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Research Article

Profile of abortion seekers and decision makers of post abortion contraceptive acceptability in Andaman and Nicobar Islands, India

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ABSTRACT

Background: Medical termination of pregnancy (MTP) represents an important aspect of women's reproductive health and right. Complications of unsafe abortion account for an estimated 9% of all maternal deaths. The present study was undertaken to study the factors influencing MTPs, the subsequent adoption of contraceptive methods following MTP and decision makers for contraceptive choice.
Methods: This cross- sectional, descriptive study was performed over a period of eight months from October 2015 to May 2016.The study subjects included 108 women who underwent MTP at the hospital. The details regarding their socio-demographic profile, previous obstetric history, reason for seeking abortion and acceptance of post abortal contraception were taken and analyzed by SPSS software.
Results: The mean age and parity of women was 28.94±4.796 years and 2.205±0.978 respectively. All were married with 84.25% having two or more living children. Majority of the women (97.22%) reported in the first trimester of pregnancy for MTP. Nearly 40% were not using any contraception at the time of conception and only 3.7% used oral contraceptive pills (OCP) and 2.8% used intrauterine contraceptive device (IUCD). The reason for seeking abortion was completed family (62.9%), previous baby too young (19.44%) and contraceptive failure (5.55%). Of the 94.4% women who opted for concurrent contraception, 58.3% opted female sterilization. Decision about contraception was taken by both in 57.4% cases, husband alone in 40.7% and wife alone in only 1.9% cases.
Conclusions: All MTP seekers should be provided information and counseling for post abortal contraceptive use and enable these women and their spouse to make an informed and voluntary choice and thus avoid the need of a repeat abortion. Contraceptive services should also include emergency contraception to prevent unwanted pregnancy due to unprotected sex.

Keywords: MTP, Post abortion contraception, Decision makers, Andaman and Nicobar Islands

INTRODUCTION

In India, complication of unsafe abortion account for an estimated 9% of all maternal deaths.[1] Safe and legal abortion is considered a key intervention for improving women's reproductive health and quality of life. With the legislation of the MTP Act in 1971, India became one of the first countries legalizing abortion on moderately liberal grounds – particularly "failure of contraceptive use" for termination of pregnancy.[2] A strong motivation to seek an abortion rests on the widespread desire for smaller families, the need to control the timing of births and the failure or inconsistent use of contraception. Misinformation and apprehension about the different contraceptive options prevent widespread contraceptive use and abortion is used as an alternative to contraception. Encouraging eligible couples to use effective contraceptive methods is yet another way to reduce MTP. This can be achieved by providing adequate

information about available contraceptive methods and helping couples to choose one that suits them.

The aim of the present study was to investigate the socio - demographic profile of pregnant women seeking MTP, the reasons for opting abortion, the subsequent adoption of contraceptive methods following MTP and reasons for not adopting contraceptive methods.

METHODS

The study was conducted in the department of Obstetrics and Gynecology, Andaman and Nicobar Islands Institute of Medical Sciences, Port Blair, India. Subjects included all consenting married and unmarried women seeking MTP at the hospital during the study period of eight months from October 2015 to May 2016. Consent of MTP seekers was taken, with assurance of complete anonymity. Failure to consent was the only exclusion criteria. Ethical approval was taken from the Institutional Ethics Committee. Total 126 women came for MTP in this period, out of which 108 women who consented for the participation in study were included. The details regarding the reason for seeking abortion and acceptance of post abortal contraception were taken among all the MTP seekers. A detailed information regarding socio-demographic profile, parity, number of living children, age of previous child, male: female ratio, number of previous abortions, duration of pregnancy, factors influencing MTP and any attempt to induce abortion before coming to hospital was collected through a pre designed and pre tested case record form and information regarding subsequent use of contraceptive methods/reason for not adopting contraception was collected. The study participants were given the questionnaire which they could fill themselves or if uneducated, with the help of family planning counsellor. Detailed clinical examination of the patient was done including per vagina examination to assess the gestational age which was later confirmed by ultrasonography.

The data obtained was analysed statistically using mean and percentage distribution.

RESULTS

Majority of the MTP seekers belonged to the age group of 26 – 30 years (n=50, 46.3%) with only 10 (9.3%) of the study subjects more than 35 years of age. The mean age of women who underwent abortion was 28.94±4.796 years. The socio – demographic characteristics of the women who underwent MTP is shown in Table 1.

Table 2 depicts the obstetric history of the study subjects. Most of the women came early for termination of pregnancy. Only 2.8% women came beyond 12 weeks of gestation for abortion. Out of the ten women having history of previous MTP, eight were done in Government hospital and only two of them were done in a private clinic. None of them tried to terminate the present pregnancy before reporting to the hospital. It was also observed that among the women who came for MTP, (70.4% n=76) had 1or 2 male living child (Table 3).

Table 1: Socio-demographic profile of women seeking MTP.

Characteristics		Number n=108	Percentage
Age (Years)	≤20	0	0
	21-25	27	25
	26-30	50	46.29
	31-35	21	19.44
	>35	10	9.25
Residence	Rural	76	70.4
	Urban	32	29.6
Educational status	Illiterate	12	11.11
	Primary	20	18.51
	Secondary	42	38.88
	Higher Secondary	23	21.29
	Graduate and above	11	10.18
Religion	Hindu	84	77.77
	Muslim	16	14.81
	Christian	8	7.40
Occupation	Housewife	101	93.51
	Working	7	6.48

Majority of the women were aware of the various contraceptive methods available. Awareness was maximum for condom (n= 96, 88.9%) followed by OCPs (n=74, 68.5%), IUCD (n=70, 64.8%), coitus interruptus (n=43, 39.8%) and injectables (n= 15, 13.9%). Regarding permanent methods, 75.9% (n=82) women were aware of female sterilisation and 17.6% (n=19) of male sterilisation. Only 12.03% of the women were having knowledge of emergency contraception (EC).

Most of the participants obtained the information regarding contraception from multiple sources. The main source of information was television (n= 78, 72.2%) followed by friends and relatives (n= 72, 66.7%), health personal/doctors (n=36, 33.3%) and print media (n=22, 20.4%).

We observed that before the present unplanned pregnancy, 28.7% (n=31) of our study subjects were using condom which has a high failure rate and needs sustained motivation, 3.7% (n=4) couples were using natural method of contraception (coitus interruptus) and almost equal number were taking oral pills (n= 4, 3.7%) or had removed IUCD before MTP (n=3, 2.8%). Around 61.1% (n= 66) women were not using any contraceptive method.

The reasons for the termination of the current pregnancy are detailed in Table 4. Completed family was noted as

the most common reason (n= 68, 62.96%) for terminating the pregnancy. Seven women (6.48%) did not give any reason for MTP.

Table 2: Obstetric profile of study group.

Characteristics		Number n=108	Percentage
Number of living children	0	1	0.92
	1	16	148
	≥2	91	84.25
Previous number of abortions	0	98	90.74
	≥1	10	9.25
Previous abortions	Induced	5	50
	Spontaneous	5	50
Gestational Age (weeks)	≤ 6	20	18.5
	7-8	52	48.1
	9-12	33	30.6
	>12	3	2.8
Age of previous child (Years)	< 1	15	13.9
	≤3	45	41.7
	>3	47	43.5
Number of deliveries	0	1	0.92
	1	18	16.7
	2	63	58.3
	3	19	17.6
	>4	7	6.5

Table 3: Male Female ratio of living children in the study group.

Male:Female	MTP Acceptors (n=108)	
	Number(n)	Percentage (%)
0:0	01	0.9
0:1	05	4.6
0:2	19	17.6
0:3	06	5.6
0:4	01	0.9
1:0	11	10.1
1:1	35	32.4
1:2	08	7.4
2:0	13	12
2:1	05	4.6
2:2	01	0.9
2:3	01	0.9
2:4	01	0.9
3:3	01	0.9

Post abortion contraception was accepted by 94.4% (n=102) women (Figure 1). Six women did not accept any post abortion contraception and the reason given was lack of support from husband.

Decision regarding the couple choice of post abortal contraception was taken by both husband and wife in 57.4% (n=62) cases, by husband alone in 40.7% (n=44) cases and by wife alone in 1.9% (n=2) cases.

Table 4: Distribution of women according to reason for MTP.

Reason for MTP	Number n=108	Percentage (%)
Completed family	68	62.96
Previous baby too young	21	19.44
No response	7	6.48
Contraceptive failure	6	5.55
Economic reason	4	3.70
Just married	2	1.85

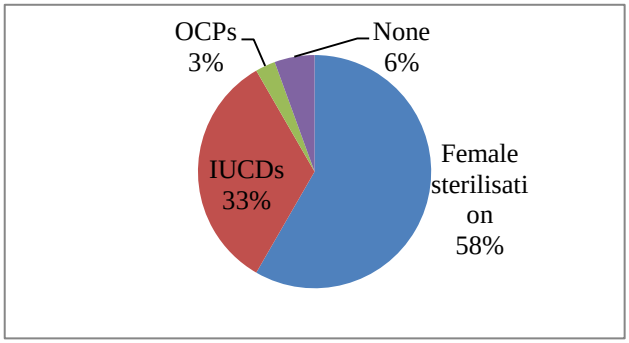

Figure 1: Post abortal contraceptive choice.

DISCUSSION

There is a gradual increase in MTP acceptance over the years due to liberalization and awareness about the MTP act, changing attitude of women towards abortion, improvement in the availability of hospital facilities and declining social stigma attached to abortion. Women of all reproductive age groups seek abortion in India. In the present study, maximum abortions (n=77, 71.3%) were noted among women of 21 – 30 years age group. Similar findings were noted in a study conducted by Agarwal and Salhan and Bahadur et al.[3,4] This could be due to the fact that 20 - 30 years of age group is reproductively most active group and constitute most of the unmet need for family planning. It may also be attributed to lack of motivation and decision making among these women for accepting contraceptive measures either to postpone pregnancy or to complete the family.

Maximum number of MTP seekers were Hindus (n= 84, 77.8%). Increased prevalence of abortion in Hindus may be because of their greater population. Moreover, Hindus are more liberal and easily opt for family planning measures including abortion. Muslim women have both less access to and less demand for induced abortion owing to religious norms.

In our study, there was not even a single case of unmarried pregnancy that came for MTP. This could be

because of the fact that they prefer private clinics / hospitals for confidential reason.

Family planning methods use increases with advancement in educational status of the women. In this study the percentage of illiterates were only 11.11% (n=12) as compared to the study of Agarwal and Salhan (70.7%), Bahadur et al (34.8%) and Srivastava et al (36.5%). [3-5]

The perception of small family norm is gradually increasing with women's education and employment. Working women will be more likely to have abortions than non-working women because of conflicts between their roles as employees and their roles as mother, along with their desire for small family size. In the present study, 6.48% (n=7) of women were working.

Majority of the women (n=76, 70.4%) undergoing MTP were from rural area signifying that these women have more unmet need for contraception.

The present study showed that 91(84.25%) MTP seekers had two or more living children, revealing the fact that in spite of the completed family size, these women got unwanted pregnancy and came for MTP. There is a lack of proper knowledge and motivation among these women for accepting contraception, which has to be overcome by the health care personnel.

Majority of the women (n=105, 97.22%) came in first trimester for MTP. Agarwal and Salhan also noted majority of abortion cases (89.4%) within 12 weeks of gestation and only (10.6%) cases beyond 12 weeks.[3] Shivkumar and Vishwanath observed majority of abortions (84.7%) during 5 – 12 weeks of pregnancy followed by 13 – 20 weeks (15.3%).[6] A larger percentage of women presenting during first trimester suggests a better awareness towards the family planning programme which has now gained popularity even amongst the rural population.

Our study showed that 9.25% (n= 10) women who sought MTP had history of one or more abortions in the recent past. Similarly, a study done by Ganguly G et al also showed that 5.7% of women had previous history of abortion.[7] This shows that there is a failure on the part of health care providers to counsel these women in need of contraception. The health care provider should insist for post abortion contraception and provide information and counseling to enable the woman and spouse to make an informed and voluntary choice and thus avoid the need of a repeat abortion.

Among those who came for MTP, 61.1% (n=66) women were not using any contraceptive methods as compared to 55.2% observed by Srivastava R et al, 39% by Young et al and 33% by Aneblom et al .[5,8,9]

Many women consider MTP as a method of contraception. This is supported by the fact that, in our study the most common reason for seeking abortion was completed family (n=68,62.96%). These are the target couples which are missed by family planning services or the counselling and motivation was inadequate in the post-partum period. This could have been avoided if a family planning method was adopted by these couples in maximum acceptability of post-partum period. 19.44% (n=21) of women reported previous baby too young as the reason for MTP. This represents the unmet need of family planning for spacing of pregnancies. 5.55% (n=6) women sought MTP due to contraceptive failure. The situations that lead to contraceptive failure are diverse like condom breakage, forgotten pills, partner withdrawing late etc.

Interestingly, none of the women opted for abortion on gender basis which is a major national concern nowadays. Khokhar and Gulati in their study on urban slums of Delhi noted that the most common reason for the abortion stated by the women undergoing MTP was unplanned pregnancy (last child very small) (62.50%) followed by inadequate income (52.08%), family complete (31.25%), contraceptive failure (10.41%), female foetus (2.08%) and health problems (2.08%).[10] Bhattacharya et al observed birth spacing as the main reason (59.8%) followed by incomplete/missed abortion (22%) for seeking abortion. Female foetus was also the reason for termination in 6.8% cases.[11] In Shivkumar and Shrivastava study, commonest reason behind abortion was unplanned pregnancy (30.7%) followed by contraceptive failure (29.3%).[6]

In our study, maximum (n=63, 58.33%) women accepted female sterilisation as a mode of contraception after MTP and bluntly refused for IUCD. Mukhopadhyay et al found that 35.8% accepted Copper T and 30% accepted permanent sterilization after MTP as a mode of contraception.[12] In a study by Suneeta M et al, out of 284 women, 111 (39.08%) did not use contraception, 108 (38.02%) accepted barrier method, 52 (18.31%) used IUCD,11 (3.87%) used OCP_s and 2 (0.7%) used other methods.[13]

The decision to have an abortion is a complex process that often involves a women's spouse and in- laws. In the present study, decision regarding choice of contraceptive method was taken by husband alone in 40.74% (n=44) cases. In 5.55% (n=6) cases "husband objected" was the reason given for non- acceptance of post abortion contraception. By providing counselling to the couple, it is expected that acceptance of post abortion contraception will improve.

In our study, 12.03% (n=13) women were aware of emergency contraception while in a study by Tripathi et al in New Delhi, it was found that none of their patients were aware of emergency contraception.[14] This reflects that EC is still an area where much work needs to be done

and strategies to increase awareness and acceptability need to be undertaken. There are concerns that women using EC pills may become lax with their regular birth control methods. However, reported evidence indicates that making EC pills more readily available would ultimately reduce the unintended pregnancies. We need to adopt an aggressive promotional and educative approach to make more and more women of reproductive age group aware of EC.

CONCLUSION

There is a need to counsel women of reproductive age group that MTP is not a way to control unwanted birth and it is not free from risk. They should be motivated by health care providers and their counselling should be based on cafeteria approach. Counselling for post-abortal contraceptive should be provided to the couple so that they can make an informed choice. Contraceptive services should also include emergency contraceptives to prevent unwanted pregnancy due to unprotected sex.

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