Research Article

Viewing induced abortion through a gender lens: a community-based study from Jamnagar district, Gujarat

Kajal Davara[1], Jitesh Mehta[2], Dipak Solanki[1]

[1]Department of Preventive and Social Medicine, GMERS Medical College, Gotri, Vadodara, Gujarat, India.
[2]Department of Preventive and Social Medicine, M.P. Shah Govt. Medical College, Jamnagar, Gujarat, India.
Correspondence to: Kajal Davara, E-mail: kbdavara23@gmail.com

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Abstract

Background: In a global context, induced abortion is restricted by law and even criminalized in many countries, where as in India abortion is legal but largely unsafe and unavailable. The medical reasons for induced abortion are limited and constitute a small proportion of all abortion cases. Induced abortion for social reasons is spreading all over the globe, one of the major reasons being sex selective abortion. Abortion is used in many countries as a means of family planning replacing contraception.

Objective: To study trends of induced abortions among married women of reproductive age group.

Materials and Methods: Study was conducted among 500 married women of reproductive age group residing in urban and rural areas of Jamnagar district from October 2010 to October 2012. A predesigned questionnaire was used to elicit information related to abortion. Verbal informed consent was taken from the participants.

Result: Women of 13.4% had a history of abortion, of that 49 (73.13%) were induced and 18 (26.87%) were spontaneous. Of the induced abortions, in 36.73% cases, the reason was family completed; followed by 20.41%, 16.33%, and 14.29% cases due to contraceptive failure, for birth spacing, and for medical advice, respectively. Six (12.24%) women had gone for an abortion because the sex of the child was female. In almost one-third of cases, both husband and wife acted as decision maker.

Conclusion: Many women seek abortion services to limit family size or space the next pregnancy which highlight the importance of improving the access to quality family planning services. Women have very little say in reproductive and sexual health decisions, including abortion-related decisions, so women should have the rights to take decision regarding her own health.

KEY WORDS: Induced abortion, sex selective abortion, family planning

Introduction

Abortion is a social problem in India as well as worldwide as it is one of the important causes of maternal morbidity and mortality. The actual incidence of abortion worldwide is not known. It is estimated that of the 210 million pregnancies each year, about 80 million are unintended.[1] Spontaneous abortions occur once in every 15 pregnancies. They may be considered "Nature's method of birth control." Induced abortions may be legal or illegal. It is evident that two-thirds of all abortions take place by unauthorized and often unskilled persons.[2] The period since the 1990s has witnessed major changes in the field of abortion, including the adoption of new legislative measures, the introduction of new technologies, and the issues of sex selective abortions.[3]

The reasons Indian women terminate unwanted pregnancies are many and varied. Conditions that can lead to a pregnancy being unwanted include: financial reasons, already

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having too many children or having too many female children, becoming pregnant after too short birth interval, experiencing health problems during pregnancy, becoming pregnant at an older age, becoming pregnant soon after marriage, suspecting husband's infidelity, having an extra-marital pregnancy, and becoming pregnant as a result of rape.[4] For the majority of the above conditions, a more proximate determinant of unwanted pregnancy is the lack of access to appropriate contraception.

Viewing induced abortion through a gender lens would mean examining how gender and social status influence women's exposure to an unwanted or mistimed pregnancy; their ability to make decisions to continue with or terminate the pregnancy; their access to appropriate, affordable, safe, and quality abortion services. This study was carried out to know the reasons for seeking abortion services and also to know the role of decision maker for getting the services.

Materials and Methods

A community-based cross-sectional study was conducted in selected urban and rural areas of Jamnagar district. The study period spread from October 2010 to October 2012. The sample size was calculated with the assumption that 50% of the reproductive women will have a preference for the boy child and 50% of the girl child. The sample size was calculated using the formula $n = 4pq/L^2$. Allowable error (L) of 10% of the prevalence was taken. Considering the non-response rate of 20% of the sample size, total sample size comes out to be 480 for the study. To make round figure, 500 study subjects were chosen. It was decided to take all married women (15–45 years) from each household. 30% (150) of the study population was taken from an urban area and 70% (350) was taken from rural areas, according to approximate urban–rural ratio of the population of the study district as per census 2011. Of the 10 talukas in the study district, one was selected for the study purpose randomly. One ward from total 19 wards of an urban area and out of 107 villages in study taluka, seven villages were selected randomly. From each selected village 50 study subjects were selected randomly. For random selection, the random number table was used. Ethical clearance has been received from the Institutional Ethic Committee of M P Shah Government Medical College, Jamnagar. Informed oral consent was taken before the initiation of the survey and their identity were kept confidential. A predesigned and pretested proforma questionnaire was used to elicit information. The data were analyzed using the Microsoft Excel 2007.

Result

Of the 500 women studied, about one-third (i.e., 38.2%) women belonged to 25–29 years age group, followed by 20.4% women in 30–34 years age group. Mean age of the women in the study group was 28.61 years. Majority of women (86.4%) belonged to Hindu religion. Overall literacy rate of women was 79.4%. One-fourth of women (i.e., 25% women) had literacy up to primary level and 23.8%, 16%, and 14.6% had education up to secondary, higher secondary level, and graduate and above. 56.2% women belong to the middle socioeconomical class followed by 27% and 16.8% women were from upper and lower socioeconomic class. 75.2% women were housewives. Almost two-thirds (i.e., 66.8%) belonged to nuclear families and 33.2% were from joint families.

Table 1 shows that of the 500 women studied, 67 women had history of abortion of which 49 (73.13%) were induced and 18 (26.87%) were spontaneous. Of the induced abortions, in 36.73% cases, the reason was family completed; followed by in 20.41%, 16.33%, and 14.29% cases due to contraceptive failure, for birth spacing, and for medical advice, respectively. Six (12.24%) women had gone for abortion because sex of the child was female. 14.81% rural women had gone for abortion of female foetuses as compared to 9.09% urban women [Table 2].

In about one-third of cases (i.e., 30.61%) both husband and wife acted as decision maker, whereas in 24.48% cases women herself acted, in 16.33% cases mother-in-law, in 14.29% cases each husband and doctor acted as decision maker [Table 3].

Table 4 shows that, those women who had gone for termination of pregnancy, 28.57% and 22.45% were educated up to primary level and secondary level of schooling. In urban area, women were educated up to secondary level (31.82%) underwent termination, followed by higher secondary (27.27%) and graduate and above level (22.73%). At lower level of literacy, prevalence of induced abortion was higher in rural area. Of the 49 women who had undergone termination of pregnancy, more than half of the women belonged to middle class (57.14%), followed by upper class (28.57%). Among urban women, 50% of each upper and middle class underwent termination of pregnancy. No women belonging to lower class underwent termination. In rural women, maximum women undergoing termination belonged to middle class (62.96%) followed by lower class (25.93%). Prevalence of induced abortion was higher in the middle class as compared to upper and lower classes.

Discussion

Induced abortion is the most controversial area of family planning and often the most important method of fertility regulation by a community in the struggle to control family size. The concern that the accessibility of the abortion services result in decreased motivation to use contraception has been shown by a number of researchers and policy makers.[5] Other trends, such as the growing demand for sex selective abortion, are likely to increase the incidence of unsafe abortion and adversely change the gender dynamics even further.[3]

In our study, in 36.73% cases and 16.33% cases, the reasons for induced abortions were because of family completion and for birth spacing, respectively. Six (12.24%) women had gone for an abortion because the sex of the child was female.

Table 1: Distribution of women according to the cause for abortion

Cause for abortion	Distribution of women		
	Urban	Rural	Combined
	No. (%)	No. (%)	No. (%)
Spontaneous	5 (18.52)	13 (32.5)	18 (26.87)
Induced	22 (81.48)	27 (67.5)	49 (73.13)
Total	27 (100)	40 (100)	67 (100)

Table 2: Distribution of women according to the reason for induced abortion

Reason	Distribution of women		
	Urban	Rural	Combined
	No. (%)	No. (%)	No. (%)
Family completed	7 (31.82)	11 (40.74)	18 (36.73)
Birth spacing	4 (18.18)	4 (14.82)	8 (16.33)
Contraceptive failure	5 (22.73)	5 (18.52)	10 (20.41)
Sex of child was female	2 (9.09)	4 (14.81)	6 (12.24)
Medical advice	4 (18.18)	3 (11.11)	7 (14.29)
Total	22 (100)	27 (100)	49 (100)

Table 3: Distribution of women according to the person who acted as decision maker for induced abortion

Decision maker	Distribution of women		
	Urban	Rural	Combined
	No. (%)	No. (%)	No. (%)
Self	5 (22.73)	7 (25.93)	12 (24.48)
Husband	3 (13.64)	4 (14.81)	7 (14.29)
Mother in law	3 (13.64)	5 (18.52)	8 (16.33)
Both partners	7 (31.82)	8 (29.63)	15 (30.61)
Doctor	4 (18.18)	3 (11.11)	7 (14.29)
Total	22 (100)	27 (100)	49 (100)

Table 4: Association between termination of pregnancy and socioeconomic characteristics

Socioeconomic characteristics	Termination of pregnancy		
	Urban	Rural	Combined
	No. (%)	No. (%)	No. (%)
1. Literacy status of women			
Illiterate	2 (9.09)	4 (14.82)	6 (12.24)
Primary	2 (9.09)	12 (44.45)	14 (28.57)
Secondary	7 (31.82)	4 (14.81)	11 (22.45)
Higher secondary	6 (27.27)	3 (11.11)	9 (18.37)
Graduate and above	5 (22.73)	4 (14.81)	9 (18.37)
2. Social class			
Upper	11 (50)	3 (11.11)	14 (28.57)
Middle	11 (50)	17 (62.96)	28 (57.14)
Lower	0 (0.0)	7 (25.93)	7 (14.29)

Only 7 (14.29%) women had gone for an abortion after medical advice. Women of 20.41% had gone for the abortion because of contraceptive failure, one of the reason for such high proportion could be that the couple may not know the correct method of use of contraception. Zodpey and Udhade[6] has shown in their study that family and domestic problems, poor socioeconomic status, short inter-pregnancy interval and completed family size were some of the important reasons quoted

by study subjects for not desiring to continue the current pregnancy. Only 1.80% cases reported failure of contraceptive method as a cause of seeking abortion services. Dhillon et al.[7] in their study in rural India found that the main reason for seeking abortion was that they do not need any more children (42%), and in 12% they specifically mentioned that they do not need any more daughters. In a study in Madhya Pradesh, women reported the achievement of desired family size as the reason in 41% abortions, the need for spacing in 30% of abortion, and health reasons in 22% abortions.[8] These studies indicate that most abortions are sought to limit family size or space the next pregnancy; whereas the proportion of induced abortion based on medical advice was very less. The increasing practice of sex selective abortion also tends to place the women for undergoing unsafe abortion done by unqualified service providers because women opting for sex-selective abortions may not get legal abortion services.[3]

A woman may make the decision to abort a pregnancy, but often the decision-making role is taken by husbands, mothers-in-law, or other household members or community level health-care providers. Decision makers may support a woman's choice, pressure her into having an abortion or object to her having an abortion.[4] In this study, in almost one-third of cases (i.e., 30.61%) both husband and wife acted as decision maker, in 24.48% cases women herself, in 16.33% cases mother-in-law, in 14.29% cases each husband and doctor acted as decision maker. For example, in a community-based study in Madhya Pradesh, husbands, unilaterally or jointly, played the major decision-making role in 20% of abortion attempts.[8] In a study done by Zodpey and Udhade,[6] majority of the subjects felt that the decision to terminate or keep pregnancy is usually taken jointly by both the husband and wife. The next most common entity involved in decision-making in this context was elder family members. Dhillon et al.[7] in their study found that the decision to terminate the pregnancy and place of abortion was made by the husband in 42.8% and 52.5% situations, respectively.

In this study, in urban area, 81.82% of women who were educated upto secondary level and above underwent termination, whereas in rural women, prevalence of induced abortion was higher at lower level of literacy. Of the 49 women who had undergone termination of pregnancy, more than half of the women belonged to middle class (57.14%) followed by upper class (28.57%). Among urban women, 50% of each upper and middle class underwent termination of pregnancy. In rural women, maximum women undergoing termination belonged to middle class (62.96%) followed by lower class (25.93%). Prevalence of induced abortion was higher in the middle class as compared to upper and lower classes. The incidence of abortion was much higher in the upper- and middle-income groups as compared to lower-income groups (MOHFW and TINNARI, 2002).[9]

Limitation of the Study

Only married women were included as participants, so non-inclusion of never married women in the measurement of levels of induced abortion results in under-estimation of abortion rates.

Conclusion

The fact that many women seek induced abortion services to limit family size or space the next pregnancy highlights the importance of improving the access to quality family planning services. The role of women as a decision maker in reproductive and sexual health decisions, including abortion-related decisions are lacking. The practice of sex-selective abortion is increasingly becoming common in many parts of the country, so there is a need to formulate effective policies and programs to prevent this practice. With these steps, the government has a bun in the oven to prevent women from resorting to sex-selective abortions, which are taken during the second-trimester and carry a high risk of complications for women.

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