

Termination of Pregnancy in a Tertiary Hospital Setting, a Holistic Review of Various Factors

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Received: 6 December 2012 Accepted: 5 January 2013 Published: 15 January 2013

Abstract

Medical Termination of Pregnancy is today treated as a convenient method of family planning. However the negative aspects have become more obvious in the following years. The desire for a male child exists in most sections of Indian society, irrespective of the socio-economic status which has reemphasized the misuse of MTP and the act. Aims and Objectives: To determine various criteria's for termination of pregnancy in a tertiary health centre, the acceptance of contraception and the opinion of women on the legalization of prenatal sex determination. Materials and Methods: This was a cross sectional study conducted in MGM Medical College and Hospital, Navi Mumbai, Maharashtra, India, including 200 patients who attended the OPD for MTP over a period of 1 year Discussion: Abortion has been and continues to be one of the most widely employed methods of fertility control in the world. A growing number of studies provide direct and indirect estimates of the incidence of sex-selective abortions ranging from 3-17

Index terms—

1 Introduction

he most important social event in the lives of most people is the birth of their own child. Despite the advances in the modern world, even today, for many women in developing nations, the sole purpose and meaning of their existence is associated with motherhood. Societal goals of reducing poverty, maternal and infant mortality, unwanted births and abortions are all affected by control of fertility.

Before the Medical Termination of Pregnancy (MTP) Act, an unwanted pregnancy in both the rural as well as urban parts of the country was managed by resorting to illegal abortion, infanticide, or abandonment of the neonate. Medical Termination of Pregnancy has today become a way of life and unfortunately has been accepted worldwide as a convenient mode of temporary contraception. The Indian Parliament liberalized the abortion laws of the country due to the socio-economic necessity. MTP is a great social boon to women and their affected families as it does not destroy their social Authors ? ? ? ? ¥ §: MBBS, MD, DGO, Asso. Professor, Dept. of Obstetrics and Gynecology, MGM Hospital, Navi Mumbai. e-mails: patilshaifali@gmail.com, nimain.mohanty@gmail.com, nidhikurkal@gmail.com, borse.rama@gmail.com future as would otherwise happen in conservative societies.

Patterns of sexual and reproductive behavior in India have changed significantly over the years. However, out of wedlock births are still considered a taboo. Family planning services were available long before the legalization of the MTP act in India. Although the community accepted these methods due to various government incentives, the awareness of contraception in the country in the lower classes of society and adolescents is yet to improve. With the MTP act being implemented, it was feared that it would be used as an alternative to family planning methods.

MTP services are available today even in the most remote areas of the country. However the negative aspects became more and more obvious in the following years. The mentality of the desire for a male child existed in

most sects of Indian society irrespective of the socio-economic state. The rates of sex selective abortions and female foeticide increased dramatically with the advent of ultrasonography. The Government thus introduced the Pre Conception and Pre Natal Diagnostic Techniques Act in 1994(PCPNDT) and made the prenatal ultrasound diagnosis of sex determination illegal.

Unfortunately illegal MTPs and prenatal sex determination continues to be carried out widely by untrained and unlicensed hands in spite of the Government and social organizations efforts against this obnoxious practice.

2 II.

Aims and Objectives 1. To determine various criteria's for termination of pregnancy in a tertiary health centre. 2. To see the role of contraception as a method of or prevention of conception 3. To determine if termination is used as a mode of contraception 4. To determine if knowledge of foetal sex would have changed the decision to terminate pregnancy 5. To determine if sex of living issues affected the decision of termination of pregnancy 6. To know if sex determination was done in any one of their prior pregnancies 7. To know the patient's preference for sex determination The desire for a male child exists in most sections of Indian society, irrespective of the socio-economic status which has reemphasized the misuse of MTP and the act.

Aims and Objectives: To determine various criteria's for termination of pregnancy in a tertiary health centre, the acceptance of contraception and the opinion of women on the legalization of prenatal sex determination.

Materials and Methods: This was a cross sectional study conducted in MGM Medical College and Hospital, Navi Mumbai, Maharashtra, India, including 200 patients who attended the OPD for MTP over a period of 1 year Discussion: Abortion has been and continues to be one of the most widely employed methods of fertility control in the world. A growing number of studies provide direct and indirect estimates of the incidence of sex-selective abortions ranging from 3-17% over different reference periods, i.e. two years preceding the survey to lifetime.

Conclusion: Among the entire criterion, it was found that the effect of age, gravid status, parity and number of female offsprings significantly affected the reasons for termination of pregnancy.

8. To know the effect of education, socio-economic status and marital status on contraception and opinion on termination of pregnancy if male/female child in utero.

III.

3 Materials and Methods

? This was a study conducted in MGM Hospital, Kamothe, Navi Mumbai ? The study included 200 patients ? All the patients who attended outpatient services for MTP were included in the study ? This was a cross-sectional study ? The Stratified Random Sampling Method was used for patient selection All the patients who attended our outpatient services as well as the indoor patients who were admitted for MTP regardless of mode of contraception or no contraception after termination of pregnancy were selected. The selection criteria were not dependant on age, education, socio-economic status or marital status. In our study we found that financial reasons were the most common reason for termination of pregnancy overall. Among all parameters, the reasons for termination of pregnancy between 20-29 years of age, 36.1% were financial followed by spacing, between 30-39 years as well as above 40 years of age was financial (48.4%, 41.7% respectively). Below the age of 20 years 40% of the reason was due to rape and another 40% was due to social reasons. Foetal anomalies accounted for only 0.3% of all the pregnancies terminated. Comparing the gravid status, the subjects who were 3rd gravida had a maximum termination (40.4%) followed by the 2nd gravida (29.4%). Among primigravidas, 60% of the subjects gave social reasons as the explanation for opting for MTP, 48.5% for spacing in gravida 2, and for financial reasons in gravida 3, 4 and beyond (43.9%, 49.3% and 44.4%). Primipara women mostly opted for MTP for spacing (45.1%), 46.5% and 57.7% of second and third parity women gave financial reasons. In our study we found that age, gravid status as well as parity significantly affected the reasons she opted for medical termination of pregnancy.

4 IV.

5 Observations and Statistical Analysis

We also compared the acceptance of contraception and we found it to be significantly associated with the level of the patients education with 71.4% of the subjects educated beyond the secondary level who accepted contraception as compared to 30.8% of the uneducated subjects who did so. We also considered the opinion of all the women regarding legalization of sex related termination of pregnancy and the only parameter that was significant was parity with women who were primiparous maximally opined that they would opt for termination if the foetus was female in contrast with those with 3rd parity who were indifferent in 85.7%.

V.

6 Discussion

Abortion has been and continues to be one of the most widely employed methods of fertility control in the world1, 2. Today 6 out of 10 of the world's population live in countries where abortion is available 'on request' during the first trimester or where the language of the law encourages broad liberal interpretation. It was found that

in cases of multiple repetitive abortions there was ambivalence towards contraception³. Pregnancy always is not synonymous with a desire for motherhood. It could be a neurotic expression full of guilt that shows that these women did not overcome a childish rivalry with their mothers.

The first country to make abortions available for social reasons was the USSR in 1920⁴. Gradually over the years abortion laws became more and more liberalized. In India, The Medical Termination of Pregnancy Act was enforced from 1st April 1972. Prior to this women resorted to illegal and unsafe methods to abort their pregnancies by unwarranted hands leading case of foetal anomalies which are incompatible with life, the act permits termination upto 20 week of gestation albeit only after the opinion of two qualified registered medical practitioners^{5,6}. However access to safe abortion services remained limited for the vast majority of Indian women, particularly in rural areas. An overwhelming proportion of induced abortions (6.7 million annually as per indirect estimate⁷) take place in unauthorized centers, which provide abortion services of varying degrees of safety. Thus the act was amended on 2002 in which the authority for approval of registration of MTP centers has been decentralized from the state to the district level ^{8, 9}. In the year 2003, the Government introduced a further amendment to MTP to a very high rate of morbidity as well as mortality due to the complications of septic abortions. The MTP act in India in a nutshell gives the liberty to every woman who is above 18 years and of sane mental constitution to legally opt for termination of pregnancy within 12 weeks of gestation on the grounds of failure of contraception, financial reasons, alleged rape, if the fetus is incompatible with life or if the pregnancy causes mental or physical anguish to the mother or in cases where the

7 Conclusion

Our study revealed that factors like the woman's age, her gravidity, parity, the sex of her offsprings as well as the number of living issues she had significantly affected her decision and reasons for termination of her pregnancy. Education played a significant role in the acceptance of contraception of a woman whereas the number of living issues she had did affect her opinion on the legalization of sex determination antenatally. Adolescent pregnancy termination in Indian society was highly influenced by the marital status of the patient. As evident in the study, all the adolescent pregnancy termination were in those who were unmarried. The thirst of the male child continues to dominate our society. Even one living male child boosted the decision of termination of pregnancy in contrast to couples with only female issues who were hesitant to undergo an abortion.

There was a marked increase in the percentage of contraceptive use by raising the standard of living with the help of proper education thus decreasing the incidence if termination of pregnancy as already evidenced in developed countries.

The preference of a male child still prevails widely over most parts of the country leading to the obnoxious and illegal practice of female feticide. Financial instability is yet the commonest cause for medical termination of pregnancy followed by spacing.

It is not one factor alone that determines the cause but a combination of factors which influence each other as well as drive a woman to opt to terminate her pregnancy.

A growing number of community-and facility based studies provide direct and indirect estimates of the incidence of sex-selective abortions. A number of studies in different parts of India report a prevalence of sex-selective abortion ranging from 3-17% over different reference periods, i.e. two years preceding the survey to lifetime²³⁻²⁶. Facility-based studies report a much higher prevalence, for example, two in five women with one or more daughters, but no living sons had had an abortion in a Patiala (Punjab, India) hospital²⁷.

The most common reasons for MTP is either financial or an unplanned pregnancy²⁸. Several other studies indicate that most abortions are sought to limit family size or space the next pregnancy^{23, 24}.

The acceptance of contraception too has been found to be associated with the level of the woman's education as well as the previous number of male issues. If a male child was among the living issues, contraception was accepted and used earlier²⁹. Fertility and contraceptive use in developing countries are associated with various markers of socioeconomic status, the most prominent of which is women's education^{30, 31}; the well documented link between female education and use of contraception plays an important role in development of family planning policies in lower income countries.

In parts of South Asia, and elsewhere, women have a considerably lower social status and autonomy than men^{31, 32}, and their low status and autonomy seems to be associated with lower fertility control. Several reports showed a positive association between women's autonomy and contraception use^{33,34}. Improving women's education has been seen one way to increase their status and autonomy, and it has been proposed that autonomy acts as a mediator of the link between education and contraception use ^{31, 35}. According to WHO, in countries where contraception was widely available such as England and Wales, USA and the Netherlands, almost half of the abortions are in women less than 25 years of age whereas in those nations with no tradition of contraceptive use, and with limited availability of contraception, and sterilization, the women were above 35 years of age ²¹. A survey done in West Bengal, India²² revealed that the maximum number of MTPs was done in the age group of 25 -29 years

The Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act that made antenatal sex determination and sex selective abortion illegal in India, was passed in 1994. It came into effect in 1996¹⁷. Amendments have also been introduced in the PNDT Act of 1994 which was necessitated as the PNDT Act had failed to curb the practice of testing for sex determination and consequent sex-selective abortion in the

7 CONCLUSION

country¹⁸. With the recent amendment to the PNDT Act, preconception and pre-implantation procedures for sex selection are banned in the country. The Amendment stipulates compulsory maintenance of written records by diagnostic centres/ doctors offering sonography service. Local authorities have also been given powers to ensure the enforcement of the Act¹⁹. However the sex ratio in India has continued to fall as Yet another obstacle faced was the sex discrimination in India. The desire for a male child is unfortunately yet very prevalent. With the practices of dowry among other things, a female child is supposed to be a burden to society whereas a male child is assumed to give security to the family¹⁰. This bias manifests as neglect of girls and women resulting in their early death ^{11, 12, 13}, female infanticide ^{14, 15} and more recently, antenatal sex determination and female feticide¹⁶.

Rules which has rationalized the criteria for physical standards of abortion facilities.

¹ ²



Figure 1:

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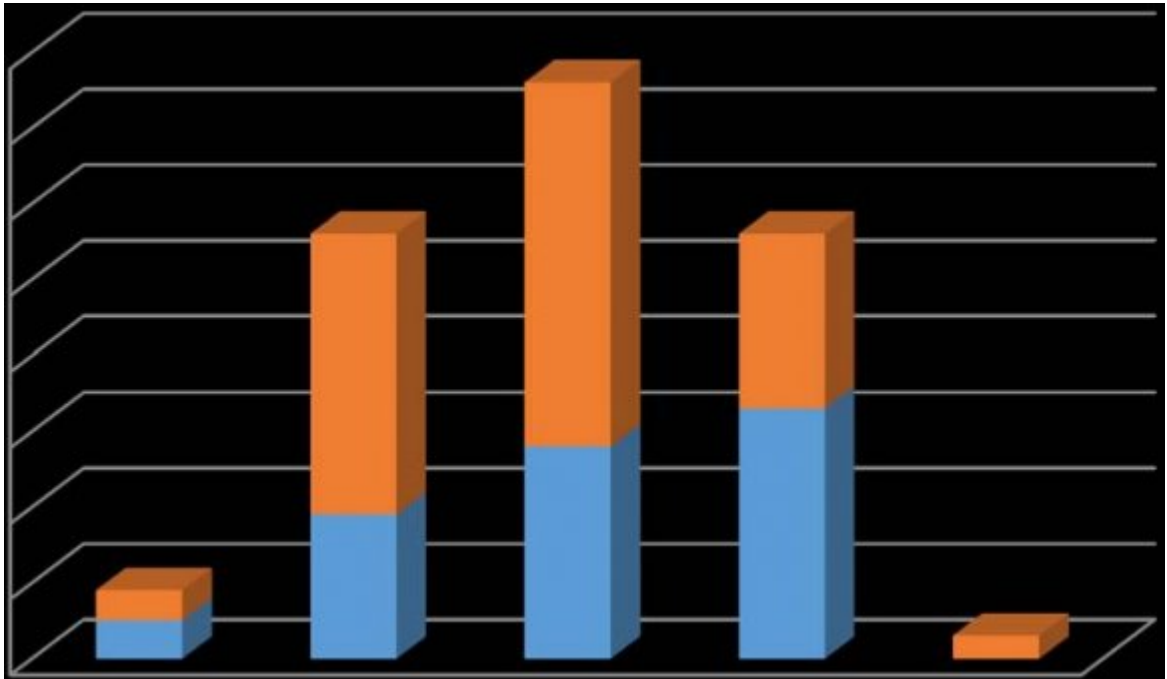


Figure 2: E

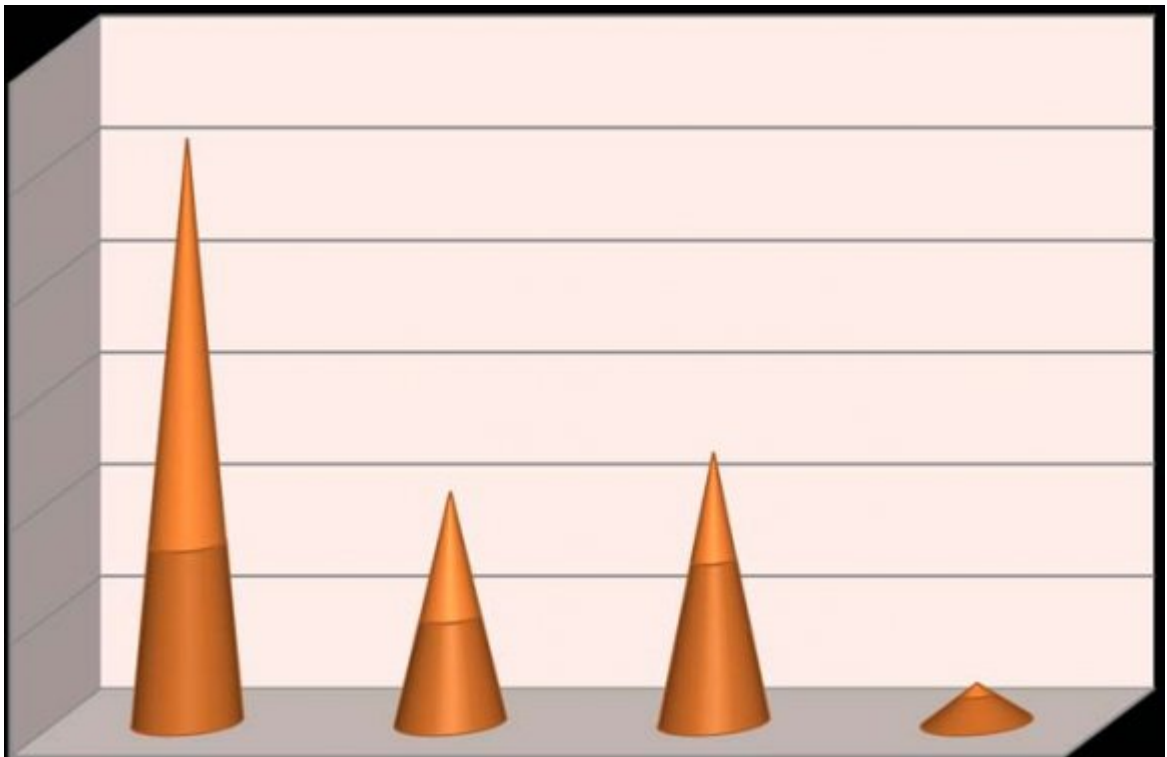


Figure 3:

1

husband to terminate her pregnancy. The Act defines the place and the requirements of the medical practitioner who can terminate her pregnancy and in

pregnancy causes deterioration of her health condition. A woman ne

Parameters	1	2	3	4	5	6	7
Age	<20 yrs 2/5 (60%)	20-29 yrs 79/233 (48.5%)	20-29 yrs 12/233 (5.2%)	30-39 yrs 44/91 (49.3%)	> 40 yrs 3/12 (23.7%)	<20 yrs 2/5 (40%)	30-39 yrs 2/5 (40%)
Gravid Status	1 (60%)	2 (48.5%)	3 (6.5%)	4 (49.3%)	3 (23.7%)	1 (20%)	3 (40%)
Parity	>3 7/52 (13.5%)	1 55/122 (45.1%)	2 11/149 (7.4%)	>3 30/52 (57.7%)	2 32/149 (21.5%)	0 0	1 3
H/o previous abortions	MTP 3/33 (9.1%)	SA 12/46 (26.1%)	MTP 3/33 (9.1%)	MTP 14/33 (42.4%)	SA 12/46 (26.1%)	0 0	SA 2/5 (40%)
No. of male offsprings	2 3/38 (7.9%)	1 55/185 (29.7%)	1 10/185 (5.4%)	2 20/38 (52.6%)	2 10/38 (26.3%)	0 0	1 1
No. of female offsprings	>2 2/11 (18.2%)	1 54/174 (31%)	>2 1/11 (9.1%)	2 28/58 (48.3%)	>2 3/11 (27.3%)	0 1000-4	1 4
Socio-economic Status (\$/year)	<1000 4/15 (26.7%)	1000-1500 29/93 (31.2%)	<1000 1/15 (6.7%)	<1000 7/15 (46.7%)	1500-2000 26/123 (21.1%)	<1000 1500-1	<1000 1
Educational Status	Primary 6/60 (10%)	Primary 5/11 (45.5%)	Primary 1/11 (9.1%)	Uneducated 78/169 (45.9%)	Primary 16/60 (25%)	Primary 2/60 (3.33%)	Uneducated 2/5 (40%)
Acceptance of Contraception							
				Table 2			
				Yes	No		
Socio Economic Status (\$/annum)							
< 1000				5(55.6%)	4(44.4%)		
1000-1500				19(33.9%)	37(66.1%)		
1500-2000				28(36.8%)	48(63.2%)		
>2000				33(58.9%)	23(41.1%)		
Dependant on Parents				0	3		
Total				85(43.1%)	112(56.9%)		

[Note: E Termination]

Figure 4: Table 1 :

[Note: $p=0.099$ (not significant) b) On the basis of educational status]

Figure 5: of Pregnancy in a Tertiary Hospital Setting, a Holistic Review of Various Factors

3

Education	Yes	No	Total
Uneducated 32(30.8%)		72(69.2%)	104(52%)
Primary	19(46.3%)	22(53.7%)	41(20.5%)
Secondary	29(60.4%)	19(39.6%)	48(24%)
>Secondary 5(71.4%)		2(28.6%)	7(3.5%)
Total	85(42.5%)	115(57.5%)	200

Figure 6: Table 3

420

120				
100				
80				
60				Column1
40				No
Uneducated	Primary	Secondary	>Secondary	Yes
Would Terminate if	Female	Male	Indifferent	P
Gravid Status	2	3	1	Value
	26/59	5/77	10/10	0.129
	(44.1%)	(6.5%)	(100%)	
Parity	1	2	>3	0.008
	29/68	5/83	30/35	
	(42.6%)	(6%)	(85.7%)	
No. of male	1	2	2	0.201
offsprings	29/112	2/20	16/78	
	(25.5%)	(10%)	(80%)	
No. of female	2	>2	2	0.262
offsprings	15/34	1/6	19/34	
	(44.1%)	(16.7%)	(55.9%)	
Socio-economic	1000-1500	>2000	1500-2000	0.335
Status (\$/year)	23/56	4/56	53/76	
	(41.1%)	(7.1%)	(69.7%)	
Educational Status	Primary	Uneducated	Secondary	0.412
Primary -10 th grade	16/35	5/102	39/57	
Secondary -12 th	(45.7%)	(4.9%)	(68.4%)	
grade				

[Note: E Termination]

Figure 7: Table 4 0 20

[Note: VI.]

Figure 8: of Pregnancy in a Tertiary Hospital Setting, a Holistic Review of Various Factors

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