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Article

Unmet Needs And Missed Opportunities: A Facility-Based Analysis of Delayed Decision-Making for Safe Abortion Among Women In Northern India

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A B S T R A C T

Unsafe abortion is a significant contributor to maternal mortality, particularly in resource-limited settings. Despite supportive legal frameworks, women in Northern India encounter delays in seeking safe abortion services. A facility-based cross-sectional study was conducted among 500 women seeking abortion services at three tertiary healthcare centers in Northern India. Data were collected using structured interviews and medical record reviews. Participants reported an average delay of 18 days in seeking abortion services. Lack of awareness about legal rights (42%), fear of social stigma (37%), and limited economic resources (29%) were significant contributors to delay. Rural women experienced longer delays than urban women. This study highlights critical gaps in awareness, access, and societal acceptance related to safe abortion in Northern India. To reduce delays, strengthened community education, improved referral networks, and better training for frontline healthcare providers are essential. Addressing these gaps at policy and programmatic levels can alleviate the burden of unsafe abortion and reduce preventable maternal morbidity and mortality. This study's findings have significant implications for improving maternal health outcomes in Northern India.

I. INTRODUCTION

Safe abortion services are integral to reducing maternal mortality and improving reproductive health outcomes worldwide, especially in countries with high fertility and constrained healthcare resources (WHO, 2012). In India, the Medical Termination of Pregnancy (MTP) Act legally permits abortion under a range of circumstances; nevertheless, unsafe practices persist, contributing to maternal morbidity and mortality (Sing, et al, 2017). Notably, in Northern India, social constraints and deeply rooted patriarchal norms often delay a woman's decision to seek timely abortion care (MoHFW, 2021). These delays encompass both personal hesitation and structural barriers, such as limited access to trained providers and lack of awareness of legal provisions (Ganatra, et al, 2017).

Multiple studies emphasize that delays in obtaining an abortion significantly elevate the risk of complications, including hemorrhage, infection, and incomplete abortion (Haddad, 2009). Such events not only imperil the woman's physical well-being but also jeopardize her psychological and social welfare. Particularly in rural segments, limited transportation options, inadequate referral systems, and prevailing stigma exacerbate challenges to early presentation (Jejeebhoy, et al, 2010). Families may discourage women from seeking timely care due to fear of community judgment, compelling them to rely on unsafe, clandestine services until the condition becomes critical (Iyengar, 2009).

Additionally, economic hardships play a pivotal role in postponing or entirely preventing formal healthcare consultation. Even with government-supported programs aimed at affordable care, out-of-pocket expenditures for medications, diagnostics, and associated travel costs can be prohibitive (Bankole, et al, 1998). Hence, while policy initiatives and legal frameworks are in place to ensure safe abortion, the effective utilization of these services remains suboptimal. Many local healthcare facilities also struggle with a shortage of trained providers, creating missed opportunities for early interventions and counseling.

Against this backdrop, this study investigates the scope and underlying contributors to delayed decision-making for safe abortion in Northern India. By adopting a facility-based approach, we seek to capture a comprehensive overview of the real-world challenges encountered by women when attempting to exercise their legal reproductive health rights. The primary goal is to inform policy-makers, public health practitioners, and clinicians regarding potential interventions that could improve timeliness and safety in abortion care. Our findings highlight the critical unmet needs and point to effective measures that, if implemented, can help minimize the impact of unsafe abortion on maternal health outcomes.

II. METHODS

Study Design and Setting

This facility-based, cross-sectional study was conducted from January to December 2023 in three tertiary healthcare centers across urban and peri-urban settings in Northern India. These centers are recognized referral hubs that cater to a broad demographic, including rural catchment areas.

Study Population

A total of 500 women seeking abortion services were selected consecutively as they presented at obstetrics and gynecology outpatient departments. Participants were eligible if they were (a) 18–45 years old, (b) requesting abortion at any gestational age permitted by law, and (c) willing to provide written informed consent. Women with severe cognitive impairments or critical medical conditions preventing consent were excluded.

Data Collection

Trained female research assistants conducted one-on-one interviews using a structured questionnaire. The questionnaire was pilot-tested on 20 women (excluded from final analysis) to ensure clarity and contextual relevance. Key data components included:

1. Demographics: age, marital status, residence (urban/rural), and education level.
2. Awareness and Knowledge: familiarity with abortion laws, perceived social stigma, and prior exposure to reproductive health campaigns.
3. Decision-Making Timeline: time elapsed from pregnancy detection to presentation for abortion, primary reasons for delay, and whether advice was sought from informal sources.
4. Healthcare Pathway: initial consultation (e.g., local clinic, traditional healer), referral steps, and any documented complications before arriving at the facility.

Medical records were reviewed to validate gestational age, type of abortion procedure provided, and clinical outcomes (e.g., hemorrhage, infection, need for hospitalization).

Data Analysis

Quantitative data were entered into SPSS (version 25) for descriptive and inferential analysis. Continuous variables (e.g., age, delay duration) were presented as means ± standard deviations. Categorical variables (e.g., level of awareness) were summarized using frequency and percentage distributions. Bivariate analyses (chi-square tests) were used to identify associations between delay duration (>14 days vs. ≤14 days) and demographic or knowledge-related factors. Variables significant at $p<0.10$ in bivariate analyses were included in multivariate logistic regression models to assess adjusted odds ratios. A p-value of <0.05 was considered statistically significant.

Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Committees of all three participating facilities. Each participant gave written informed consent. Confidentiality was strictly upheld through anonymized data coding. Participants were counseled regarding safe abortion practices and referred for additional support services as needed. The study adhered to the ethical standards outlined in the Declaration of Helsinki.

III. RESULT

Overview of Study Participants and Delay Patterns

A total of 500 women were enrolled, with a mean age of 28.3 ± 5.1 years. Nearly half (48%) resided in rural areas, while 52% reported living in peri-urban or urban localities. The average delay from recognizing pregnancy to seeking abortion services was 18 days (range: 7–42 days). Approximately 34% (n=170) sought a medical opinion within two weeks of suspecting pregnancy, whereas 66% (n=330) presented after two weeks.

All participants reported at least one factor contributing to the delay. The most frequently cited reasons included insufficient knowledge of legal entitlements (42%), social stigma (37%), and concerns over familial or spousal reactions (31%).

Table 1. Sociodemographic Profile of Participants

Variable	n (%)
Age Group	
18–24	190 (38)
25–34	240 (48)
≥35	70 (14)

Education Level	
No formal education	80 (16)
Primary/secondary	290 (58)
Higher secondary and above	130 (26)
Residence	
Rural	240 (48)
Urban/Peri-urban	260 (52)
Marital Status	
Married	470 (94)
Unmarried/Separated	30 (6)

Barriers to Early Decision-Making

Several overlapping barriers emerged:

1. Awareness Deficit: Only 35% of participants reported being cognizant of specific legal provisions under the MTP Act, highlighting a substantial knowledge gap.
2. Sociocultural Pressures: Women commonly described fear of social ostracism and family condemnation. This factor was more pronounced among rural participants (p=0.02).
3. Economic Constraints: Roughly one-third cited inability to afford direct and indirect costs, including transportation and medicines, as a reason for postponement.
4. Healthcare Access: Limited availability of skilled providers in remote areas forced many women to travel long distances to urban centers, heightening logistical challenges.

Table 2. Major Reasons for Abortion Decision Delay

Reason for Delay	Frequency (n)	Percentage (%)
Lack of legal awareness	210	42
Fear of social stigma	185	37
Family disapproval/partner hesitation	155	31
Financial constraints	145	29
Limited access to skilled providers	90	18
Others (personal or health-related reasons)	75	15

Healthcare-Seeking Trajectories

It was noted that 28% of participants first approached informal healthcare providers, such as traditional healers, before consulting a registered medical practitioner. Another 20% visited local pharmacies seeking over-the-counter medications. Over half of these women reported exacerbation of complications (e.g., pain, excessive bleeding) prior to referral to the tertiary facilities.

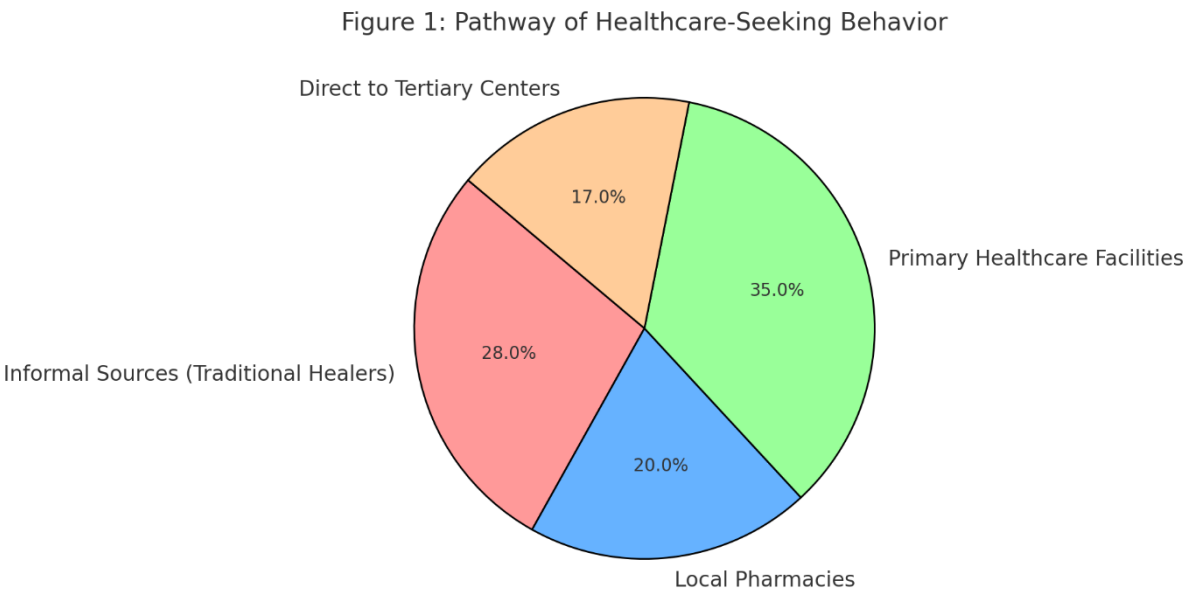

Figure 1. Pathway of Healthcare-Seeking Behavior

A flowchart illustrating initial contact with informal sources (28%), local pharmacies (20%), primary healthcare facilities (35%), and direct referral to tertiary centers (17%).

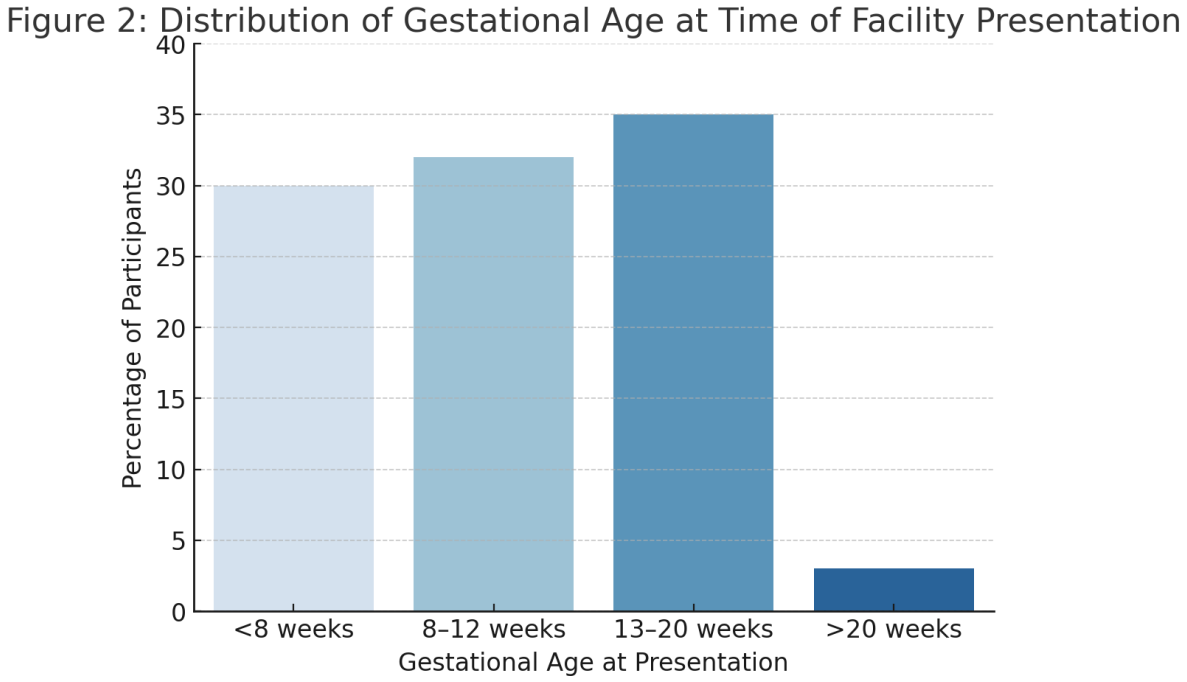

Figure 2. Distribution of Gestational Age at Time of Facility Presentation

A bar chart showing <8 weeks (30%), 8–12 weeks (32%), 13–20 weeks (35%), and >20 weeks (3%).

Additional Findings

Among participants who were aware of legal provisions, the average delay was shorter (14 days) than those lacking such awareness (20 days), suggesting that knowledge significantly influenced timely care-seeking. Also, multivariate logistic regression indicated that higher educational

attainment (adjusted OR=1.8, 95% CI: 1.2–2.5) and urban residence (adjusted OR=1.5, 95% CI: 1.1–2.1) were associated with reduced likelihood of delaying abortion beyond 14 days.

IV. DISCUSSION

This facility-based study reveals persistently significant delays in accessing safe abortion services in Northern India, reflecting entrenched social and structural factors. Several of our findings align with global evidence indicating that knowledge gaps, stigma, and financial constraints collectively act as core impediments (Kassebaum, et al, 2014). The average delay of 18 days highlights the lost window for timely intervention, which can exacerbate complications and raise healthcare costs (Sedgh, 2016).

Our analysis underscores the critical role of legal awareness in expediting care. Women possessing at least a rudimentary understanding of abortion laws were more likely to seek medical assistance promptly. This observation supports previous investigations that emphasize the value of disseminating accurate legal and medical information (Stillman, et al, 2014). Moreover, sociocultural pressures and stigmatization continue to deter women from openly seeking abortion services, consistent with studies conducted in other South Asian contexts (Ganatra, et al, 2014). The fact that a sizable fraction of participants first approached informal or traditional healers underscores both the scarcity of accessible formal facilities in rural regions and the deep-seated trust in community-based practitioners.

Economic constraints emerged prominently in our survey. Women frequently mentioned travel costs, consultation fees, and diagnostic expenses as hurdles, especially when referrals spanned multiple facilities. These findings corroborate the notion that addressing financial barriers can significantly advance the utilization of safe abortion services and reduce recourse to dangerous alternatives (Johnston, et al, 2007). Investing in community-level healthcare infrastructure, coupled with training nurses and mid-level providers in abortion care, may particularly benefit remote areas.

Although the current legal framework in India is relatively permissive regarding abortion, our data show that gaps persist in its enforcement, especially in regions where clandestine or unsafe methods remain prevalent. Further research focusing on provider attitudes would enrich our understanding of how stigma might be mitigated from the supply side. Integrating reproductive health education into routine antenatal and family planning sessions could also serve to preempt delays among at-risk groups (Chhabra and Nuna, 2014).

While this cross-sectional design captures a snapshot of prevailing challenges, it relies heavily on self-reported data, which may be influenced by recall or social desirability bias. Nonetheless, our multi-center approach enhances the generalizability of the findings within Northern India. To move forward, targeted policy interventions and community-based educational campaigns are warranted. By bridging the knowledge gap, reducing stigma, and expanding the availability of competent healthcare professionals, it is possible to shorten the interval between pregnancy detection and safe abortion services. Implementing these strategies effectively could significantly reduce the burden of maternal morbidity and mortality associated with unsafe abortion.

V. CONCLUSION

This study highlights major barriers, including inadequate legal awareness, social stigma, and financial limitations, which contribute to delayed decision-making for safe abortion among women in Northern India. Our findings underscore a critical need for multifaceted strategies: improved

public education on legal rights, enhanced provider training, and expansion of primary-level facilities equipped to handle early abortion care. Such interventions could substantially reduce delays and mitigate adverse health outcomes. Ultimately, empowering women with accurate information and dignified services is paramount to safeguarding their reproductive health and fulfilling the promise of safe abortion as a fundamental right.

REFERENCES

Bankole A, Singh S, Haas T. Reasons why women have induced abortions: evidence from 27 countries. Int Fam Plan Perspect. 1998;24(3):117–127.

Chhabra R, Nuna SC. Abortion in India: An Overview. New Delhi: Veerendra Printers; 2014.

Ganatra B, Gerdts C, Rossier C, Johnson BR Jr, Tunçalp Ö, Assifi A, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. Lancet. 2017;390(10110):2372–81.

Ganatra B, Tunçalp Ö, Johnston HB, Johnson BR Jr, Gülmezoglu AM, Temmerman M. From concept to measurement: operationalizing WHO's definition of unsafe abortion. Bull World Health Organ. 2014;92(3):155.

Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. Rev Obstet Gynecol. 2009;2(2):122–126.

Iyengar K, Paul M, Iyengar SD. Availing abortion services in Rajasthan, India: delays and health consequences. J Biosoc Sci. 2009;41(3):387–399.

Jejeebhoy SJ, Kalyanwala S, Zavier AJF, Kumar R, Jha N. Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages. Reprod Health Matters. 2010;18(35):163–174.

Johnston HB, Gallo MF, Benson J. Reducing the costs to health systems of unsafe abortion: a comparison of four strategies. J Fam Plann Reprod Health Care. 2007;33(4):250–257.

Kassebaum NJ, Bertozzi-Villa A, Coggeshall MS, Shackelford KA, Steiner C, Heuton KR, et al. Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis. Lancet. 2014;384(9947):980–1004.

Ministry of Health and Family Welfare, Government of India. Medical Termination of Pregnancy (Amendment) Act 2021. New Delhi: MoHFW; 2021.

Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, et al. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. Lancet. 2016;388(10041):258–267.

Singh S, Remez L, Sedgh G, Kwok L, Onda T. Abortion Worldwide 2017: Uneven Progress and Unequal Access. New York: Guttmacher Institute; 2017.

Stillman M, Frost JJ, Singh S, Moore AM, Kalyanwala S. Abortion in India: A Literature Review. New York: Guttmacher Institute; 2014.

World Health Organization. Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd ed. Geneva: WHO; 2012.

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