

## Post legalisation challenge: minimizing complications of abortion

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### Abstract

Abortion has been legalized in Nepal since September 2002 by 11<sup>th</sup> amendment to the Muluki Ain. The present study was conducted in Paropakar Shree Panch Indra Rajya Laxmi Devi Maternity Hospital to assess the magnitude of induced abortion, its causes and the types of complications, in the post legalization phase. Prospective descriptive analyses of the patients who were admitted with history of induced abortion from 16<sup>th</sup> Dec 2003 to 13<sup>th</sup> March 2004 was carried out. A total of 305 cases of abortion complications were admitted during the three-month study period, which is 39.7% of the total gynaecological admissions (768). Of these 31 (10.25%) patients had history of induced abortion. Half of the induced abortion cases (52%) were of age group 21-29 yrs and 42% had three or more children. 39% of the cases had history of induced abortion at more than 12 weeks and almost half of the cases (48%) had history of family planning. The most common reason for seeking abortion was too many children (59%) followed by illegitimate pregnancy (16%). Twenty-one patients gave history of abortion being performed by doctors and the most common method used was D&C (75%). 77% of cases presented as incomplete abortion and one case presented with uterine perforation, bowel injury and peritonitis. Twenty patients had evacuation under sedation while five had manual vacuum aspiration (MVA); one patient required laparotomy. In two third of the patients intravenous fluid and antibiotics were used. Four patients required blood transfusion. Abortion complications constitute almost 40% of the total gynaecological admissions. Ten percent of the abortion cases had history of induced abortion. Medical persons, mainly doctors, performed most of the cases of induced abortion and D&C was the most commonly used method. However the patients had faced various types of complications. Untrained provider, resulting in serious life threatening injuries, performed more than a third of the cases of induced abortion at more than twelve weeks gestation. This points to the need for improved monitoring of the quality of services provided, and adherence to the criteria set by the procedural order.

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At the United Nations International Conference on Population and Development (ICPD) in Cairo in 1994, governments identified unsafe abortion as a public health problem. Worldwide 46 million or 22% of all pregnancy end in induced abortion<sup>1</sup>. Of these 20 million occur under unsafe condition. Each year an estimated 80,000 women die from complications of unsafe abortion accounting for 13% of global maternal mortality<sup>2</sup>. The rates at which women seek abortion are strikingly similar for women living in developed and developing countries<sup>3</sup>. However, the chances of receiving a safe abortion vary widely and are determined by a variety of socioeconomic, legal and cultural factors. When performed by trained providers in sanitary conditions, abortion is one of the safest medical procedures<sup>4</sup>.

In our country, the recent legalization of abortion law has put forward Procedural Order, which has been formalized since December 2003. The law states that abortion is legal under certain conditions, following the rules and regulations laid by the Procedural Order. It demands that a trained and listed provider should provide abortion services, within the limits as set by the law.

The present study was carried out to assess the magnitude of cases admitted with abortion complications, to analyze the cases of induced abortion and the types of complications of induced abortion.

### Patients and Methods

The study population comprised of patients who were admitted in Paropakar Shree Panch Indra Rajya Laxmi Devi Maternity Hospital from 16<sup>th</sup> December 2003 to 13<sup>th</sup> March 2004 (1<sup>st</sup> Poush to 30<sup>th</sup> Falgun, 2060) with history of induced abortion. A total of thirty-one cases were admitted during the study period. These patients were interviewed and their management followed. Retrospective statistical data of abortion complications during the same time period in the previous year was taken from statistics department for comparison.

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### Correspondence

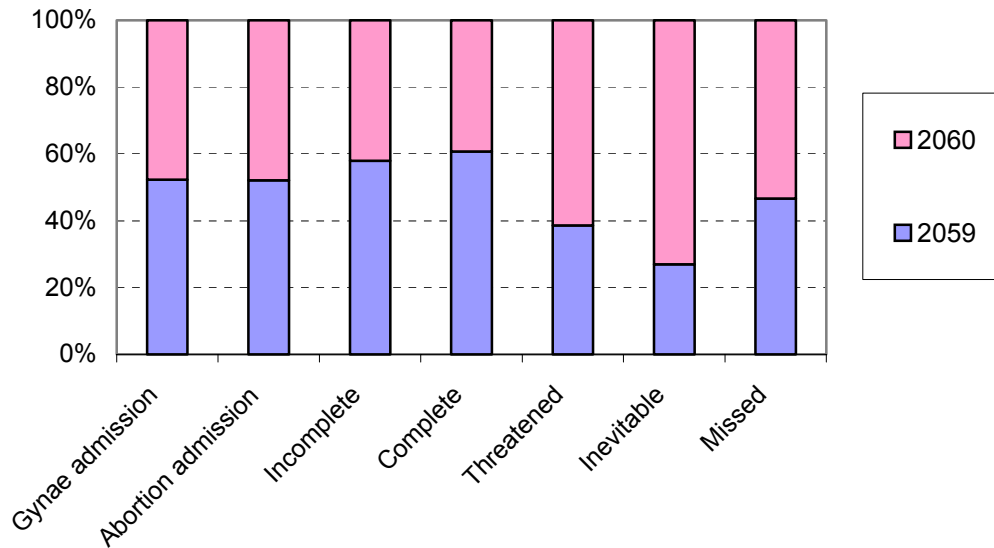
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**Results**

There was a total of 305 abortion complication cases (39.7%) out of the total 768 gynaecological admissions during the study period. of these 31 patients (10.25%) had history of induced abortion. Tow of these 31

patients were unmarried. There was not much difference in the total number of abortion complications cases in the study period and in the same three months the previous year, prior to legalization of abortion.

**Gynae and abortion admission before and after legalization**

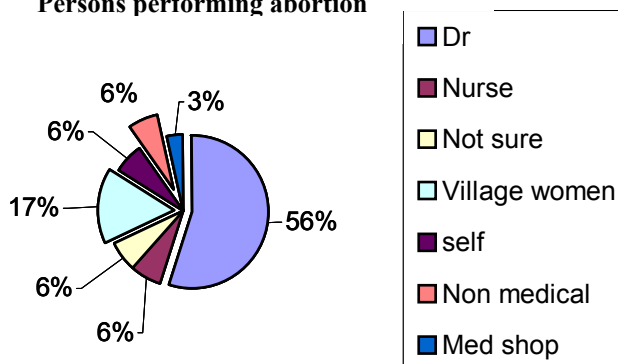


**Patient Characteristics**

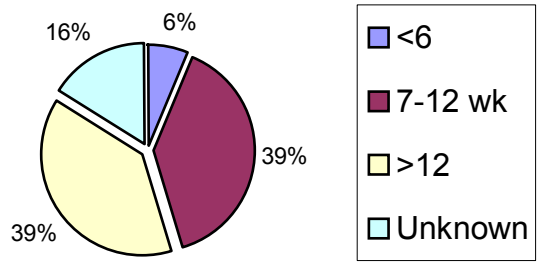
16 patients were in the age group of 20-29 years, while 14 were 30 years and above. One patient was under the age of 20 years. 29 patients were married, while only 2 were unmarried. 23 patients (74.2%) came from Kathmandu valley and the remaining 8 (25.8%) came from outside the valley. Four were primigravida, and the majority 17 (54.8%) patients were gravida 2 to 4. 10 patients were gravida 5 or more. Only 2 patients had abortion at less than 6 weeks gestation. 5 women could

not tell the gestational period, and remaining 12 patients in each group had abortions at 7-12 and more than 12 week, respectively. 15 (48.4%) of the patients had used contraception previously, but 5 had stopped due to side effects. There were 7 cases of contraceptive failure and three others had stopped using due to various causes. The most common reason cited for not using contraception was fear of side effects (6), and lack of knowledge.

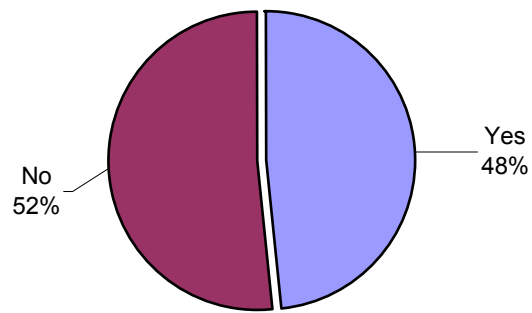
**Persons performing abortion**



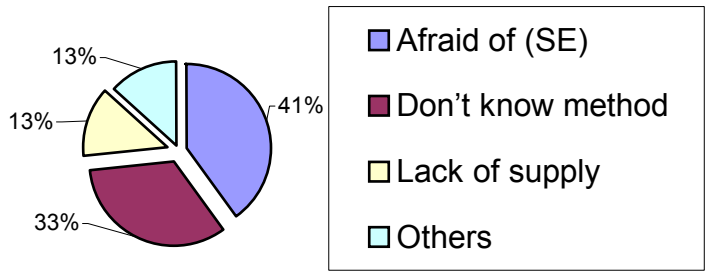
**Gestational weeks at induced abortion**



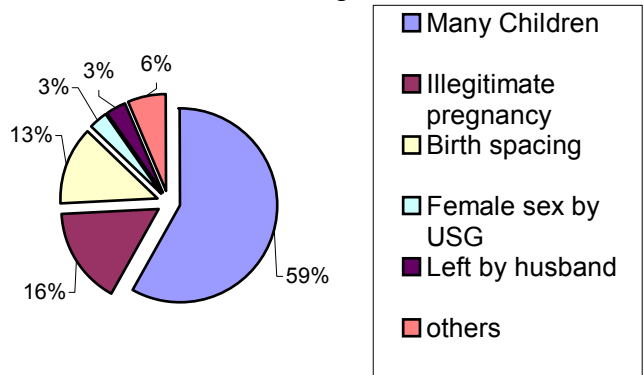
**Family Planning method used**



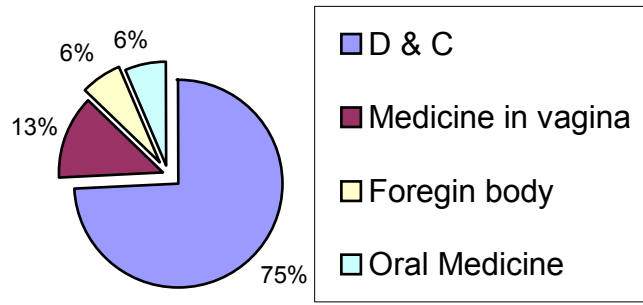
**Causes of not using FP after last child birth**



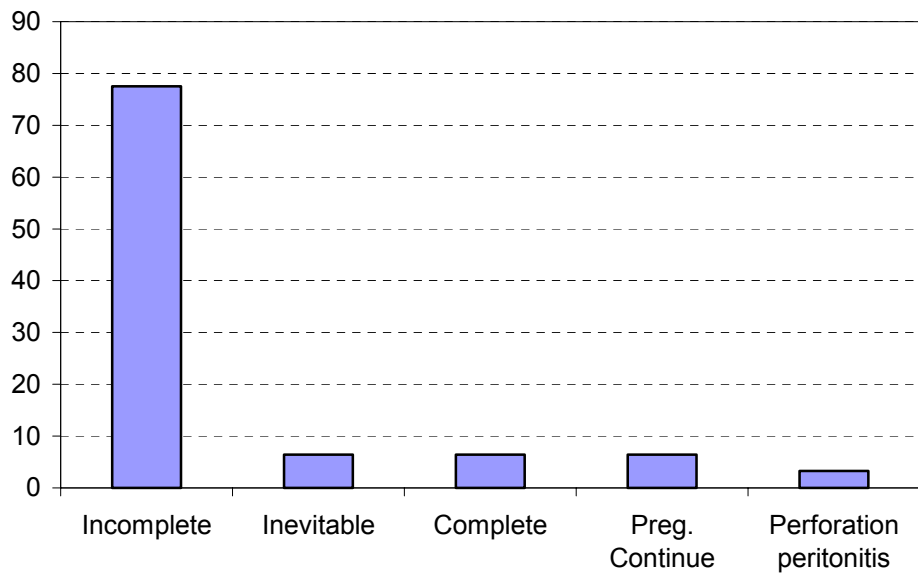
**Reasons for seeking abortion**



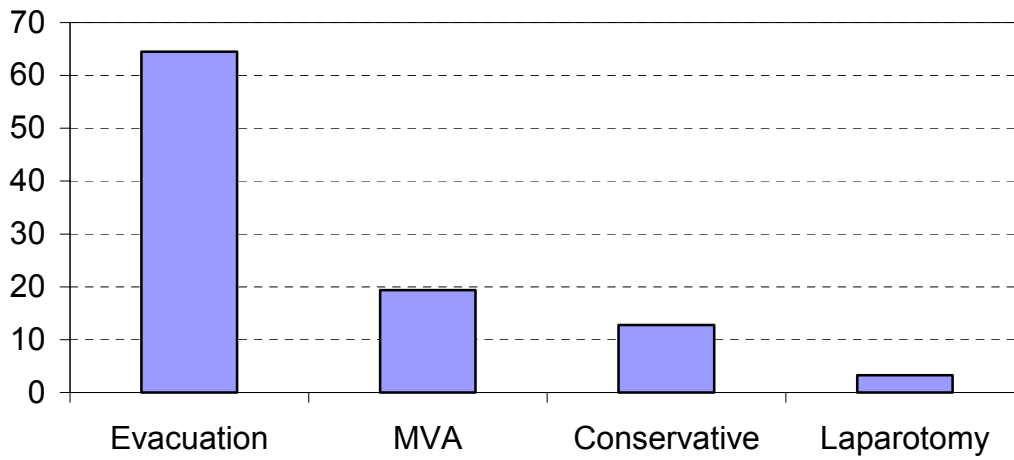
### Methods used for Abortion



### Clinical Presentation



### Definitive Treatment Given



### **Reason for seeking abortion**

Too many children were cited as the main reason (58.1%), followed by illegitimate pregnancy (16.1%) and for spacing (12.9%). One of the cases was a selective termination of an ultrasonically detected female foetus.

### **Case study**

Mrs. YS. 28 yrs G3 P2 was admitted on 60.11.8 with pain and distension of abdomen and history of induced abortion in a private clinic following amenorrhoea for 15 weeks. On examination, she looked sick and feel; her pulse rate was 104 per minute and her blood pressure was 120/80 mm of Hg. She was febrile with temperature of 101° F. Vaginal examination revealed no active bleeding, about 200 gram foetus without head was lying in the vagina, the cervical os was open and products of conception were felt inside the uterus. Uterine size could not be assessed as the patient was tense and there was abdominal rigidity. A provisional diagnosis of Induced incomplete abortion with peritonitis due to uterine perforation was made. Initial resuscitation was done and she was prepared for laparotomy. On exploration of uterine cavity, a small chunk of placental tissue was removed, and perforation of the uterine wall was suspected. At laparotomy there was collection of about 200 ml old blood in the peritoneal cavity. There was about 1 inch hole in the posterior wall of the uterus. There was bowel injury with transection at the recto sigmoid junction. Uterine perforation was repaired and a surgeon was called who performed an end colostomy of sigmoid colon, with closure of the proximal end of the rectum Two months later, a recto sigmoid anastomosis with transverse colostomy was done. The patient is yet to undergo colostomy closure.

### **Discussion**

Safe abortion requires the provision of good quality abortion services, which should include proper counselling, trained human resources, infection prevention practices and adequate logistic support. For many women, especially in developing countries like ours, safe abortion may not be available or affordable despite the liberalization of abortion law. Medical safety however, by itself does not address all of the women's needs. Solution lies in targeting the social norms and demand for sons<sup>4</sup>.

Abortion complications cases comprise the main gynaecological admission in most hospitals of Nepal. A study conducted by CREHPA in 1999 at five major hospitals showed that abortion related admissions accounted for 20-48% of the total gynaecological admissions<sup>5</sup>. This is comparable to 39.7% abortion cases admissions in this study.

In a hospital-based study in Nepal, of 276 cases of abortion related complications 17.4% were induced abortion. Economic burden of large family was cited by 68%, poor health by 10% and 8% wanted to space their next pregnancy<sup>6</sup>. This study also cited too many children (59%) as the most common cause for going for induced abortion followed by illegitimate pregnancy (16%).

Experience from Bangladesh has shown that 95% or more Menstrual Regulation services are availed by married, relatively better-educated women with average age around 26 years with two or more children. Relatively older and less educated women with a larger number of children depend upon untrained providers to abort their pregnancies. Adolescents/ unmarried girls and widows / divorced women also use unsafe services. The reasons for such differentials have been believed to be lack of knowledge, strong desire for secrecy, financial constraints and restriction by the families<sup>7</sup>.

In the present study, most of the abortions (17 cases) with complications had been performed by medical doctors, and curettage was the chosen method. This points to the need for adequate training It is well known that vacuum aspirations are better than sharp curettage, for treatment of incomplete abortion<sup>8</sup>. Experienced gynaecologists feel more comfortable with vacuum aspirations, either electric or manual for termination of pregnancies. Manual Vacuum aspiration was utilized less than surgical evacuation for the treatment of induced incomplete abortion in the present series. This could possibly be due to MVA services being available only within certain hours of the day.

Thirty nine percent of the cases had abortion at more than twelve weeks gestation (the legal limit is twelve weeks, when there are no additional conditions). It is well known that abortions done earlier in pregnancy are safer than late terminations. The reason for late termination in some of the present cases was waiting for ultrasonic sex detection of the foetus, but in others simple lack of knowledge was the factor identified for late terminations. The need for monitoring of the services is clearly evident, as also the need for more advocacy and IEC efforts.

One fifth of the cases had opted for traditional methods like inserting foreign body or some medicine in the vagina by a non-medical person. This is a socio legal challenge and women need to be informed of the rights and criteria for legal abortion.

### **Conclusion and Recommendations**

Abortion complications constitute almost 40% of the total gynaecological admissions. Ten percent of the

abortion cases had history of induced abortion. Medical persons, mainly doctors, performed most of the cases of induced abortion and D&C was the most commonly used method. However the patients had faced various types of complications. More than a third of the cases of induced abortion were performed at more than twelve weeks gestation. This points to the need for improved monitoring in the quality of services provided, and adherence to the criteria set by the procedural order.

Issues like the need to follow the Procedural Order should receive more attention. More should be made to disseminate information and create awareness especially in villages and suburban areas about the availability of safe and legal abortion services. Strengthening the existing health facilities and extending the availability of service to the periphery should improve access to quality abortion services, as well as contraceptives. Reporting and recording of cases of abortion complications and post abortion care in all health facilities should be encouraged.

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