Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/mjafi

Original Article

Acceptance of family planning methods by induced abortion seekers: An observational study over five years

Brig S.K. Kathpalia*

Consultant (Obst and Gynae), Base Hospital, Delhi Cantt, 110010, India

ARTICLE INFO

Article history:

Received 16 April 2015

Accepted 6 August 2015

Available online 17 October 2015

Keywords:

Postabortion

Family planning

Contraception

ABSTRACT

Background: Prior to legalization of abortion, induced abortions were performed in an illegal manner and that resulted in many complications hence abortion was legalized in India in 1971 and the number of induced abortions has been gradually increasing since then. One way of preventing abortions is to provide family planning services to these abortion seekers so that same is not repeated. The study was performed to find out the acceptance of contraception after abortion.

Methods: A prospective study was performed over a period of five years from 2010 to 2014. The study group included all the cases reporting for abortion. A proforma was filled in detail to find out the type of contraception being used before pregnancy and acceptance of contraception after abortion. The existing facilities were also evaluated.

Results: 1228 abortions were performed over a period of five years. 94.5% of abortions were during the first trimester. 39.9% had not used any contraceptive before, contraceptives used were natural and barrier which had high failure. The main indication for seeking abortion was failure of contraception and completion of family. 39.6% of patients accepted sterilization as a method of contraception. The existing post abortion family planning services are inadequate.

Conclusion: Post abortion period is one which is important to prevent subsequent abortions and family planning services after abortion need to be strengthened.

© 2015 Published by Elsevier B.V. on behalf of Director General, Armed Forces Medical Services.

Introduction

Prior to legalization of abortion, pregnancies could be terminated on medical grounds only; but at times there were some personal, social or humanitarian reasons when pregnancy had to be terminated. Since there was no provision to terminate pregnancy other than on medical grounds; the patients had to

resort to illegal methods of pregnancy termination. This type of illegal abortion resulted in many complications. To put a check on rising incidence of illegal abortions along with its complications and to control population explosion; abortion was legalized in India in 1971 and the number of induced abortions has been gradually increasing since then.¹

Contraception can reduce the incidence of unwanted and unplanned pregnancies, thereby avoiding both legal and illegal

* Tel.: +91 9599600375 (mobile).

E-mail address: kathpaliasukesh@gmail.com

<http://dx.doi.org/10.1016/j.mjafi.2015.08.001>

0377-1237/© 2015 Published by Elsevier B.V. on behalf of Director General, Armed Forces Medical Services.

abortions. Patients who have had an induced abortion are highly motivated to switch from inadequate and infrequent methods to effective contraceptive methods.² When patients come for induced abortion they are very receptive to accept subsequent family planning measures^{3,4}; hence the patient requesting for abortion should be counseled about family planning. Post Abortion Family Planning (PAFP) involves the provision of contraceptive counseling and supplies to patients after they have had an abortion and it should be done before leaving the hospital. This is important as ovulation can start within two weeks after induced abortion.⁵ PAFP is an essential component of post abortion care (PAC), PAC is an important strategy to reduce maternal mortality by treating complications like hemorrhage and sepsis related to unsafe abortions, and PAFP services will prevent unplanned pregnancies and repeat abortions.⁴ A prospective study over five years was performed to find out the acceptance of contraception after abortion and critically evaluate the existing PAFP services and suggest measures to improve these services.

Material and methods

A prospective study was performed over a period of five years from 2010 to 2014. All the cases who reported for medical termination of pregnancy (MTP) to the hospital and those cases who had been admitted for any complication after undergoing induced abortion elsewhere were enrolled in the study. Those requesting for MTP were examined, investigated and underwent abortion provided all the criteria of MTP Act – 1971 were fulfilled. This was performed as outpatient or as in patient depending on the period of gestation and medical or surgical method being adopted. Socio demographic parameters like age, parity, period of gestation, indication for abortion etc were recorded. All the cases were enquired about their future planning regarding contraceptive after abortion. The cases that had undergone abortion elsewhere were also part of the study if they had reported to the hospital for any complication like hemorrhage, fever or sepsis. They were asked the same questions about the contraception planning as other cases. Post abortion follow up and any other untoward outcome if any were recorded. The data was collected, analyzed and compared with data available in literature. The procedures being practiced regarding PAFP were observed and evaluated, gaps noticed if any and measures recommended for improving these services.

Results

This prospective study was conducted at one of the service hospitals; where in the data for five years from 2010 to 2014 was collected. Age of the study group varied from 17 to 36 years, with average age being 23 years, parity of the study group is depicted in [Table 1](#). 1228 induced abortions were included in the study over a span of five years, of these 31 had undergone abortion elsewhere and were admitted for some complication. There were 1157 first trimester (94.2%) and 71 (5.7%) second trimester abortions ([Table 2](#)). Of the first trimester abortions 322 were performed by medical methods

Table 1 – Parity of the study group.

Parity	Number	Percentage
Nulliparous	36	2.9
Primiparous	471	38.3
Para three	688	56.0
Para four	31	2.5
Para five	02	0.16

Table 2 – Period of gestation and method of abortion.

Year	2014	2013	2012	2011	2010	Total
First trimester						
Medical	72	84	61	52	53	322
Surgical	182	210	149	146	148	835
Total	254	294	210	198	201	1157
Second trimester						
Medical	12	18	11	13	15	69
Surgical	01	00	00	00	01	02
Total	13	18	11	13	16	71

and 835 by surgical methods (dilatation and evacuation) whereas of 71 second trimester abortions; only two were performed surgically (hysterotomy). Surgical method was resorted to in second trimester as the medical methods had failed or were contraindicated.

A large number of cases (39.9%) had not used any definite contraceptive prior to this pregnancy, 31.1% had used male condom not so regularly and 25.9% were using natural methods including lactation. 38 of 71 cases of second trimester abortions had conceived during lactation. A small number of cases were on oral contraceptive (2.8%) but not regularly. There was one case of IUCD and sterilization failure each ([Table 3](#)). The two commonest indications ([Table 4](#)) for abortion in first

Table 3 – Contraception prior to index pregnancy.

Contraception	Number	Percentage
No contraception	490	39.9
Natural	319	25.9
Barrier	382	31.1
Oral pills	35	2.8
IUCD	01	0.1
Sterilization	01	0.1
Total	1228	100

Table 4 – Indications for abortion.

Year	2014	2013	2012	2011	2010	Total
First trimester						
Failure of Contraception	115	122	140	149	144	670
Completion of family	136	172	69	46	55	478
Unmarried	03	01	01	03	02	10
Total	254	294	210	198	201	1157
Second trimester						
Failure of contraception	00	00	01	00	00	01
Completion of family	08	14	10	09	12	53
Congenital Malformation	05	03	00	04	04	16
Unmarried	00	01	00	00	00	01
Total	13	18	11	13	16	71

Table 5 – Family planning method accepted.

Method	2014	2013	2012	2011	2010	Total
Female sterilization	92	128	102	85	79	486
Male sterilization	19	14	12	09	08	62
IUCD	32	29	18	19	21	119
Inject able	02	03	02	01	02	10
Barrier	54	39	42	51	43	229
Oral Pills	13	10	09	11	12	55
Nuva Ring	02	01	00	00	00	03
Unspecified	53	88	36	35	52	264
Total	267	312	221	211	217	1228

trimester were failure of contraception (57.9%) and completion of family (41.3%) while it was completion of family (77.4%) and detection of congenital malformation (22.5%) in second trimester abortion. 83 (6.7%) cases had undergone one or more induced abortions in the past. No abortion was conducted after fetal sex determination. There were 11 unmarried girls who had requested for abortion. 24 cases were denied abortion as duration of pregnancy was beyond 20 weeks and two were counseled to continue pregnancy, one had severe anemia and one was a case of previous two cesarean sections and wanted to delay pregnancy.

Female sterilization (Table 5) was the commonest method of family planning (39.6%) adopted by the couples and barrier contraception was the second (18.6%). Male sterilization was accepted by very few (5.0%). There was a large number (21.4%) who agreed to use contraception on their own; but did not disclose the exact details; presumably the choice was natural methods. Nuva Ring was a new introduction for the last two years and this was primarily the patient's choice. Nuva Ring is a new contraceptive and is not available free in the government supply.

There was no documentary record of 'Family Planning Counseling' to these patients who were seeking abortion. Due to overcrowding in the OPD and lack of space; the husbands were usually not part of the counseling as a routine. The option for family planning including the type of method offered was done casually and not individualized. The choice was not left to the patient as is expected in 'Cafeteria Approach' wherein every available method is offered to her and she herself makes the informed choice. The Lady Health Visitor (LHV) spent very little time on explaining and the same was done where she was doing her routine work, no privacy was provided. There were no arrangements for counseling for patients who had not opted for any permanent or semi permanent method of contraception at time of discharge from the hospital.

Discussion

Over 35 million abortions occur in developing countries each year; many of which are unsafe. If contraception services were accessible, used consistently and correctly by patients wanting to avoid pregnancy, maternal deaths would decline by an estimated 25–35%.⁴ Patients who undergo abortion spontaneously or induced require adequate medical care before, during and after abortion. PAC

includes treating the complications like hemorrhage and sepsis but it should include family planning services also which would reduce unplanned pregnancies in future since ovulation returns⁵ within two to three weeks after abortion, hence lack of family planning counseling and services may lead rapidly to another pregnancy and abortion. A patient who requests for abortion did not and probably does not want to get pregnant; hence she/couple should be provided adequate counseling followed by contraceptive of her/their choice.

This study was performed over five years to find out the acceptance of family planning after abortion and evaluate existing PAFP services. First trimester abortion is easier and safer,⁶ most of the cases (94%) in the study had reported well in time to be eligible for undergoing first trimester abortion. Second trimester abortion was done in 71 cases, 38 cases had conceived during lactational amenorrhea; when pregnancy was diagnosed they had already reached second trimester.

Though India was one of the first countries to launch a formal family planning programme in 1952 yet a large number of pregnancies occur due to non adoption of family planning methods.⁷ Contraception if any being used before this pregnancy was enquired into, 39.9% of the cases had not used any contraceptive. The rest had used barrier, natural and other methods and their use was inconsistent hence resulted in failure. There was one case of IUCD and sterilization failure each. In a study done in India showed that 70.4% of patients requesting for abortion had not used any contraceptive and this non use varied over different states.⁸ The main reasons for undergoing abortion were failure of contraception and completion of family, 54% and 39% respectively. Reasons for abortion reported in literature are similar that is 56% and 43% respectively as mentioned by Zaviet et al.⁸ in their study, which also mentioned that many women wanted to wait for normal menstruation before commencing contraceptive use. Contraception should be started immediately as pregnancy can occur before commencement of menstruation.

Half of the women undergoing abortion had accepted permanent or semi permanent methods of contraception, similar percentages were reported by Dhillon et al.,³ Mittal et al.⁹ and Mukhopadhyay et al.¹⁰ IUCD was the preferred method in their studies where as sterilization was so in this study. Male sterilization acceptance (5%) remains to be low.

Patients who come for abortion are the ones who have already been pregnant and that pregnancy was unwanted and unplanned. They are prone to conceive again hence family planning services should always be made available to them.¹¹ Studies from various settings in India have shown that 49%–96% of abortion clients want contraceptive methods after an abortion.³ Encouraging couples to use effective contraceptive methods is a valuable way to reduce voluntarily induced abortions either illegal or otherwise. This can be achieved by providing adequate information about the available contraceptive methods and helping couples to choose one that suits them.¹²

The existing PAFP services need to be improved and following are suggested-

- There should be separate room for counseling, where group, individual and couple counseling is possible.
- Husbands should also be part of counseling procedure.
- More time should be devoted to the procedure of counseling and to the satisfaction of the clients.
- Unmarried girls should be counseled regarding prevention HIV.
- Availability of contraceptives choices should be wider; it should include non government free supply contraceptives also.
- The option for family planning should be left to the couple and this should be an informed choice after all the knowledge is imparted.
- The staff needs to be trained in PAFP which is a unique situation and should be handled in a special way.
- Since the clients are already in the hospital, one needs a facility based implementation to improve family planning acceptance. Another round of counseling should be done before leaving the hospital.
- Proper documentation should be maintained.

Although the need for safe abortion services will not disappear if women's contraceptive needs are met, the link between abortion and family planning cannot be ignored if the epidemic of abortion is to be curbed and women are to have alternatives to often desperate choices.¹³

“If the woman we treat for postabortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice.” – Cynthia Steele Verme, 1994.

Conflicts of interest

The author has none to declare.

REFERENCES

1. Patel T, Leuva B. A 17 year review of voluntary termination of pregnancy. *J Obstet Gynaecol India*. 2006;56:522–528.
2. Bulut A. Acceptance of effective contraceptive methods after induced abortion. *Stud Fam Plann*. 1984;15:281–284.
3. Dhillin BS, Chandhiok N, Kambo J, Saxena NC. Induced abortion and concurrent adoption of contraception in the rural areas of India (an ICMR task force study). *Indian J Med Sci*. 2004;58:478–484.
4. Carolyn C, Douglas H, Tamarah M. Postabortion family planning: addressing the cycle of repeat pregnancy and abortion. *Int Perspect Sex Reprod Health*. 2010;36:23–35.
5. Goodman S, Hendish SK, Reeves MF, Foster RA. Impact of immediate postabortion insertion of intrauterine contraceptive device on repeat abortion. *Contraception*. 2008;78:143–148.
6. Barlett LA, Berg CJ, Shulman HB, et al. Risk factors for legal induced abortion related in the United States. *Obstet Gynecol*. 2004;103:729–737.
7. Sangeeta R. Participation of slum women in family planning programme in India: a case study. *Int J Mainstream Soc Sci*. 2011;1:3–7.
8. Francis ZAJ, Padmadas SS. Postabortion contraceptive use and method continuation in India. *Int J Gynaecol Obstet*. 2012;118:65–70.
9. Mittal S, Bahadur A, Sharma JB. Survey of the attitude to, knowledge and practice of contraception and medical abortion in women attending family planning clinic. *J Turk Ger Gynecol Assoc*. 2008;9:29–34.
10. Mukhopadhyay AK, Ghosh A, Goswami S, Adhikari S. Fertility regulation – 5 year study. *J Obstet Gynaecol India*. 2008;58:421–424.
11. Helena A. Factors influencing contraceptive uptake among women with induced abortion presenting at Kath, Kumasi-Ghana. *Glob Educ Res J*. 2014;2:209–242.
12. Parvati VB, Ashwini P, Pratap K, Sreekumar N. Contraceptive knowledge, practice and acceptance among women seeking termination of pregnancy at secondary level hospital in southern Karnataka. *Health Popul Perspect Issues*. 2008;31:157–162.
13. Salgar SG, Vijaya MR, Raina C. Postabortal acceptance of contraception. *Int J Pharm Biomed Res*. 2012;3:181–184.