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FIGO INITIATIVE

Replacement of dilation and curettage/evacuation by manual vacuum aspiration and medical abortion, and the introduction of postabortion contraception in Pakistan

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ABSTRACT

Manual vacuum aspiration (MVA) and medical abortion were introduced to replace dilation and curettage/evacuation for incomplete abortions, and postabortion contraception was provided in 5 selected public hospitals in Pakistan. In the largest hospital, an Ipas MVA training center since 2007, MVA use reached 21% in 2008. After the International Federation of Gynecology and Obstetrics (FIGO) and UNFPA provided MVA kits, MVA use increased dramatically to 70% – 90% in 2010 – 2013. In 2 of the remaining 4 hospitals in which the Society of Obstetricians and Gynecologists of Pakistan trained doctors in May 2012 and January 2013, the target of having 50% of women managed by MVA and medical abortion (MA) was met; however, in the third hospital only 43% were treated with MVA and MA. In the fourth hospital, where misoprostol and electric vacuum aspiration use was 64% and 9%, respectively, before training, an MVA workshop introduced the technique. Postabortion contraception was provided to 9% – 29% of women, far below the target of 60%.

1. Introduction

Unsafe abortion continues to be extremely common in Pakistan, despite changes in the legislation implemented in 1997 permitting pregnancy termination not only when required to save the woman's life, but also in the early stages of pregnancy to provide "necessary treatment" [1]. No further definition of this term was established, leaving its interpretation open to healthcare providers and to the population. However, the community and most of the policymakers and healthcare providers remain unaware of this change in legislation, and no public sector hospital performs pregnancy terminations for any indication other than to save the woman's life. This is also due to the heavy emergency workload of the public sector hospitals. Therefore, most induced abortions are performed in the private sector [2] by many different categories of healthcare providers including doctors, nurses, midwives, and dais (traditional birth attendants) [2]. The most common method used is dilation and curettage (D&C) [2–4].

The lack of service delivery statistics makes it difficult to determine the precise number of abortions in Pakistan. A nationwide study conducted by the Population Council in 2012 estimated the number of women admitted to either private or public healthcare facilities for abortion (based on in-depth interviews with a representative sample of healthcare professionals and a survey of healthcare facilities) to be 696 000, with 267 000 admitted to public sector facilities and 429 000 to private institutions. A study with similar methodology was conducted in 2002, and a comparison of the two studies shows that the number of women with abortions treated in public sector healthcare facilities in Pakistan rose only slightly between 2002 and 2012 (from about 246 000 to around 267 000), with population growth accounting for much of this increase [5].

The contribution of abortions, both spontaneous and induced, to maternal mortality was 5.6% according to the Pakistan Demographic and Health Survey (PDHS) 2006 – 2007, which covered 95 000 households [6]. This is much lower than the 11% reported in an earlier hospital-based survey performed by the Society of Obstetricians and Gynaecologists of Pakistan (SOGP), including over 100 000 births in

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1989 — 1990 [7]. The latter figure is closer to the 13% quoted for South Asia [8,9].

To avoid confusion, the terms dilation and curettage (D&C) and dilation and evacuation (D&E) need to be explained. In hospitals in Pakistan, dilation of the cervix and uterine evacuation (D&E) is carried out in cases of incomplete abortion, missed abortion, or septic abortion whenever the cervical os is closed. This is the same procedure mentioned in the World Health Organization (WHO)'s Safe Abortion Manual in the chapter "Clinical care of women undergoing abortion" for second trimester pregnancy termination [10]. After gradual dilation of the cervical os with Hegar dilators, the products of conception are removed with sponge-holding forceps or ovum forceps, and at the end, the uterine cavity is explored with a sharp or a blunt curette to ensure that it is empty. In some parts of the country, for example Punjab, the term evacuation and curettage (E&C) is used. The term dilation and curettage (D&C) is applied when a sharp curette is used to treat a first trimester incomplete abortion, to evacuate the uterus in cases of missed abortion (fetal demise), or for first trimester pregnancy terminations. In first trimester pregnancy terminations, the uterine contents are removed with a sharp curette after cervical dilation.

The off-label use of misoprostol for the induction of labor and uterine evacuation began in some hospitals in this country about 15 years ago when reports of its efficacy started appearing in the literature. After it was put on the WHO Essential Drug List, advocacy efforts were made with the support of the Research and Advocacy Fund to the provincial Departments of Health to include its use for reproductive health purposes. This proposal was approved in 2012.

Parity is generally high among women seeking induced abortions in Pakistan, with 88.7% having had 3 or more children and 68.2% having had 5 or more children [2]. This is not surprising, considering the low contraceptive prevalence rate of 35% and the high total fertility rate of 3.8 reported in the PDHS 2012 — 2013 preliminary report [11].

The present paper assesses the extent of the success achieved so far in replacing D&C/D&E with manual vacuum aspiration (MVA) and medical abortion for the management of incomplete abortion in 5 public sector hospitals. It also reports data on the number of women counseled and provided with a contraceptive method, as recorded by the trained attending physicians.

2. The International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences

Dr Dorothy Shaw began this initiative in 2007 during her term as FIGO President. The rationale behind this global initiative was the high rate of induced abortion resulting from unwanted or mistimed pregnancies, and the significant mortality and morbidity resulting from this cause in many countries [12,13].

Pakistan joined the FIGO initiative at its inception in 2008. Its plans of action were based on a situational analysis of unsafe abortion [3], and modeled on the 4-pronged preventive approach suggested by the general coordinator [14]. An important component of this approach is improving the treatment of complications of abortion in the cases admitted to the hospitals. Both FIGO and WHO [15,16] recommend a shift from sharp curettage to the use of aspiration techniques, particularly MVA, and to medical treatment with misoprostol, and this has been part of the objectives of the FIGO initiative in Pakistan for some years. Providers need to be trained and MVA equipment and misoprostol must be available to treat women with an incomplete abortion. Another important approach is the prevention of repeat unintended pregnancies, which will end in another abortion, by immediately providing not only postabortion counseling in family planning, but also a contraceptive method. The present article describes the progress achieved in Pakistan in the process of applying these approaches to the prevention of unsafe abortion and its consequences.

3. Interventions aimed at replacing curettage with MVA and misoprostol for the treatment of incomplete abortion

The interventions were performed in public sector hospitals, since this would enable a wide range of healthcare providers to be trained and counseled in the procedures, benefiting a greater number of women requiring these services. The hospitals selected were the Jinnah Postgraduate Medical Center (JPMC), Karachi; the Abbasi Shaheed Hospital (ASH), Karachi; the Sandeman Provincial Hospital (SPH), Quetta; the Nishtar Medical College Hospital, Multan; and the Hayatabad Medical Complex (HMC), Peshawar. These hospitals are all affiliated with a medical college and are also recognized by the College of Physicians and Surgeons, Pakistan (CPSP) as providers of postgraduate training in obstetrics and gynecology.

Prior to the interventions sponsored by FIGO and carried out by the Society of Obstetricians and Gynaecologists of Pakistan (SOGP), the JPMC was selected by Ipas in 2007 to be the first MVA training center in the country, since, with trainers and a large patient workload for "hands-on" training, it was considered a logistically suitable venue for an MVA workshop. Ipas conducted an MVA workshop for professionals at the ASH in December 2008; however, the hospital failed to obtain MVA kits because of their high cost and the procedure was not implemented.

The FIGO/SOGP intervention was initiated in 2010 when FIGO and UNFPA provided MVA kits, and FIGO supported two workshops (with part of the 2010 FIGO emergency funds) at the JPMC in January and July 2011. In 2012 and 2013, senior doctors trained their junior colleagues and the hospital began to purchase MVA equipment to ensure the continuous availability of this service.

Training was carried out in Peshawar and Multan in May 2012, and in Karachi for doctors from Quetta and Karachi in January 2013. Only doctors were included in these training sessions.

The initial workshops held between 2007 and 2009 trained doctors in MVA alone; however, from 2010 onward, training also included medical abortion and later (from 2011 onward) training was added on counseling and provision of a contraceptive method, particularly long-acting reversible contraceptive (LARC) methods, in collaboration with the reproductive health service centers at these hospitals.

4. Procedure for evaluating the impact of the interventions

Prior to and during the workshop, the participants were informed about the need to provide pre- and post-workshop data regarding abortion management and postabortion contraception to assess the impact of training on service delivery.

At the JPMC, Karachi, women with an incomplete abortion receiving treatment with misoprostol were not admitted to hospital and the necessary data were not recorded. For this reason, only the surgical treatment of incomplete abortion is reported for the period from January 2007 to September 2013. In the other 4 hospitals, the analysis compares the proportion of women with an incomplete abortion who were treated with curettage, misoprostol, MVA, or electric vacuum aspiration (EVA), before and after training, and after commodities were supplied.

5. Results

5.1. The number of doctors trained in MVA and medical abortion

Table 1 shows the number of doctors trained in the 5 participating hospitals, the source of support for the workshops, and the subject matter of the training courses. FIGO emergency funds were used from 2011 onward to train 94 doctors in the selected hospitals. They, in turn, trained