Determinants of Induced Abortion at Referral District Hospital and Preventive Steps to Reduce Them

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***Abstract*- Aims and objectives-** To study the trends of induced abortion at district hospital, to study the determinants of induced abortion, to reduce the factors responsible for induced abortion. **Material and methods** –Retrospective study of 10 year duration of patients undergoing induced abortion .Total 1212 patients were studied. **Key words –** induced abortion, health education, women's autonomy. **Conclusion-**Except medical grounds all other grounds can be minimized to significant extend. It requires vigilance, health education, sex education, and couple counselling.

***Index Terms*-** induced abortion, health education, women's autonomy

I. Introduction

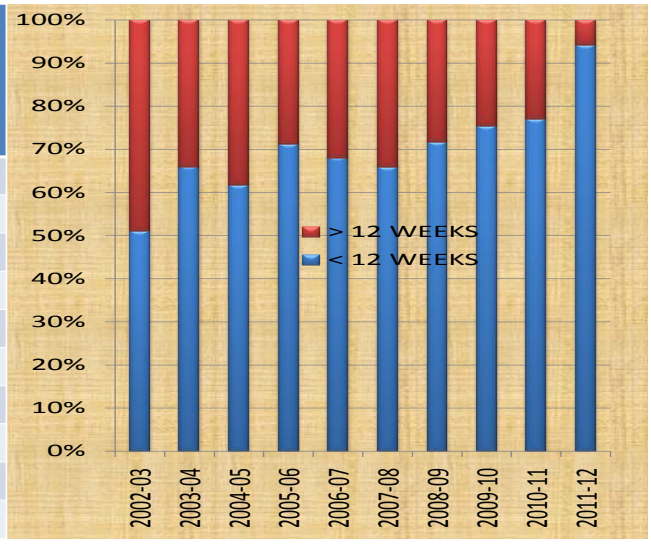
Human groups have since early times, developed attitudes against the willful destruction of foetus; at the same time they have also recognised its permissibility in exceptional circumstances .In India prior to 1972, abortion was illegal , but after the report of Shantilal Shah (1964) an act was implemented now known as Medical termination of pregnancy act (MTP act) all over India from November 1 ,1976. Since then the number of induced abortion has been rising tremendously. Because of its great safety & even greater impact on population control the importance of induced abortion cannot be undermined.

II. Material and Methods

This is a retrospective study of 10 year duration May 2002 to April 2012 conducted at government hospital , sangli.Total 1212 women undergoing abortions were studied according to their ages, parity, grounds for abortion , their socioeconomic positions ,their depth of knowledge regarding MTP and contraceptive methods were analyzed. Post abortion contraceptive method was also highlighted. The adolescent pregnancies especially unmarried females were questioned and councilled accordingly.

III. Observations

YEAR	TOTAL NUMBER OF ABORTIONS	< 12 WEEKS	> 12 WEEKS
2002-03	149	76	73
2003-04	153	101	52
2004-05	167	103	64
2005-06	170	121	49
2006-07	138	94	44
2007-08	120	79	41
2008-09	92	66	26
2009-10	110	83	27
2010-11	61	47	14
2011-12	52	49	3



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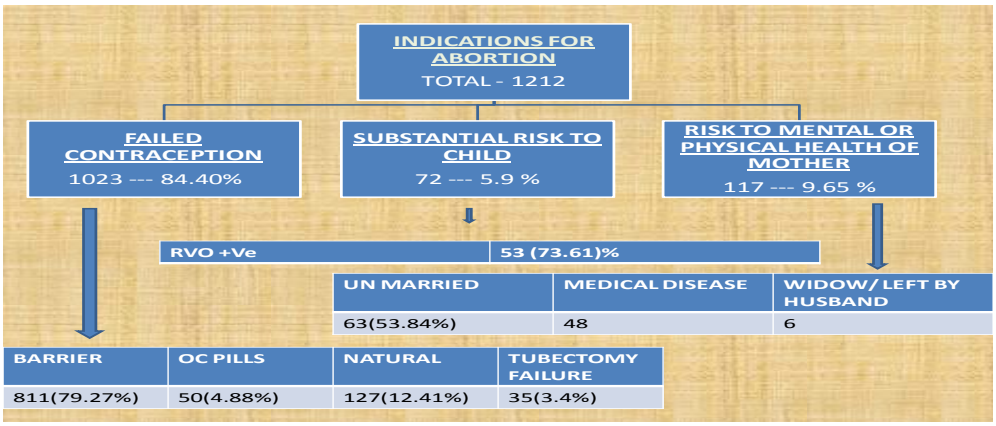
Total number of induced abortions have been reduced in our institute. The above graph shows the declining trends of induced abortion in our institute in relation more than 12 weeks.

Grounds under which these abortions were carried out were as follows



Distribution according to age and parity is tabulated as

15-19	20-24	25-29	30-34	>35
3.87%	43.39%	32.75%	13.86%	6.1%
G1	G2	G3	G4 and above	
6.43%	24.25%	52.31%	16.99%	

Future contraception opted by couples

Temporary contraception (IUD)	292	24.09%
Permanent contraception (sterilisation)	841	69.38%
councelling	75	6.18%

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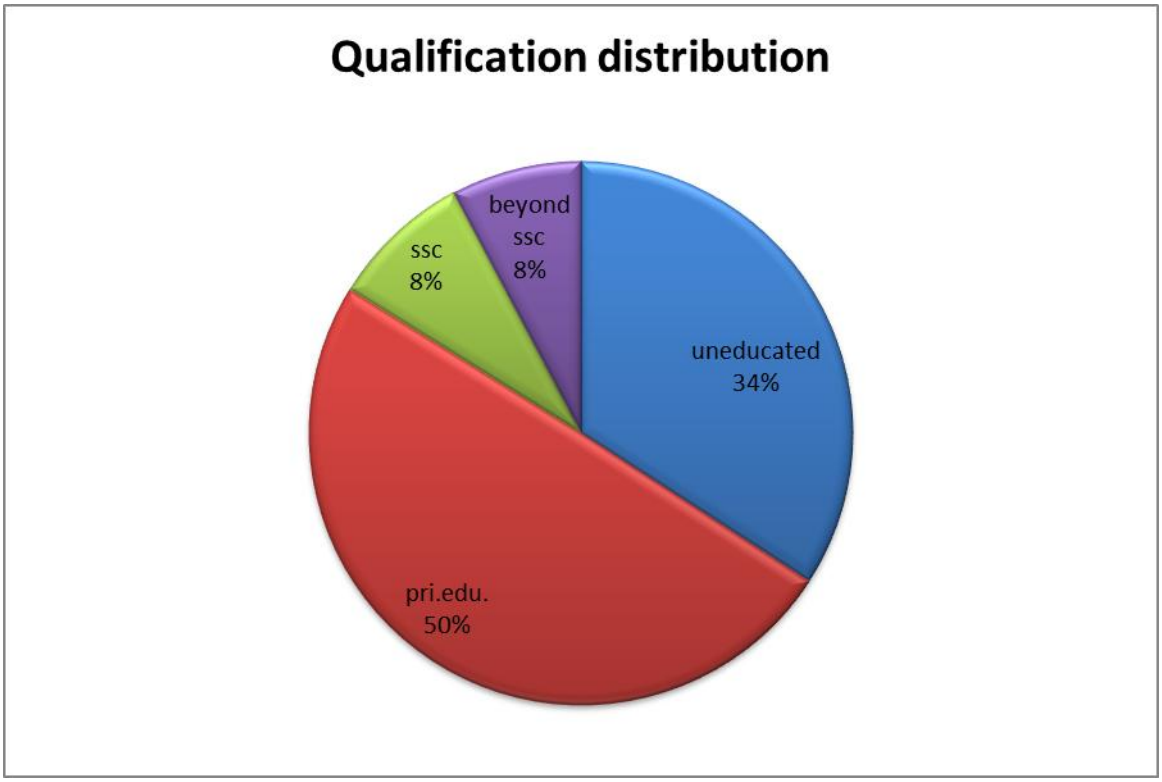
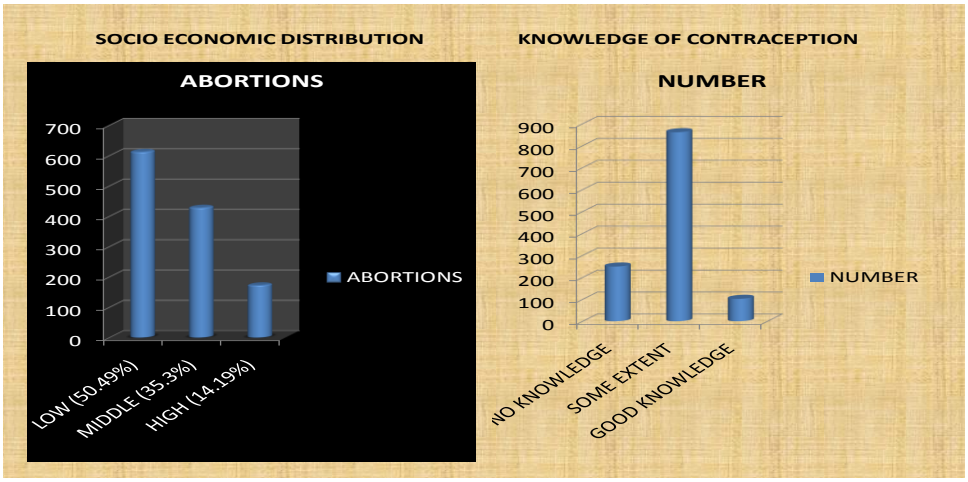
Qualification wise distribution of patients



Socioeconomic positions and knowledge regarding contraception and mtp



Patients from rural areas 582(48.01%) and from urban areas 640(51.99%).

IV. Results

Total number of induced abortions in this duration were 1212.The total number of abortions have been declined in our institute from 149 per year to52 per year. The number of patients undergoing first trimester abortion have been steadily rising from51% to94.23%.while second trimester abortions have reduced from 48.99% to 5.76%.

The commonest ground for termination of pregnancy was failed contraception.. Most couples were using barrier contraception (79.27%) next was natural methods 12.41%,o.c. pills (4.8%) The number of tubectomy failure was(3.42%) .Maternal ground for termination of pregnancy (risk to physical or mental status of mother) constituted 117(9.65%) out of which unmarried mothers comprised 63(53.84%) while others as medical disease of mother (41.02%) and widow ,left by husband 6 (5.12%). Continuation of pregnancy had substantial risk to baby constituted 72 patients out of 1212. 53 (73.61%) were with seropositive mothers ;others included congenitally anomalous fetus ,drug exposures (26.65%).

The observations concluded that age group 20-30 years constituted major bulk for termination of pregnancy (75.14%)while gravid a3 with two living issues were commonest (52.31%) to approach to district hospital for termination of pregnancy. We had 49.66% patients with primary education and uneducated were 34.15%; total being 83.81%. Patients with low socioeconomic and middle socioeconomic positions were 50.49% & 35.31% respectively while 14.19% were from high socioeconomic position. We did not find much difference between rural and urban area; 48.01% &51.99% respectively.

Patients with no knowledge about MTP and contraception constituted 249(20.54%) while patients with some knowledge were 861(71.03%)and good knowledge 102(8.41%).69.38% patients opted sterilisation as future method of contraception while 24.09% opted for intrauterine device .6.18% were councilled for future sexual behaviour while 3 patients refused any contraception ,one had conceived and then underwent sterilisation procedure ,while one absconded.

V. Discussion

The subject of abortion i.e termination of pregnancy is charged with emotion, superstition and religious beliefs. Indian law recognises the fetus as a special aggregation of cells with a potential of independant life and in this way protects the right of unborn child. With the establishment of MTP act , a woman in India can legally have abortion of unwanted child on some particular grounds . As this study is carried out at government district hospital it is reflection of that part of society which is at at most need of such kind of services. In our study the number of patients for induced abortion is declined from 2002 (149) to 2012(52) The historical abortion data of India Shows a steady rise in number of abortion from 1972 (24,300) per year to 25,29,979 in 2012.

In our institute the patients approaching for induced abortion before 12 weeks has been rising steadily while more than 12 weeks has declined. Bonne Scott Jones ,JD [1] mention that many women need access to abortion care in the 2nd trimester .Several studies indicate that the factors causing woman to delay abortion until second trimester include cost and access barriers ,late detection of pregnancy and difficulty in deciding whether to continue the pregnancy or not[2,3]. As thers is risk associated with pregnancy increases with weeks of gestation ,one study found that the risk of death increased by 38% for each additional week of gestation throughout the pregnancy. [4]The medical termination of pregnancy act and its amendments to remove the provisions which are discriminatory to women has significantly reduced the incidence of second trimester abortions Most patients approaching for induced abortion are in the age group of 20-30 years , ,multiparous and from low socioeconomic positions .. Patients with primary education constituted 49.66% .R Kongo ,Noorani kK.J.,[6] state that prevalance of poverty ,illiteracy grand multiparity are strong determinants of induced abortion .The low education & lower socio economy throws a woman into low levels of personal autonomy & she experiences significant difficulties in using family planning services.

Promotion of health education ,sex education at most primitive areas will definitely influence a woman to control her pregnancy according to her wish.

Despite the use of effective contraceptive methods , the majority of women requesting for termination became pregnant during use of these methods. This data reflects lack of compliance.[7] Although geographical access to family planning services remains a problem , the principle reasons for non use of contraception is lack of knowledge , fear of side effects , social and familial disapproval. The health programmes are likely to be successful when they reach beyond conventional boundaries of service provision to influence and alter the cultural and familial factors that limit voluntary contraceptive use.[8]

In our study the other ground for induced abortion was adolescent unmarried girl .The problem of adolescent pregnancies constitute a major social domain . Growing expansion of communication and transportation networks , urbanisation & in migration of population to urban areas,is creating a different sociocultural environment which is conducive to more social interactions between young girls and boys. Rising age of marriage has now opened a window of opportunity for premarital and unsafe sexual activity amongst young people.[9] It is very common among school girls ignorant of contraception.[10] .We not only advocate introduction of sex education in schools but also provision of contraception in school. Postabortal counselling must be taken into consideration..

HIV positive status of mother is one of the highest of all medical grounds for termination of pregnancy. Even with the invention of Antiretroviral regimens and ICTC programmes, offering the option of termination of pregnancy to prevent the least chance of transmission of disease to newborn can't be undermind. [11]

The termination of pregnancy on any ground is not much comfortable to mother. It carries emotional and ethical issues, especially when termination is carried out for congenitally anomalous baby or teratogenic exposure to a normal fetus . The ultimate decision regarding pregnancy outcome and management including termination belongs to pregnant couple.Clinicians will only council however the responsibility of clinicians is to help couple to make their own decisions based upon their personal, moral and cultural values [12.]

VI. Conclusion

The induced abortion for unwanted pregnancy should be only backup method but not a primary method of birth control. Except medical grounds all other grounds for induced abortions can be reduced to a significant extend. It requires vigilance, health education at grass route level, adolescent sex education in schools, postpartum clinics couple counselling. The autonomy of female must be respected throughout as she is the ultimate to enjoy or suffer.

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