

Rising demand for comprehensive abortion care services in Nepal

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Abortion by and large is the second most important obstetric event in women's life next to pregnancy. Generally it means disruption of a nonviable pregnancy at or before 22-24 weeks period of gestation or when the aborted fetus weighs around 500gm. It has been postulated that out of 210 million pregnancies each year 46 million (22%) end in induced abortion globally, 78% occurring in the developing world. It has been also documented that in every year 20 million women who undergo unsafe abortion, nearly 97% are believed to occur in developing countries killing more than 70,000 women annually as a result of the procedure performed by individuals without the requisite skills, or in environments below minimum medical standards or both; besides leaving many women with permanent damages or serious morbidities.

The WHO estimates that one in eight pregnancy-related deaths result from unsafe abortions. In the developing world as a whole, an estimated five million women are admitted to hospital for treatment of complications from backyard abortion "clandestine abortion" such as infection, sterility or of death. National estimates of abortion-related hospital admissions in women aged 15-44 years compiled for 13 developing countries: Africa (Egypt, Nigeria, and Uganda), Asia (Bangladesh, Pakistan, and the Philippines), and Latin America and the Caribbean (Brazil, Chile, Colombia, Dominican Republic, Guatemala, Mexico, and Peru), when combined with supplementary data from five countries in sub-Saharan Africa (Burkina Faso, Ghana, Kenya, Nigeria, and South Africa) to obtain estimates for the three world regions, the annual hospitalisation rate varied 3 per 1000 women in Bangladesh to as high as about 15 per 1000 in Egypt and Uganda. Nigeria, Pakistan and the Philippines had rates of 4-7 per 1000, and two countries in Latin America with recent data have rates of almost 9 per 1000.¹

Experiences from our own country Nepal is no less. Isolated reports from the University Teaching Hospitals like, BPKIHS and TU Teaching Hospital; where many women seeking remedy from illegitimate and unwanted pregnancies (more on the grounds of lots of children) have either ultimately died due to complication of induced septic abortion or were compelled to live a life of forced barrenness (being hysterectomised) or bed ridden due to permanent damage (hemiplegia)²⁻³

Thus recognizing fundamental right of women and not denying access to safe abortion services, Nepal too decided to follow the world trait and legalized abortion in 2002 September, by 11th amendment to the Muluki Ain; which is a conditional law, allowing any woman to terminate the pregnancy d" 12 weeks (necessitating adolescent 16 years or below; to be accompanied by their parents/guardians) and pregnancy within 18 weeks that have resulted from rape or incest or at any time if pregnancy poses danger to the health of the mother and fetus.

For the first time, new wing for comprehensive abortion care (CAC) services was established in one of the main tertiary hospital of the Kathmandu Valley; Paropakar Shree Panch Indra Rajya Laxmi Devi Maternity Hospital (Prasutigirha, Thapathali), situated in the heart of the country on 18th March 2004 in addition to already existent MVA Unit which has been providing post abortion care (PAC) services, now for a decade since it's inception in 1995.

Abortion and it's complication seems to be one of the most important reason for admission in this hospital as vast number of women 20,043 (42% of total 45,077 gynecological admission over a period of a decade (1995-Dec 31st 2006)) were treated, mostly by manual vacuum aspiration for

incomplete abortion obtaining better client satisfaction with a touch of family planning counseling in the MVA Unit now improvised with the extension of PAC service all round the clock through 24 hours a day. Currently CAC Unit has shaped to be one of the country's largest service and training providing centre, shouldering 11% (n = 9620) of the country's total 85,984 abortion cases and catering 58 batches of training for 215 doctors and 199 assistant nurses.

As of the recent database developed by Family Health Division (FHD) and approved by Department of Health Services (DOHS), already 155: [Government (82) and private sectors (73)] CAC sites are listed consisting of wider coverage in 71 districts, with the completion of trainings of 311 service holder through 74 training sessions. [Sanju Bhattarai, Indira Basnet. Non –listed providers and non listed sites are the major challenges for ensuring access to safe abortion services.

Around the same time, other valley group of hospitals have also has started CAC services, to name Kathmandu University Teaching Hospital, which is also carrying research on medical abortion, Kathmandu Model Hospital and recently TU Teaching Hospital.

However it is surprising that in a nationwide study done by CREHPA (Centre for Research on Environmental Health and Population Activities), led by Ananda Tamnag, Mahesh Puri, Ashma Rana, Bishakha Yonzon] carried in 22 authorized CAC sites (13 governmental and 9 non governmental selected by stratified random sampling out of 87 sites) only ½ of the 2293 (85% of 2710) who received abortion service, did not know that the abortion was legal though the findings addressed more demand for the abortion service as only 64% (n=2710) of the total 4245 who visited the site for TOP (termination of pregnancy) could avail the service on the same day.

Non use of contraceptives among 200 women interrogated in Feb 2007 in Myagdi, Nepal were the main reason for pregnancy termination overlapping with the findings in the developed western world meeting 925 in teenagers which should be taken as serious issue.⁴

The development of manual vacuum aspiration to empty the uterine contents as a surgical procedure has now been followed by the use of misoprostol an oxytocic agent or mifepristone (anti progesterone) approved by CDC for medical abortion, used for research purposes in Nepal as an ongoing research project in KMCTH or as thesis topic in MD in Obstetric and Gynaecology in TUTH: with proven success rate in latter in 88-92% cases and has a better future tomorrow, being lesser invasive with no fear of *Clostridium sordellii* infection related to surgical procedure.⁵

Seen today, is the reduction of maternal death from induced septic abortion as observed even in TU Teachings Hospital Mortality Statistics in the recent 5 years period (2002-2006; MMR = 267/100,000 LB with 6 (13 %) out of 46 total maternal mortality in comparison to yester years (1997-2001) attributing to 7/37 (19%) total maternal deaths without much change in MMR expressed as 268/100,000 LB.

But our primary responsibility is to stop unintended pregnancy right in the beginning by making more adolescents and women aware that the answer to the unwanted pregnancy is contraception and not the abortion, latter having some complications even if they are fewer; by providing adequate education about contraception at the same time making sure that they are available or accessible learnt presently from growing demand for safe abortion services in Nepal.

References

1. Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet*. 2006 Nov 25; **368(9550)**:1887-92.
2. Sharma M, Uprety D, Pokhrel M, Karki A, Sharma U, Babu S. Maternal mortality at B P Koirala Institute of Health Sciences, Nepal: review of 6 years. *Trop Doct* 2005; **35(1)**: 25-6
3. Rana A, Pradhan N, Gurung G, Singh M. Induced septic abortion: a major factor in maternal mortality and morbidity. *J Obstet Gynaecol Res* 2004; **30(1)**: 3-8.
4. Beal MW. Update on medication abortion. *J Midwifery Womens Health* 2007; **52(1)**: 23-30.
5. Harvey N, Gaudoin M. Teenagers requesting pregnancy termination are no less responsible about contraceptive use at the time of conception than older women *BJOG*. 2007; **114(2)**: 226-9.