Termination of Pregnancy as a Method of Birth Spacing in Educated Class

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Objectives: The objective of this study was to find out prevalence of termination of pregnancy in educated class as a method of birth spacing. Reasons for considering the pregnancy as unwanted were asked and analyzed. **Study methods:** A study was carried out at a private clinic on patients visiting for gynecological or obstetrics problems. The patients who had termination at some stage of reproductive life and agreed to impart further information were interviewed using a standard questionnaire. **Results:** A large number of patients (28%) revealed that they have had terminated pregnancy at some earlier stage. 80% patients reported that the pregnancy was unplanned and unwanted. Main reason for termination being, birth spacing, adequacy of children, economic problems, worries about children's future, occupational status of the couple, educational responsibilities of one or both partners.. Unfamiliarity, unacceptability and non-availability of family planning services and failure of contraceptive measures were found to be the main causes of unwanted pregnancy. **Conclusion:** Despite being educated and having exposure to Family Planning Services, incidence of unwanted pregnancy is high even in this class. This puts the female partner at a risk of illegal abortion. Failure of acceptance of birth spacing methods is mainly due to lack of counseling on the part of health workers.

Key words: Termination of Pregnancy(TOP), Maternal Mortality Rate (MMR), Family Planning.

The term *'abortion'* covers both accidental and intentional interruption of pregnancy, although the word *'termination'* is often used for intentional act. Termination of pregnancy (TOP) entails risk of severe complications even mortality. Generally the patients are not aware of these risks. Even those patients who are aware of the risks of possible post-abortion complications, seek induced abortion. The patients approach all types of 'Health Care Providers' for terminating unplanned/unwanted pregnancies. The methods used for termination are generally known to the patients. The choice of the Health Care Provider is based on access, availability, presumed safety and cost.

In Pakistan TOP is allowed only in case of abnormal fetus or when the pregnancy endangers life of the mother. TOP due to choice of the patient is illegal in Pakistan. Therefore, the providers of this service generally work clandestinely. Due to this reason the quality of service, competence of the professional/quake and facilities available are generally below the requisite level. This inherent deficiency adds to the risks which are already prevalent in the very procedure. Since the service is generally provided in a secretive manner, efforts are made to cover-up the ensuing complications which further complicate the situation. As a result, the patients do not get proper advice and assistance in post-TOP phase. In many cases, these complications attain unmanageable proportion. The social environment and legal restrictions on TOP in Pakistan is the main cause of lack of data on TOP.

A few case studies available provide only partial data on this subject. Data on abortion deal mainly with women who are admitted in hospital for serious post-abortion complications. Termination of pregnancy ending in complications and subsequent admission in public hospitals have always been a focus of study. There are innumerable terminations which remain unnoticed and are never reported. These are the ones which give confidence to the abortion seekers and the service providers. Aim of this study was to assess:

1. The magnitude of terminations carried out in Pakistan in a year
2. Experiences of women having TOP,
3. Couples' knowledge of available family planning services
4. Factors leading to termination of pregnancy in restrictive, socio-cultural environment where choice abortion is illegal
5. Short and long term post-TOP complications,
6. Procedures adopted for TOP,

Patients and methods:

This study spans over a period of two years from January 2001 to December 2003. A total of 3752 patients were examined in the Out-Patients Gynae Department in a private hospital. All patients attending the Clinic for gynecological or obstetrical problems were enquired about miscarriages and TOP. Patients of all age groups who had had earlier TOP and were willing to provide further information were interviewed in detail. Information was collected according to a set questionnaire. 1,050 patients revealed that they had had their pregnancies terminated. Many of them had more than one termination and some of those had two/three terminations and a few had had even four terminations (Table-1)

Table-1: Number of TOP of a patient

	n=	%age
One Termination	58	51
Two Terminations	422	40
Three Terminations	62	06
Four Terminations	28	03

Confidence of couple on TOP was such that they opted for Second, third and even fourth termination instead of adopting a Family Planning method. Most of them did not have any serious complication which enhanced their confidence in TOP at the cost of family planning methods. The questions were aimed specifically to obtain information about reproductive morbidity, methods used for TOP, education of the couple. The reasons for termination, who made the decision, who provided the service and the methods used for termination were also inquired. Finances involved alongwith post-abortion advice was also noted. The reasons for not using routine family planning methods by some patients and knowledge of nearby family planning centers was also recorded. The reasons for unwanted/unplanned pregnancy were reported as under:

1. Contraceptive failure
2. Lack of cooperation from the husband,
3. Non use of family planning methods due to fear of side affects
4. Non availability and poor knowledge of family planning services
5. Emergency contraceptive advice was never taken. Even the educated couples were not aware of emergency contraception.

Results:

A total of 3,752 patients were questioned, out of which 1050 patients informed that they had had terminated pregnancy at some stage of reproductive life. 578(55%) couples (Table-2) opted for termination for birth spacing. However, in 231 (22%) cases, pregnancy was terminated due to large family size. Financial constraints were reported by 136(13%) couples for TOP. While 63(5%) quoted family circumstances for TOP as they had no help available to raise children since both parents were working.

Table 2: Reasons for termination (n=1050)

	n=	%age
Birth spacing	578	55
Too many children	231	22
Financial problems	136	13
Family circumstances	063	06
Medical disorders	042	04

Table 3: Mother's age at the time of termination

Age groups (Year)	n=	%age
15-20	126	12
21-25	231	22
26-30	242	23
31-35	073	06
36-40	094	09
Above 40	084	08

Age spread of the patients is detailed in Table-3. 746(71%) females were between 21-35 years Most probably, unknowingly they had taken such a high risk at a very young age. Maternal education has important influence on maternal mortality. Nigeria and Sri Lanka are equally poor countries having a literacy rate of 13 and 83 percent which reflects on the MMR in these countries i.e. 800 and 50 respectively[1]. The literacy rate is 22.3% in Pakistan and the mortality rate is high as compared to European countries[2]. Most of the couples were educated (Table-4) but still were not fully aware of the available family planning services. 61% contraceptive users reported failure of the contraceptive measures. Most of the women reported that their unplanned pregnancies were due to the husbands unwillingness in employing family planning methods, non-use of family planning methods by women due to fear of side affects as well as their minimal decision-making role in the realm of sexual relationship..

Table-4: Educational Level of the couples

	Husband		Wife	
	No.	%age	No.	%age
Matric	126	12	326	31
Intermediate	178	17	294	28
Bachelors	473	45	273	26
Masters	231	22	126	12
Higher qualification	042	04	031	03

Table-5: Decision makers

	n=	%age
Couples decision	483	46
Husband (only)	273	26
Wife(only)	210	20
Family members	074	07
Friends and neighbors	011	01

Most women had consulted their husbands prior to terminating their pregnancies (Table-5). However, a few had made the decision on their own due to conflict with the spouse or family. The in-laws had usually not been consulted. However, friends and in most cases neighbors had been involved in the decision making and subsequent TOP. 714(68%) husband and 830(79%) wives were not aware of the fact that TOP is punishable under law in Pakistan (Table-6). Most of the husbands, about (68%) (Table-7) were not aware of the available family planning services, even the location of the family planning centers and facilities were in their knowledge. In general, they had been consulting medical stores for family planning advice. The women were generally aware of the family planning centres and services but showed reluctance to visit the family planning centers. The reasons of their dissatisfaction were reported as under:

1- Unfriendly and discouraging environment.
2- Incomplete knowledge
3- Inadequate birth spacing advice.
4- Prompt in recommending tubal ligation,
5- The staff could not monitor and follow up the side effects of contraceptive medicines .
6- Poor counseling

7- Many workers encourage TOP instead of recommending family planning measures.
8- Indifference to the cultural and religious perspective.

Table-6: Awareness about the legality of TOP

	Husband		Wife	
	No.	%age	No.	%age
Aware	36	32%	221	21%
Unaware	714	68%	830	79%

Table-7: Awareness about availability of family planning services in their vicinity

	Husband		Wife	
	No.	%age	No.	%age
Aware	339	8%)	78	5%
Unaware	11	2%	472	45%

(It is assumed that the wives are more aware of the services. In Pakistan Society it is thought that it is the responsibility of women to seek family planning advice)

Table-8: Pre-TOP awareness of family planning methods and their failure rates.

	Husband		Wife	
	No.	%age	No.	%age
Oral contraceptives	231	22%	578	55%
Injectables	378	36%	735	70%
Sheaths	924	88%	819	78%
IUCD	336	32%	924	88%
Tubal Ligation	620	59%	977	93%
Vasectomy	273	26%	242	23%)
Emergency contraception	94	09%	126	12%

Failure rates of different family planning methods were not known to the couples (Table–8). Since most of the couples were educated, they had some idea about the complications of TOP. Therefore, they [651{62%}] approached a general practitioner or qualified specialist for TOP (Table-9). Method used for TOP was mainly dilatation and curettage [915 (87%)] and a few had used oral tablets. A number of patients had approached Hakims and homeopathic doctors for TOP. Some patients had gone to midwives and nurses who terminated the pregnancy by placing foreign bodies in the in the uterus (Table-10).

Table-9: Termination carried out by :

Midwives/LHV/Nurses	339	38%
General practitioners	483	46%
Specialists Obs. & Gynea	168	16%

Table-10: Methods of termination

Dilatation & curettage	914	87%
Placing foreign body in the uterus	94	09%
Oral tablets	21	02%
Homeopathic/Hakeems	21	02%

The cost of TOP ranged from Rs. 3000/- to Rs. 20,000/- The cost of the services of the specialist and the proper hospital facilities had been in the range of Rs. 20,000/- .Generally the patients had not been given any post-TOP family planning advice by the service providers except for the specialist doctors (Table-11).

Table-11 Post-TOP family planning advice

No advice	78%
Advice given	22%

The reported post-TOP complications were mainly general weakness, pain, fever, depression and menstrual cycle disturbance. Long term complications as chronic pelvic pain, chronic pelvic inflammatory diseases and infertility were reported (Table-12). Most of the couples were using some form of contraception after TOP while 346 (33%) couples were not taking contraception seriously even after TOP.

Table 12 : Post TOP Complications

Immediate	n=	%age
Generalized weakness	913	87
Pain	725	69
Fever	273	26
Excessive bleeding	336	32
Depression	367	35
Long Term		
Menstrual Cycle Disturbance	441	42
Chronic Pelvic pain	387	37
Infertility	189	18
Chronic pelvic inflammatory disease	252	24

Discussion:

Literate women are more likely to have TOP, probably education leaves them more aware of the benefit of small family size. Contraceptive failure rate is high in Pakistan as majority of the women who had TOP were using temporary methods of contraception. Most of these terminations were carried out in immediate post-partum period. Difficulty in the choice of the available methods of contraception is reflected in the high TOP rate and surgical sterilization rate. Although abortion is illegal in Pakistan, the service providers are performing terminations due to the need in the market and economic gains. It is promoted as a safe and risk free procedure by the service providers..

World wide 585,000 women die every year (one every minute) as a result of pregnancy or child birth[3]. Over 98% of all maternal mortalities occur in the developing countries[4]. 10-20 million women risk their lives every year by subjecting themselves to clandestine termination of pregnancy[5]. Before the enactment of the Abortion Act of 1967 in the United Kingdom, rate of maternal mortality was very high. This Act empowers the mother to decide about the TOP on her own. As a result the maternal mortality has reduced to insignificant level. In the UK, the terminations are done by skilled personnel under aseptic conditions in hospitals.

In this study, the patients belonged to educated middle and upper middle class. These patients generally approached skilled personnel. Therefore, the complications were minimum. The rich patients can afford private trained doctors which reduces risk of complications. But the poor pregnant females due to financial constraints end up with

untrained midwives/quakes for TOP and run very high risk of serious complications. More than one in four women is having pregnancy terminated. Therefore, there is a need for Government to enact a comprehensive abortion law to cover all aspects of the problem. In South East Asia, abortion laws are restrictive, therefore maternal mortality is higher as compared to European countries. In 1999 out of 54 African countries 26 allowed TOP only to save mother's life which has reduced mortality rate in those countries significantly. Pakistan reports an official estimated maternal mortality of 340/100,000 live births. Various studies from different areas of Pakistan report even higher figures [6]. Data collected in a large public hospital in Karachi over a period of 10 years (1981 to 1990) demonstrated that an estimated 10% of maternal deaths were due to abortions where the maternal mortality ratio was estimated as 710/100,000 live births. In a study by Sara Saleem and Fariyal Fikree [7] the abortion rate in Karachi was estimated 25.5 per 1000 ever married women of reproductive age. This rate is likely to be even higher if unmarried women were included. This high rate is suggestive of an unmet need for contraceptives among married women. However, this study revealed that most of the couples were using some form of contraception, still they ended up with unwanted pregnancy. Causes of the failure rate of the contraception needs to be studied. Almost all couples were unaware of emergency contraceptive measures. Emergency contraceptives should be made available at the pharmacies, specially the pharmacies near the health centers and also with the private practitioners.

The issue of TOP was discussed at length in the International Conference on women health held in Cairo in 1994 and in Beijing in 1995. This problem was again taken up in the Netherland at The Hague International Forum in 1999 where it was admitted that **abortion should on no account be promoted as a family planning method.** Despite of restrictive laws, TOP seems to be on the rise not only in poor class for birth spacing but also in younger generation of women who are educated and wish to continue their studies in urban environments. It is a serious public health issue particularly when it is performed illegally and by untrained personnel. The post-TOP complications such as infection, hemorrhage, uterine perforation, infertility, etc. burden the health services as a high number of patients are admitted in gynecological wards in public hospitals due to these complications.

In recent times, the younger generation is resorting to terminations at an earlier age, more frequent and earlier in the woman's reproductive life. It is due to economic reasons, to control fertility, and as a means of birth spacing, It is more common among women who become pregnant during post-partum period. This fact raises the question of access to family planning services and womens' acceptance of modern contraceptive methods and as to how women are assisted after they have had an abortion. In this study, 70% women had not been given any advice after a termination regarding prevention of pregnancy in future. Mis-perceived side affects and 'nuisance value' of the available family planning methods have a demoralizing effect on the patients. Motivated, well informed and properly trained family planning personnel should run the family planning centers.

Higher prevalence of TOP points to a change in behavior in matters of fertility and management of sexual relationship. These aspects should be taken into consideration in public health programs. Most often, women turn to TOP when a family planning need could not be met. Its frequency could be reduced through better access to the programs that are particularly intended for adolescent girls and young women. Improved access to family planning services, flexible abortion laws and post-abortion assistance will undoubtedly limit the health risk entailed in the clandestine TOP.

Even where health services are readily available, women may not use the service if the quality is poor. The quality of care, the respect given to the women in the family planning centers and the faith in the competence of the staff will encourage women to seek more help and advice from the family planning centers. Quality can be improved by imparting proper training to the staff, timely provision of drugs and supplies, increasing the number of female workers, establishing convenient hours, adequate staffing and ensuring privacy and confidentiality.

Another important aspect of the family planning service is to involve the husbands alongwith wives to educate them about the available family planning methods and their benefits. For this purpose male health workers should be trained and employed in the family planning centers.

Council for Women Health Project, WHO, UNICEF, FIGO and a number of NGOs working towards same goal. Efforts should be made to improve co-ordination amongst these departments and minimize overlapping which will help to achieve better results.

References

1. Briggs N: Illiteracy and maternal health: educate or die Lancet, 1993; 341 (8852): 1063-64.
2. UNICEF: A better future for children and women in Pakistan, Lahore 1995.
3. Count C. World Health Organization claims maternal mortality has been Underestimated BMJ 1996; 312: 398
4. Abu Zahir C, Royston E, eds|: Maternal Mortality: a fact book. Geneva: World Health Organization, 1991: 3 – 14.
5. Henshaw S.K. Induced Abortion: A World Review. Fam Plann, Perspect, 1990: 22:72-76
6. Jamil, S, Fariyal F.F: Determinants of Unsafe Abortion – Three Squatter Settlements of Karachi, Pakistan: The Agha Khan University, 1998.
7. Sarah F F.Fikree A Community and Hospital Based Study to Examine the Magnitude of Induced Abortion and Associated Gynecological Morbidity in Karachi, Pakistan. Agha Khan Hospital 1996 – 1998.