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Original Article

Comprehensive abortion care service at Kathmandu Medical College – An experience

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Abstract

Introduction: His Majesty's Government amended the Nepal Criminal Code (Muluki Ain) – for Liberalising abortion law in the month of Chaitra 2058 (March 2002) and Royal Assent was given on 10th Asoj 2059 (27th September 2002). Accordingly Comprehensive Abortion Care (CAC) Services was initiated in the country. Kathmandu Medical College after enlisting with Ministry of Health started this service from June 2004.

Objective: This study was carried out to know-

1. Reasons for undergoing CAC service.
2. The complications after the CAC services.
3. The various contraceptive methods adopted by the client following CAC

Methodology: Hospital based prospective study was carried out in Department of Obstetrics & Gynaecology at KMCTH from the period July 2004 to April 2005. Total 160 patients who asked for CAC were enrolled in the study. Counselling, history taking and general examination and per vaginal examination was carried out at the visit. CAC was performed with premedication with Doxycycline 100 mg and Ibuprofen 400 mg half an hour before the procedure. Paracervical block was also given with 1% xylocaine. MVA was performed as described in standard techniques. Patient was discharged after 1 – 2 hours of observation and with contraception opted by the clients.

Results:

- Main reason for performing CAC was unwanted pregnancy in 66.75%.
- Complication following CAC was 1.25%.
- Post CAC contraception was adopted by 93%. Most preferred method was Inj. Depoprovera

Conclusion: The reason for CAC service asked by the patients was unwanted pregnancy. CAC service performed had minimal complication and also gave the opportunity for contraception.

Key words: Comprehensive Abortion Care, Contraception, Safe Abortion.

Abortion, whether spontaneous or induced, is one of the most common obstetric events in the world secondary only to childbirth. Each year forty-six million women around the world undergo abortion. 26 million who undergo abortion do so in countries with liberal abortion laws. 20 million undergo abortion in countries where it is either restricted or illegal (AGI 1999). Abortion performed early in pregnancy led to fewer complications (CDC 1995, 1999). Most of the women who decide to terminate a pregnancy are married or live in stable unions and already have several children[1]. Women can find themselves with an unwanted pregnancy for many reasons:

- Contraception is out of reach: At least 350 million couples worldwide do not have access to information about contraception and a full range of modern contraceptives. Contraception is unavailable for 120 million women of developing countries. Unsafe abortion is a by product of failure to provide adequate contraception for prevention of unwanted pregnancy (Adv. In abortion care 994(1)1-4 (reproductive health training material)[2]
- Failure of Contraceptive methods: between 8 and 30 million pregnancies each year are the result of contraceptive failure – either inconsistent or incorrect use of family planning methods,[3] or failure of the methods themselves

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- Sexual coercion or rape: in studies around the world, between 20% and 50% of women and girls report sexual coercion.

- A variety of social and economic reasons that include: they are unmarried, have been abandoned by their partners, are adolescents, are in an unstable partnership, have too many children to support, and/or live in poverty.

Each year 20 million unsafe abortion are performed worldwide,[4] resulting in 80 thousand maternal deaths and hundreds and thousands of disabilities. Everyday 55,000 abortions take place. 95% occurs in developing countries. They are responsible for 1 in 8 maternal deaths. Globally 1 unsafe abortion takes place for every 7 births. Between 10 to 15% of women who undergo unsafe abortion need medical care for treatment of complications which consumes 50% of total hospital budget. In the developing world (excluding China) the death rate from abortion (safe or unsafe) is 330 maternal deaths for 100,000 abortions. (AGI 1999).

At the 1994 International Conference on Population and Development (ICPD), the world's nations agreed that unsafe abortion is a major public health concern, and that governments should work to eliminate unsafe abortion and make abortion safer in countries where it is legal (UN, 1994; WHO, 1998a). 26 million legal and 20 million illegal abortions were performed worldwide in 1995. Resulting worldwide abortions 35 per/1000 in women aged 15 – 44. Eastern Europe had highest 90/1000 and Western Europe with lowest of 11/1000. Among countries were abortions is legal without restriction the highest abortion 38/1000 was reported from Vietnam, 7/1000 from Belgium, 5/1000 in the Netherlands. (Henshaw S.K., Singh S., Hasst. The incidence of abortion worldwide the Alan Guttmacher institute New York, USA)[5] Eliminating unsafe abortion requires an integrated, comprehensive approach involving health workers, policymakers, and advocates. Societies must ensure high-quality, compassionate treatment for complications resulting from unsafe abortion that includes post-abortion and contraception counselling. Provide universal access to contraception reform restrictive laws and policies that hinder the availability of safe services and trained providers. Ensure safe abortion services.[6]

In Nepal, for every 100,000 live births, 539 women die due to pregnancy and childbirth-related complications. According to the Ministry of Health Maternal Mortality and Morbidity Study of 1998, approximately 5.4% of all maternal deaths are due to abortion related complications. A 1994 a community study estimated the rate of covert abortion to be 117/1000 women of 15 – 49 age group in Nepal (Thapa et al 1994). Improving access to safe abortion care services while decreasing reliance on unsafe abortion is one of the major goals of reproductive health services in its efforts to reduce maternal mortality and morbidity. (Nepal CAC services 2003 draft)[7] Access to safe abortion care in Nepal is hampered because we do not have enough trained CAC service providers and enlisted institution to provide CAC services all over Nepal. We have 99 physician and 59 nurses till January 2005 as services providers and only 27 centres are enlisted. Poor transportation facilities hamper treatment in tertiary clinic. We need to involve more private clinics and teaching hospitals. Women have less access to education health and social services than men in our society which can lead to health related disparities. Linkage between Community and service providers is a key factor in preventing unwanted pregnancies and abortions. This linkage is lacking in our country because of the disturbed political situation at present.

Materials and Methods

This is hospital based prospective and descriptive study which was carried out in the Department of Obstetrics & Gynaecology at KMCTH from July 2004 to April 2005.

The study population comprised of women who came to the obstetrics & gynaecology OPD at KMCTH for CAC service from July 2004 to April 2005. Total number of patients was 160. Pregnancies more than 12 weeks of gestation were excluded from the study. Informed consent was taken. Counselling was done regarding the safe abortion procedure, contraception, complication and need to follow up for if any untoward complication occurred. Premedication with tablet Doxycline 100 mg and Ibuprofen 400 mg was given half an hour before the CAC procedure. Paracervical block was given with 1% xylocaine. Manual Vacuum Aspiration procedure was carried out using vacuum aspiration syringe and plastic cannula with aseptic measures using standard technique. After the procedure was completed, patients were observed for one hour. Vital signs - pulse, blood pressure, and respiration, tenderness per abdomen, per vaginal bleeding were noted. The client was allowed to drink or eat if desired**.** The client's companion was allowed to be with her if desired and only if it would not violate the privacy of other patients. Infection prevention measures were properly followed in the CAC room. CAC forms and register was properly maintained. The forms has particulars of the patient, consent, perspeculum and per vaginal

examination findings, duration of procedure, amount of bleeding and product obtained, reasons for CAC and contraception opted by clients after the abortions.

These forms were supplied from Ministry of Health, CAC division. It was properly filled up and maintained. CAC register is maintained properly with all the above mentioned points.

Table 1: The age distribution (n=160)

Age group	Number	Percentage
< 19 years	8	5%
20 – 29	110	68.76%
30 – 39	37	23.12%
> 40	5	3.12%
Total	160	100%

Table 2: Gravida (n=160)

Gravida	Number	Percentage
Primi	15	9.37%
2 – 3	123	76.87%
4 – 5	19	11.88%
>6	3	1.88%
Total	160	100%

Table 3: Education status (n=160)

Education Level	Number	Percentage
Illiterate	21	13.13%
Literate	53	33.13%
School Leaving Certificate (Primary education)	59	36.87%
Graduate	20	12.50%
Master	7	4.37%
Total	160	100%

Table 4: Uterine Size (n=160)

Size of Uterus	Number	Percentage
6 – 7 Weeks	88	55%
8 – 10 Weeks	65	40.63%
>10 Weeks. below 10-12Weeks	7	4.37%
Total	160	100%

Table 5: Reasons for CAC service (n=160)

Reasons	Number	Percentage
Small baby	43	26.87%
Unwanted Pregnancy	106	66.25%
Contraceptive failure	1	0.63%
Rape	1	0.63%
Unsettled	6	3.75%
Medical cause	3	1.87%
Total	160	100%

Table 6: Complications following CAC

Reasons	Number	Percentage
No complications	158	98.75%
Complications	2	1.25%
Total	160	100%

Table 7: Contraception Adopted post CAC (n=160)

Methods	Number	Percentage
Oral Contraceptive pills	30	18.75%
Depo provera Inj.	60	37.5%
Copper-T	25	15.62%
Norplant	4	2.5%
Vasectomy	4	2.5%
Tube ligation	1	0.63%
Condom	9	5.63%
Not followed	27	16.87%
Total	160	100%

Results

- Main reason for performing CAC was unwanted pregnancy 66.75%.
- Complication following CAC was 1.25%.
- Post CAC contraception opted was 93% most preferred method was Inj. Depoprovera
- Age group between 20 – 29 years was 75%. 76.88% of the patient was of gravida 2 and 3.
- Regarding the education status of the patient for the CAC 36.87% were School Leaving Certificate (SLC) passed (Primary education generally comprising of 10 years of schooling)

Discussion

160 women were included in the study with the pregnancy of gestational age less than 12 weeks. 75% were of age group of 20 – 29 years**.** 8 patients were below 19 years and wanted to continue their education and were not well established in their family life. 76.87% of the women were G2 and G3. 36.87% of the women had completed primary education because it is common in Nepal for girls to be married off at an early age and sometimes don't continue their education.

The most common reason for asking CAC service was unwanted pregnancy. The reason given was because they did not want to have more children or did not want the pregnancy as they were perusing studies.[5] It was 66.25% in a study done by (Ojha N et. al) at Prasuti Griha, Nepal. 54.8%of the induced

abortion cases also had the same reason. In this study, complications following CAC were 1.25% because the CAC was performed in gestation age of less than 12 weeks. Termination of pregnancy is safer at early stages of gestation. Advances in early abortion techniques have helped to increase popularisation of early procedure – Safest type. Vacuum aspiration is the most common method[9] for termination of pregnancy <12 weeks. (AGI 1999)

The complication rate of 1.25% is less compared to the rates of unsafe abortion. (10 to 50% WHO 1998a). Two patents had complications. They came with PV bleeding and features of incomplete abortion. Evacuation was done for both the patient; one patient had fever and was admitted in the hospital for two days and was treated with IV antibiotics and antipyretics.

Contraception counselling was done for all the patients and 93% accepted the methods offered. Mostly they preferred Inj. Depoprovera which is called 'Sangini' in Nepal. In this study the CAC needed for contraceptive failure was 1 (0.63%).The reason for contraceptive failure because the patient forgot to take oral contraceptive pills regularly. As contraceptive use becomes the norms, abortion rate falls substanitially. In Russia effective contraception increased from 19% to 24% during 19990-1994, and abortion rate/1000 women dropped from 109-76.[5] In Nepal contraceptive prevalence rate has increase from 38.43% in 2059/60 B.S. to 40.69% in 2060/2061. Depoprovera users were 9.3% in 1976 to 2001. (Annual report Nepal Demographic and Health Survey 2001 FHD, DOHS, MOH) [10]

Conclusion

CAC service performed at KMC had very few complications. Contraception counselling provided the clients with an opportunity to choose and also get information on various contraceptive methods available in Nepal. The reason for undergoing CAC service was mainly unwanted pregnancy.

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