preference for medical abortion, providers often do not offer a choice between surgical and medical methods. Given pervasive fear of surgery in low-resource settings (possibly due to complication rates tending to be higher because of insufficient staff skills and low adherence to protocol), women desiring to take pills are often unsure of where to go since many facilities do not offer a choice of medical abortion.

There is evidence of women increasingly seeking abortion services from informal providers or chemists. The annual sales of mifepristone and misoprostol in India are estimated at 11 million doses, while reported abortions number a mere 700,000. This huge gap is probably due to under-reporting of medical abortion by formal providers, and widespread provision by informal providers—in a survey of 577 chemists, 80% admitted providing mifepristone and misoprostol; they, however, had little information on accurate dosage, eligibility, or side-effects. Self-medication after procuring pills from an informal provider poses risks because gestational age is not assessed and contraindications are not screened out. Medical abortion at later gestations, especially after 12 weeks, is associated with increased rates of complications such as haemorrhage, incomplete abortion, and need for surgical intervention. Further, the cost of treating complications of unsafe abortion adds a substantial financial burden to both the health system and women. Hence access to safe medical abortion through well trained, formal providers also makes economic sense.

Sweeping amendments have been proposed to the abortion law in India, including certification of a wider range of providers. These proposals have faced vehement opposition from professional associations. However, even within the scope of the current law, some key actions could help to substantially improve access to safe abortion in primary care settings. Most women prefer medical abortion over surgical abortion. Medical abortion is far more amenable to provision in primary care settings than surgical abortion, since the most important skill required for provision of medical abortion is assessment of gestational age and not uterine evacuation. Women’s eligibility for medical abortion can be accurately assessed by non-specialist providers using a simple checklist to assess gestational age and rule out contraindications. Hence a checklist along with pelvic examination would enable non-specialist doctors to safely prescribe medical abortion.

As a first step, training doctors posted in rural facilities to offer medical abortion would help reduce the gap in availability between rural and urban areas. Second, some key tasks may be reallocated to less qualified individuals. At the community level, health-care workers and volunteers can guide women on where to go, whereas within facilities, nurse-midwives can perform several
tasks related to abortion care, such as counselling, administration of pills and contraception, and follow-up assessment. Third, reducing the mandated clinic visits for medical abortion would make it more accessible for women. Recent evidence suggests that repeat clinic visits for using misoprostol or routine follow-up are not required,\textsuperscript{12} even among less educated communities having limited communication facilities.\textsuperscript{13} Hence service delivery protocols could offer rural women the option of using misoprostol at home and carrying out self-assessment of completion. Finally, reorientation of providers on ensuring confidentiality, consent, and choice of post-abortion contraception, would help address provider barriers.

Hence, although efforts to match the law to the changing context of safe abortion continue, policy makers must recognise that considerable leeway exists for increasing access within the current legal framework. To enable this change, however, the health system would have to make medical methods and simplified protocols the lynchpin for providing abortion services. This change would help to substantially reduce the rate of unsafe abortion in India.

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We declare no competing interests.

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