 DOI: 10.5958/2394-2754.2015.00021.1

Impact of Post Abortal Counselling and Acceptability of Concurrent Contraception

Hema Gayathri Arunachalam[1,*], Savitri Subramanyam[2], Mala Vijayakrishnan[3]

[1]Resident, Department of OBG, NRI Medical College & Hospital, Guntur
[2]Honorary Professor, Post Graduate Medical Centre, [3]Consultant, Obstetrician & Gynaecologist, Vijaya Hospital, Chennai

***Corresponding Author:**
E-mail: ahgayathri@yahoo.co.in

ABSTRACT:

Background: *Throughout developing world there is a large gap between people desire to space and their use of contraception **(UNMET NEED)** and this end up in unwanted pregnancy. In India 20 % of pregnancies are unwanted and more than half undergo unsafe abortion contributing to 8% of maternal death. 'You cannot die from a pregnancy you don't have'. India being the second populous, to combat unmet need is a national emergency, and post abortal counselling is an effective tool.*

Aim: *This prospective observational study was conducted to assess the impact of post abortal contraception counselling and to determine the acceptability of concurrent contraception.*

Material and Method: *All 258 women who had abortion and who had been provided post abortion counselling between October 2007 and September 2009 were the main source of study. The women were enquired about any contraception use and compliance, before abortion. Following post abortion counselling, the number of women who accepted to use contraception in the immediate post abortal period were determined. Women who accepted concurrent contraception were followed up by phone call 5months later, with emphasis on practices towards contraception and perseverance.*

Statistical data: *Calculated by simple percentage, p value, odds ratio.*

Result: *Following post abortal counselling the contraceptive acceptance increased remarkably by 74.2% and use of modern method increased by 2 fold (79.5% compared to 29.2 % prior counselling). Extended follow up after 5 months showed that women persevered with contraceptive usage when it was initiated in the immediate in the post abortal period (p 0.0). 10.3 % discontinued in the interval period.*

Besides increase awareness in multiparous (76%), unplanned pregnancy was high (76.48%) due to poor compliance (41.76%) and the rest of patients discontinued due to fear of side effects and myth about contraception. In my study education and socio-economic class did not significantly affect the acceptability of contraception (p 0.239, p 0.730).

Conclusion: *Women having had an unplanned pregnancy and abortion is anxious to avoid repeating it again and also more receptive. Hence post abortion period is an opportune time for health professionals to have a major impact on reproductive health outcomes.*

Keywords: *Unmet Need, Post abrotal counselling, Concurrent contraception.*

INTRODUCTION

Interestingly, if unmet need for contraceptives was adequately met, India's total fertility rate would drop to replacement level[1,2]**.** And, the freedom of couple to choose when and how often to become pregnant is a fundamental human right[3] and hence providing contraception is a social obligation. Moreover, every year 44 million women have induced abortion and 47,000 women die due to unsafe abortion, accounting for about 13% of all maternal deaths[4, 5].

Although in our country contraceptives are available free of cost, they are underutilized. This mainly due to lack of knowledge among community, cultural sensitivity, uncompassionate attitude of the provider and lack of post abortion care[6]. Another reason is woman do not seek medical help unless they end up with an accidental unexpected pregnancy.

Post–abortion counselling incorporated into post abortion care has been regarded as an appropriate venue or vehicle to decrease unwanted pregnancies and induced abortion[7].

Detrimental effects of miscarriage are enduring and display complex course of resolution both physically and psychologically. Hence postabortal women are more sensitive, approachable and receptive, they can be easily moulded and encouraged to use contraception. Left with the sense of guilt and agony, these women have the quest to evolve the views on contraception besides their social taboos.

Hence in abortal services counselling the patient especially with regard to anxiety and encouraging them to use contraception are as important as clinical skills.

MATERIAL AND METHOD

This prospective observational study was carried out at the maternity department of Vijaya Hospital, located in the urban area ofChennai during a two year period from 1st October, 2007 to 31st September, 2009 after ethical clearance. The study

includes women with both spontaneous abortion and induced abortion.

Questionnaires for the survey were prepared centrally in English and were translated into regional languages. The questions pertaining to women's perceptions, opinions, knowledge, awareness and attitudes regarding contraception, were open-ended. Women's data pertaining education, socioeconomic class, previous termination and obstetric history were also recorded.

Counselling was conducted in a private room. Information about modern contraceptive methods was detailed. The probable responses and acceptability/non- acceptability of concurrent post-abortal contraception were listed.

Five months after the abortion date, women were followed up by telephone call. But only 241 women could be reached, followed and interviewed. 17 women could not be reached. Few women among them were reluctant to participate in the study. Follow up carried out with emphasis on practices towards contraception and perseverance.

Inclusion criteria:

1. Women of reproductive age group, with uterine pregnancy confirmed by USG and had abortion, able to understand and give consent.
2. Index miscarriage occurred prior to 24 week of gestation
3. Completed management of index miscarriage.

Exclusion miscarriage:

As such there is no contraindication for post abortion counselling. But the women mentioned below were excluded.

1. Women presenting with threatened miscarriage
2. Women presenting with multiple pregnancy on scan with demise of one fetus and continuation of the other.

RESULTS

Total abortions during the study period were 258. Of these 195 patients had induced medical termination of pregnancy (29 were induced on medical grounds, 16 patients for contraception failure, and the rest 148 for social reasons).

Almost 63.56% (164) of women had knowledge on contraception(temporary method), besides the fact that awareness is universal for sterilization .Among temporary methods condom was more popular (Figure 1). Inspite of increase awareness, 178 pregnancies were unplanned and the unmet need for contraception was almost 101(56.74%). Among newlywed, unplanned pregnancy was mainly due to inadequate knowledge of contraception. Awareness was only 33.33%.

In women married for more than a year, though the awareness of contraception was high (75%), the unmet need was high (69%) due to apprehension, lack of motivation until they face reality and also myth about side effects.

In our study induced abortion was found to be more in the age group between25-34 (62.6%). Though the distribution is less in the extremes of age group, the termination rate is almost 100%, indicating high unmet need (Table 1).

Vijaya Hospital being a corporate set up, most of the women who approached us completed high school and was graduates (64.0%) and belonged to middle class. Hence both variables education and social class did not affect contraceptive use (Table 1) which shows that besides education and awareness, motivation is the prime factor required to balance the high unmet need. Educated women though fail once, they are sensible enough not to repeat it. Post abortion counselling significantly reduces subsequent unwanted pregnancy. Besides high unmet need in the study population; repeat aborters were less (5.9%).

Our study showed the most common reason for termination of pregnancy, was tostop child bearing(SCB -40%),followed by to postpone child bearing (PCB-36.41%).(figure 2) Among newly married couples the reason given for termination were professional commitment, complete graduation, travel abroad, two among them were not married and not in steady relationship. Among parous women the common reason given was first child was too young Unfortunate are those with contraception failure.16 women met with contraception failure (Table 2).

The women were enquired about prior contraception use (before abortion) and contraception acceptance in immediate post abortal period, following post abortion counselling were compared (Table 3). Following post abortal counselling the contraceptive use increased by 74.2% and use of modern method increased by 2 fold (79.5% compared to 29.2 % prior counselling). Obvious in our study that 67 out of 78 women who want stop child bearing readily accepted sterilization following post abortion counselling (34-4%).

Among temporary method intrauterine contraceptive device (IUCD) leads the list (17.4%) followed by pills and barrier. Injectable contraceptives (1%) were less accepted in our study group, because most women were working and preferred cyclical control

Odds Ratio for total contraceptive use O.R, 8.46 95% C.I (5.1-14.1), p-value 0.0 *(Among previous contraception users 16 met with contraception failure, 5 IUCD users discontinued due to bleeding disturbances and the rest were not compliant)*

The percentage of women not using contraception decreased with increasing age(p 0.0)

and parity(p 0.0) marital years (p 0.0), previous abortion history (p 0.023).Odd's ratio follow the same significant line, decreased risk of women not using contraception with increasing age, parity and marital years. Remarkable for parity (24 times decreased risk with increasing parity). We failed to convince few women (15.9% denied contraception) and the reasons given were recorded (Table 4).

Follow up: Women who had post abortal counselling were followed up by phone call 5months later. Extended follow up showed that women persevered with contraceptive usage when it was initiated in the immediate in the post abortal period (p 0.0). 10.3 % discontinued in the interval period.

However women with spontaneous miscarriage (63) and women, who had termination for fetal anomalies (13), though accepted concurrent contraception (39) on an average used contraceptionfor 2 month period. Later 78%, discontinued for the obvious reason that they were anxious to conceive.

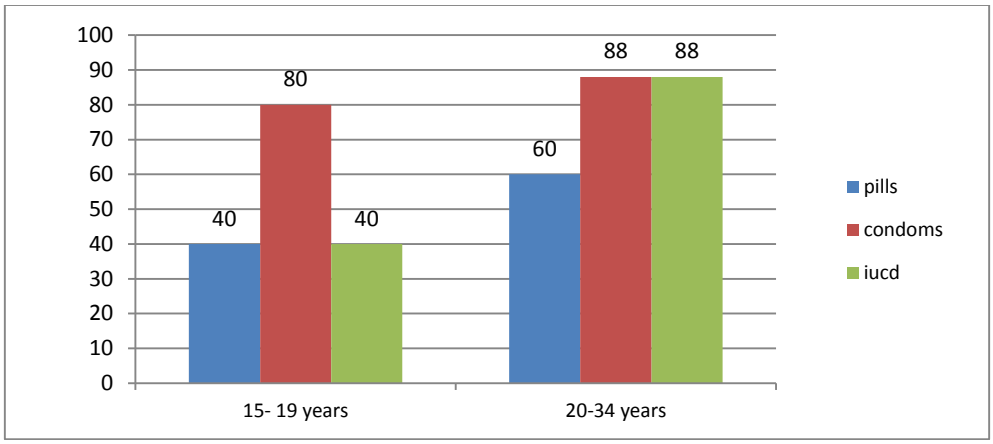

Figure 1: Knowledge of Pills, Condoms and IUCD at Vijaya Hospital

Table 1: Descriptive features of 258 women who had abortion and 195 who were induced among them were compared

Age (Years)	Total Abortion's (258) (Spontaneous + Induced)	Induced (195)
15-19	5 (1.9)	4 (2.1)
20-24	56 (21.7)	34 (17.4)
25-29	92 (35.7)	61 (31.3)
30-34	68 (26.4)	61 (31.3)
35-39	35 (13.6)	33 (16.9)
> 40	2 (0.8)	2 (1)
Gravid Status		
Primigravida	102 (39.5)	61 (31.3)
G2	55 (21.3)	43 (22.1)
G3	67 (26.0)	58 (29.7)
G4	23 (8,9)	22 (11.3)
G5	7 (2.7)	7 (3.6)
≥ G6	4 (1.6)	4 (2)
Education		
Illiterate	2 (0.8)	1 (0.5)
Literate		
Primary school	26 (10.1)	20 (10.30
High school or more	165 (64)	120 (61.5)
Professional	65 (25.2)	54 (27.7)
Socio Economic Status		
Lower	0	0
Upper Lower	15 (5.8)	10 (5.1)
Lower Middle	130 (50.4)	100 (51.3)
Upper middle	73 (28.2)	70 (35.8)
Upper	40 (15.5)	15 (7.69)

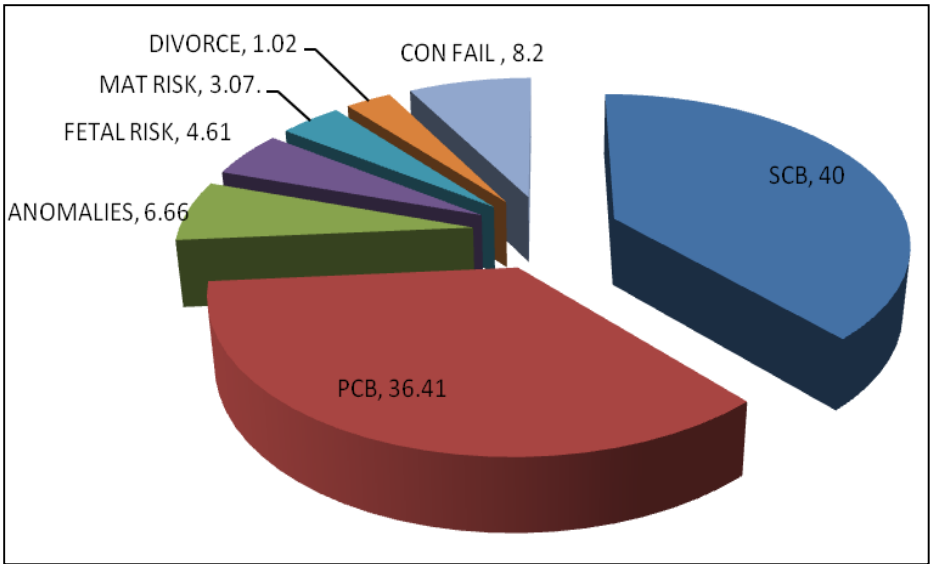

Figure 2: Reason for termination (%)

Table 2: Contraception failure

Method used	Contraception failure with ….(n)	Post abortal Contraception accepted
Rhythm method	12	All
Condom	1	All
IUCD	1	None
COC pill	-	-
Emergency pill	2	All

Table 3: Acceptance of concurrent contraception

Contraceptive Methods	Used Before abortion	Acceptance in immediate post Abortal period
	n (%)	n (%)
None used	120(61.5)	31(15.9)
Coitus interrupts and other traditional methods	24(12.3)	9(4.6)
Total modern methods	51(26.2)	155(79.5)
Tubal ligation	-	67 (34.4)
IUCD	6(3.1)	34(17.4)
Contraceptive pills	8 (4.1)	27 (13.8)
Condom	35 (17.9)	24 (12.3)
Injectable	-	2 (1.0)
Emergency contraception	2(1.0)	-
Vasectomy	-	1 (0.5)

Table 4: Reasons for Non acceptance

Reasons for Non acceptance	N
Wants to follow natural Method	8
I want to get pregnant	4
My husband is away from me	4
Fear Contraception failure	2
Reaching menopause	1
Unmarried	2
I have divorced	2
No reason	3
Total	31

Table 5: Concurrent contraception

Study Place	Acceptability Of Concurrent Contraception
Vijaya hospital 2007-09	79.5%
Mittal et al	63.8%
Turkish Family Planning study 2004	75.9%
Vermaashok et al (2003)	53.08%
ICMR STUDY (2004)	48.9%

DISCUSSION

Unmet need for family planning one of the primary causes of induced abortion[8].Despite adopting different strategic approaches the family planning programme in India has had a long and somewhat turbulent history and unwanted pregnancy is around 20%[1].

In our study majority were graduates, although the awareness is universal for sterilization, for temporary method it was only satisfactory.

Besides increase contraception awareness among women, unmet need was high (because many were not compliant).Unmet need was also high because for many professionals, carrier was the priority unlike home makers who are more likely to accept an unplanned pregnancy.

Contrary to National Family Health Survey 3(NFHS 3), traditional method (rhythm method) was followed more in our study group in combination with barriers. Educated women paradoxically developed fear for hormonal methods (OCP) and were more reluctant compared to illiterate population (concerned about weight gain and cancer).

In ICMR study though 42% women did not want any more children, misinformation and apprehension about different contraceptive options prevents widespread contraceptive use[9]. Instead abortion was considered as an alternative.

Ali Ceylan et al in his study observed 55.3% did not use contraceptive, despite the fact that contraceptive were available free of cost at PHC's. On exploring many had no reason, rest believed they will not become pregnant, or the reason being they have recently delivered[14].

As comparable to other studies, the most common reason for termination was that women do not want any more children, followed by to post pone child bearing. Comparable to other studies contraception failure was only 8.2% in our study group. In ICMR study the contraception failure rate was 7.8%[9].

Contraceptive use has remained a mirage for long but post abortal counselling gave a different dimension and scope. Voluntary post abortion contraception is recommended to reduce unintended pregnancies and repeat abortions and to reduce the risks of adverse maternal and perinatal outcomes for pregnancies following induced or spontaneous abortion[11,12].Comparable to other studies post abortal contraceptive acceptability was striking in our women(Table 5).

Study by Mittal.S et al, also showed increase contraceptive usage following post abortion contraceptive counseling[13]. IUCD was the preferred method of choice in the above studies (46.5%).

In our study permanent sterilization was more readily accepted in women who completed their family (34.4%), followed by IUCD (17.4%) in women who wanted to space.Also use for modern method increased by 2 fold, and use of traditional method and coitus interruptus decreased by 62.5% .

Education and socioeconomic class had no positive effect. Turkish study[14] also showed, age, education level, future fertility plan, previous induced abortion showed no potential significance. FIGO, ICM, and ICN have committed to fully collaborate across their professions to optimize the provision of post abortion care[15].

15.9% did not accept concurrent contraception. Two women in our study group had 4 prior abortions for social reason, still reluctant to use contraception on religious grounds.

However in ICMR study, one-third of women the reason given was "HUSBAND OBJECTED". Counselling couple as a whole was expected to improve contraception[9].

CONCLUSION

Once bitten, twice shy. The post abortal period is the best time to introduce contraceptive advice, since this would be the time women be more receptive to receive messages to avoid another unwanted pregnancy. Motivation can further be enhanced by a '**couple counselling'** where available contraceptive choices can be detailed clearing their myths and taboos. Appropriate sharing of responsibilities among doctors, midwives, nurses and community health workers can ensure a quality care.

REFERENCES

1. International Institute for Population Sciences (IIPS) and Macro International. National Family Health Survey (NFHS-3), 2005-06, vol. I. India, Mumbai: IIPS; 2007.
2. Saroj Pachauri. Priority strategies for India's family planning programme Indian J Med Res 140 (Supplement), November 2014, pp 137.

3. Henshaw, S.K. and Morrow E, "Induced Abortion: A Worldwide Review", Family Planning Perspective, 22:76-89, 1990.
4. World Health Organization (WHO). (2011). Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. 6th Edition. Geneva.
5. Sedgh G, Singh S, Shah IH, Ahman E, Henshaw S, Bankole A. Induced abortion: Incidence and trends worldwide from 1995 to 2008; Lancet 2012; 379 (9816), 625–632.
6. Johnson HB. "Abortion Practice in India. A Review of Literature". Abortion Assessment Project –India. CEHAT: May 2002
7. Odeyowu OI. Contraceptive use, prevention of unwanted pregnancy and unsafe abortion: the need for post abortion counselling. Women's Health Forum 2000; 5:6 - 7.
8. Smith R, Ashford L, Gribble J, and Clifton D. Family planning saving lives. 4th Edition.Washington, DC: Population Reference Burea 2009
9. BS Dhillon, N. Chandhiok. Induced abortion and concurrent adoption of contraception in the rural areas of India (AN ICMR task force study). Indian Journal of Medical Sciences: 2004, Vol.58, 11; Pg.478 - 484.
10. Bedi N. Kambo I, Dlullon BS, Sauena BN, Singh P. Maternal deaths in India – Preventable strategies (ICMR Task Force Study). I Obestet Gynaecol India. 2001; 51:86- 92.
11. High Impact Practices in Family Planning (HIP). (2012). Post abortion family planning: strengthening the family planning component of post abortion care. Washington, DC: USAID. Availablefrom: www.fphighimpactpractices.org/resources/postabortion-family-planning-strengthening-family-planning-component-postabortion-care.
12. Marston C. Report of a WHO technical consultation on birth spacing, Geneva, Switzerland, 13–15 June 2005.
13. Mittal S. Contraception after medical abortion. Contraception 2006 Jul; 74(1): 56- 60.
14. Ali Ceylan, Meliksah Ertem, Crum off Salka. Post abortion family planning counselling as a tool to increases contraceptive use. BMC Public Health. 2009; 9:20.
15. Family planning: A key component of post abortion care .Consensus Statement: International Federation of Gynaecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), and the United States Agency for International Development (USAID), 25 September 2009.