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Unsafe Abortion and Post Abortion Care: Patients Profile and Perceptions in Lagos, Nigeria

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Abstract: Postabortion care is a strategy for reducing the major contribution of unsafe abortion to maternal mortality. Its deployment has been lukewarm in many developing countries and an appraisal of the patients and factors that might hinder its uptake would be worthwhile to reduce the incidence of unsafe abortion. Questionnaires were applied to 435 patients who presented at the emergency ward with complications of unsafe abortion. Information sought included socio-demographic details, past obstetric history, reasons for procuring abortion, method, place and pedigree of the abortionist. Others were perception of the abortion process, knowledge of postabortion care and attitude to its various components. About 72% of the respondents were educated, 56% were married while 75.5% had experienced an abortion before the index case. About 64% did not employ any contraception in between the abortions due to various misconceptions while 94% regarded abortion as an acceptable mode of contraception. Almost half of respondents believed that contraception could predispose to infertility. These findings highlight that major components of postabortion care were deficient and will need to be incorporated into practice to attain the MDG 5.

Key words: MDG, postabortion care, unsafe abortion, IPAS, contraception, Nigeria

INTRODUCTION

About 75 million unwanted pregnancies occur annually worldwide, accounting for 4 in every 10 pregnancies (Ekanem *et al*., 2005). An estimated 46 million induced abortions are performed annually (The Alan Guttmacher Institute (AGI, 1999) of which about 20 million are unsafe with 95% of them occurring in developing countries (WHO, 1998). Complications from spontaneous abortions and unsafe induced abortions pose a serious global threat to women's health and lives (Corbett and Turner, 2003). Unsafe abortions accounts for an estimated 13% of maternal deaths representing about 67000-80,000 women and serious complications in many others (UN, 2008; WHO, 2003; Henshaw *et al*., 1998).

The World Health Organisation defines unsafe abortion as any procedure for terminating an unwanted pregnancy either by persons who lack the necessary skills or is conducted in an environment that lacks the minimal medical standards or both (The Alan Guttmacher Institute, 1999) and tragically, unsafe abortion is the most easily preventable cause of maternal mortality (Starrs, 1997). In Nigeria, the abortion law prohibits induced abortion except for medical reasons in order to save the life of the woman. In spite of the law, it has been estimated that 610,000 induced abortion occurs yearly in Nigeria (UN, 2008; Henshaw *et al*., 1998). Prevalence of induced abortion has been quoted as ranging from 25-55% among adolescents in schools and 88-94% among out of school single women (UN, 2008; Emuveyan and Agbogboroma, 1997). Strategies for reducing the high incidence of unsafe abortion include health education and the implementation of postabortion care.

The term postabortion care was proposed by IPAS in its 1991 strategic planning document which sought to encourage the integration of postabortion care and family planning services in health care systems as a means of breaking the cycle of repeated unwanted pregnancy and improving the overall health status of the women in the developing world (Ipas, 1991).

Lagos State University Teaching Hospital is one of the busiest tertiary gynaecological centers in the most populous country in Sub-Saharan Africa. It is the major hub for the management of post abortion complications and it has been reported that abortion related deaths constituted 25% of maternal deaths in a study from the hospital.

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It was therefore considered appropriate to study patients with complications of unsafe abortion seen at the hospital with a view to appraising their socio-demographic characteristics, the quality of postabortion services they received both before and during the index event, their perception, understanding and acceptance of the various components of postabortion care and identifying factors that might be responsible for the weaknesses in the regional PAC model.

MATERIALS AND METHODS

This study was carried out between 1st January 2007 and 30th of November 2008 at the Lagos State University Teaching Hospital, Ikeja. The Research and Ethics Committee of the Hospital approved the study design. All patients who presented with complications of unsafe abortion to the Casualty clinic and the Gynaecology clinic of the department of Obstetrics and Gynaecology were counseled. All 435 patients who consented were recruited for this study.

Pre-tested and semi-structured questionnaires were administered by the researchers to these postabortion care patients. Questions asked included the age of the patients, past obstetric history, marital status, level of education, reasons for the abortion where the abortion was performed and level of service provider and the method employed, contraceptive practice before last pregnancy, type of contraceptive used and reasons for failure.

They were asked to assess the quality of PAC received on a numerical value scale rating from 0 (poor) to 10 (very good) for those who had experienced previous abortion experiences before the index one.

The results were collated and data analyzed with the SPSS version 11. The Pearson Chi-square test was used to compare variables with level of significance set at $p<0.05$ and other data were expressed in simple percentages.

RESULTS AND DISCUSSION

About 400 questionnaires were completed and analyzed a percentage of 92.

Age distribution: The mean age of the respondents was 28.2 (SD 5.53) years. Majority of the patients (69.5%) were between ages 19-30 years while there was no respondent below age 19 years and only 2 (0.5%) above 42 years (Table 1).

Marital status: More than half of the patients 224 (56%) were married, 168 (42%) patients were single and 2 (0.5%) patients were widows (Table 1).

Educational status: Majority of the patients (70.4%) attained either secondary or tertiary education. Only 5 patients (1.3%) had just primary education while 108 (28.3%) patients had no formal education (Table 1).

Past obstetric history: All the patients had been pregnant at least once and a maximum of seven pregnancies were recorded, 288 (74.2%) patients had between 1 and 3 pregnancies and only 6 (1.5%) patients had >6 pregnancies, 147 (43%) patients had not had any delivery while 163 (47.7%) patients have had 1-3 deliveries. The modal group is para 0. About three quarters of the patients, 302 (75.5%) reported only 1 abortion before the index case while 12 (3%) patients reported having had 4 abortions (Table 2).

Table 1: Shows the age, marital status and educational level distribution among these patients

Age (years)	No. of patients	Percentage
19-24	130	32.5
25-30	148	37.0
31-36	94	23.5
37-42	26	6.5
Above 42	2	0.5
Total	400	100.0
Marital status		
Single	168	42.0
Married	224	56.0
Divorced	6	1.5
Widowed	2	0.5
Total	400	100.0
Educational level		
None	108	28.3
Primary	5	1.3
Secondary	139	36.5
Tertiary	129	33.9
Total	381	100.0

Table 2: Shows the past obstetric history of the patients

Characteristics	No. of patients	Percentage
No. of pregnancy		
1-3	288	74.20
4-6	94	24.20
>6	6	1.50
Total	388	100.00
No of deliveries		
No delivery	147	43.00
1-3	163	47.70
4-6	32	9.36
Total	342	100.00
No. of previous abortion		
0	25	6.30
1	302	75.50
2	52	13.00
3	9	2.30
4	12	3.00
Total	400	100.00

Influence of religion: Protestant Christians constituted 44.9% (162) while Muslims constituted 34.3% at 124. Christians of the catholic denomination alone made up 20.8% of the respondents (p = 0.01), Christian to Muslim ratio.

Justification for index abortion: Concerning the reasons for the index abortions, 111 patients (29.3%) were not ready to be parents and 108 patients (28.5%) though ready but not financially capable to care for a baby. Only 10 patients (2.6%) claimed the abortion was for health reasons.

Inferred quality of the abortion process: Table 3 shown the inferred quality of the abortion process. More than half of the patients 206 (52.6%) had their last abortion in a hospital while 97 patients (24.7%) had it performed at home. Amongst these patients 213 (54.1%) had their abortion performed by nurses. Doctors performed it in 147 patients (37.3%) and 6 (1.5%) patients performed the abortion on themselves. Almost two-third of the patient, 246 (63.1%) had dilatation and curettage or Manual Vacuum Aspiration (MVA). Most patients did not differentiate between the two. About 16 patients (4.1%) used native herbs.

Table 3: Shows quality of the abortion process

Abortion details	No. of patients	Percentage
Location		
Hospital	206	52.6
Chemist shop	20	5.1
Nursing home	69	17.6
Home	97	24.7
Total	392	100.0
Service provider		
Doctor	147	37.3
Nurse	213	54.1
Chemist	14	3.6
Native doctor	14	3.6
Self	6	1.5
Total	394	100.0
Method used		
Native herbs	16	4.1
Oral tablets	54	13.8
Dilatation and curettage/MVA	246	63.1
Vaginal pessaries	24	6.2
Injections	50	12.8
Total	390	100.0

Contraceptive practice preceding index abortion: When asked about contraceptive practice before the pregnancy that led to the index abortion only 260 patients who had had earlier abortions responded. About 166 (63.8%) claimed not to have employed any contraception. Increasing age seemed to have significantly impacted positively on contraceptive use ($X^2(3) = 16.703$, $p<0.05$ (two tailed) and there was an inverse correlation between the number of previous abortions and contraceptive use ($X^2(2) = 11.823$, $p = 0.003$ (two tailed) (Table 4).

Further analysis of the forms of contraceptive used and perception of abortion revealed that the condom was the most used method by 32 (35.6%) of clients while about 60% claimed to have utilized some other unnamed, effective, modern contraceptive methods. An alarming 374 patients (94%) out of 398 respondents actually perceived abortion as a form of contraception. Reasons given by the respondents for not utilizing any contraceptives are shown on Table 5. Nearly half of the patients 76 (49.4%) had fear of not getting pregnant in future after they use contraceptives while 40 (26%) patients wanted another pregnancy and only 2 (1.3%) had no access to family planning services.

Patients assessment of the postabortion care received: When asked to rate the quality of postabortion care received in totality from all the care givers including the index abortion after the initial counseling on what it

Table 4: Contraceptive use by age groups and previous abortions

	Age (years)					
Use of contraceptives	19-24	25-30	31-36	37-42	Above 42	Total
Used	9.0	51.0	23.0	9.0	2	94.0
Percentage	16.7	48.1	31.1	37.5	100	36.2
Did not use	45.0	55.0	51.0	15.0	-	166.0
Percentage	83.3	51.9	68.9	62.5	-	63.8
Total	54.0	106.0	74.0	24.0	2	260.0
Percentage	100.0	100.0	100.0	100.0	100	100.0
	No. of abortions					
Use of contra-ceptives	1	2	3	4		Total
Used	56.0	32.0	2.0	4.0		94.0
Percentage	31.1	55.2	20.0	33.3		36.2
Did not use	124.0	26.0	8.0	8.0		166.0
Percentage	68.9	44.8	80.0	66.7		63.8
Total	180.0	58.0	10.0	12.0		260.0
Percentage	100.0	100.0	100.0	100.0		100.0

Table 5: Shows the various reasons for not using contraceptives among the patients

Reasons	No. of patients	Percentage
Wants another pregnancy	40	26.0
No access to family planning services	2	1.3
Fear of not getting pregnant in future	76	49.4
Fear of side effects of contraceptives	19	12.3
Husband or partner's disapproval	7	4.5
Did not know about family planning	10	6.5
Total	154	100.0

entails, more than half of the patients 220 (55.8%) rated the services received as fair while 89 (22.6%) patients felt that the services were poor.

This study highlighted either the absence or ineffectiveness of a formal postabortion care protocol at the community level where 63.8% of patients emerging from an abortion experience still did not use any contraception before another recurrence; more worrisome perhaps is the perception of abortion as another method of contraception by 94% of 398 of the patients.

The mean age of the patients in this study was 28.2 years with 69.5% between ages 19-30 years which though a period of intense sexual activity encompasses late adolescence and the single out of school period (Emuveyan and Agbogboroma, 1997). This also was the age bracket where contraceptive use after earlier abortion was distinctly different at 16.7% for ages 19-24 years compared to 48.1% for ages 25-30 years and was probably modulated by other factors such as marriage and job demands.

It is significant that there was no patient younger than 19 years in this study. This is incongruent with the findings of other authors who showed that over 60% of females have had sexual intercourse by age 18 whereas over 80% of them do not use any form of contraceptives. National Population Commission Nigeria, 2000; Oye Adeniran *et al*., 2005) and constitute a significant proportion of abortion seekers in the country (Adewole *et al*., 2002). This might indicate that people in this age bracket do not get to the hospital and might not benefit from post abortion care which is a strong indication for setting up youth friendly centres.

Married status, education and did not influence the uptake of postabortion care in this study as there was no significant difference in the number of patients for the two variables. This might be an indirect corroboration of earlier findings that though education and marital status are strong influences on the use of contraceptives (Oye Adeniran *et al*., 2005; Zlidar and Gardner, 2003) the educated women are more likely to have an abortion if their contraceptive fails and terminate a pregnancy which might interfere with their schooling or joining the work force (Oye Adeniran *et al*., 2004). The role of religion has been contentious so much so that a meeting of various religious leaders held in 2004 to debate the inclusion of reproductive health education into the curriculum for secondary schools in Nigeria discouraged the promotion of the use of condoms or the use of terms like unprotected sex and safer sex (Faithbased Dialogue, 2004). However, it would appear that more christians, catholic denomination inclusive were involved in unsafe abortion and might suggest either a poorer uptake of contraception or a less restrictive disposition to seeking abortion.

Almost all the reasons given to justify the abortions are clear-cut indications for contraception and an indication of the unmet postabortion care needs in the community.

About 25% of the patients had their abortions performed at home. There is the need to intensify the counseling component of PAC both to the providers and clients to reduce such risk taking and further propagate the advantages of manual vacuum aspiration over curettage whenever the need arises. Counseling will also allay the fears of women that kept them from contraceptive practice.

The preference for condom as the method of choice in 35.6% of those who practiced contraception before their last pregnancy is a shift from earlier reports (The Alan Guttmacher Institute, 1999) and conforms with findings in recent studies probably reflecting the response to the educational campaigns and social marketing of condoms in response to the HIV epidermic (Oye Adeniran *et al*., 2005). It also might be a pointer to potential benefits of enhanced postabortion care propagation.

A significant limitation of this study was that it was institution based and might not have captured those women in the community who had no complications inspite of undergoing unsafe abortion. It was also not possible to exclude recall bias when patients were asked to rate earlier abortion processes and postabortion care received.

CONCLUSION

An estimated 120-165 million women including 12-15 million unmarried women want to prevent or space their pregnancies but are not using any methods (UN, 2008). This no doubt exposes them to unwanted pregnancies and likely unsafe abortions. The absence of a comprehensive and effective postabortion care structure in this environment has been highlighted by the high rate of recurrent unsafe abortions. The poor rating given to the postabortion care services by the patients in this

study should suggest the need for a change to the authorities. Expanding the scope of postabortion care into the community, integrating the treatment component and provision of contraceptive counseling and commodities within the same premises and incorporation of other reproductive health services as currently recommended (Corbett and Turner, 2003) will be necessary to attain the 5th MDG.

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