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CLINICAL ARTICLE

Postabortion contraception a decade after legalization of abortion in Nepal

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ABSTRACT

Objective: To assess the contraceptive information received and methods chosen, received, and used among women having abortions one decade after legalization of abortion in Nepal. **Methods:** We examined postabortion contraception with questionnaires at baseline and six months among women obtaining legal abortions ($n = 838$) at four facilities in 2011. Multivariate regression analysis was used to measure factors associated with method information, choice, receipt, and use. **Results:** One-third of participants received no information on effective methods, and 56% left facilities without a method. The majority of women who chose to use injectables and pills were able to do so (88% and 75%, respectively). However, only 44% of women choosing long-acting reversible contraceptives and 5% choosing sterilization had initiated use of the method by six months. Levels of contraceptive use after medical abortion were on par with those after aspiration abortion. Nulliparous women were far less likely than parous women to receive information and use methods. Women living without husbands or partners were also less likely to receive information and supplies, or to use methods. **Conclusion:** Improvements in postabortion counseling and provision are needed. Ensuring that women choosing long-acting and permanent contraceptive methods are able to obtain either them or interim methods is essential.

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1. Introduction

The legalization of abortion in Nepal in 2002 and subsequent scale-up of safe abortion services were important steps toward reducing high pregnancy-related morbidity and mortality [1,2]. Legalization also presented new opportunities to offer postabortion contraceptive information and supplies—important for reducing repeat unintended pregnancy and abortion [3]. Abortion visits are occasions to reach women who may not otherwise access health and contraceptive services. Accordingly, Nepal's Safe Abortion Policy has emphasized contraceptive counseling as integral to abortion care [4].

A systematic review found that postabortion contraceptive uptake in low-income countries was consistently higher among women receiving counseling and services (26%–67% increase) [5]. Willingness to adopt a method can be influenced by counseling content, including the range of methods discussed [6,7]. The one study evaluating the impact of counseling on repeat pregnancy and abortion found small beneficial effects [8].

After steady improvements, contraceptive prevalence in Nepal has plateaued since 2006 [9]. Only 43% of married women use modern methods, most commonly sterilization (23%) and injectables (9%), and women on average have almost one child more than desired [9]. Women seeking abortion are at elevated risk for repeat abortion; in a recent study, one-third of women at major abortion facilities in Nepal had experienced a prior abortion [10]. Empirical data on postabortion contraceptive services are needed to identify barriers to service delivery and method use. Data from Nepal's Health Management Information System indicate that half of women obtaining abortions at public facilities from 2009 to 2011 received a contraceptive method at the visit [1]. However, these data are reported by public facilities only and by the facilities themselves, and do not provide information on methods discussed, women's method preferences, or whether women use the methods they received.

The objective of the present study was to examine the contraceptive services received by women after an abortion and to identify gaps in services. We assessed sociodemographic factors associated with receipt of method information and supplies, as well as method choice and use, to determine which women may be at highest risk for repeat abortion.

2. Materials and methods

We used data from a prospective cohort study of 838 women obtaining legal, elective abortion at four health facilities in Nepal. The

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study sites—two nongovernmental clinics and two government hospitals—were selected to represent facilities across diverse geographies. The clinics are high-volume reproductive health facilities in the Western and Eastern regions. One hospital, in Kathmandu, is one of Nepal's largest maternity hospitals and receives referrals from throughout Nepal. The other, in the populous agricultural Terai region bordering India, is an important referral facility for surrounding districts. All nonpermanent contraceptives were available free-of-charge, except clinic 1 that charged a small fee for intrauterine device (IUD) and implant insertions, and clinic 2 that charged a small fee for removals.

From March 27 to May 13, 2011, we recruited women aged 16–35 years after an aspiration abortion or a medical abortion (MA) visit. (The Nepali MA protocol is mifepristone, followed 24 hours later by misoprostol, typically taken at home. At baseline, participants having medical abortions had taken mifepristone.) Before study initiation, female research assistants received intensive training on confidentiality, recruitment, and interviewing. Research assistants explained study procedures and obtained verbal informed consent. At three of the facilities, nearly all eligible women were enrolled (95% [604/635]). At clinic 2, 51% (234/460) were enrolled owing to high patient flow and limited staff.

In private rooms at each facility, interviewers administered baseline questionnaires in Nepali including items on sociodemographics and abortion experience. Six-month follow-up interviews were carried out in a private location preferred by the participant: usually her home, sometimes a clinic, or elsewhere. Interviewers asked about contraceptive methods used since enrollment. Participants received small gifts after each interview. Data were kept confidential: surveys were assigned unique numbers and did not contain identifying information. The study was approved by the University of California, San Francisco, Committee on Human Research, and the Nepal Health Research Council.

Participants were asked whether anyone had spoken to them about contraceptive methods at their abortion visit and which methods had been discussed. To measure the outcome *receipt of contraceptive information*, we created a variable indicating whether the woman had been told about any of the more effective contraceptive methods, defined as hormonal methods, long-acting reversible contraception (LARC: IUD and implant), and female or male sterilization. Condoms and other relatively less effective non-hormonal methods were not included as “effective methods.” We asked who had provided counseling and whether they had been told when they could become pregnant again. Our second outcome was *effective method chosen*, investigated using the question: “Did you choose/decide on a method of family planning today?” Women were asked which method(s) they had chosen or reasons for not choosing one. The third outcome was *effective contraceptive supplies received* at the abortion visit. We used data from the six-month interview to create a fourth outcome variable, *effective method used* at any time since baseline.

Sociodemographic variables included age, marital status, education and husband's education, and current cohabitation with husband or partner. We assessed socioeconomic status using a standardized scale of amenities (e.g. electricity) in women's households. Reproductive characteristics included parity, desired timing of pregnancy, participant's and husband's happiness if she became pregnant within six months (not at all versus very/somewhat/a little/don't know), and most effective contraceptive previously used.

We calculated frequencies of participant characteristics and the four postabortion contraceptive outcomes: contraceptive information received, methods chosen, methods received, and methods used. For women choosing each effective method at baseline, we assessed the percentages who received that method, a different effective method, or no effective method. Similarly, using six-month data, we described contraceptive methods used by participants and assessed the percentages who used the method they chose after the abortion, a different effective method, or no effective method. Bivariate and multivariate logistic regression analyses were conducted to investigate factors associated with each contraceptive outcome. Husband's education and

desired pregnancy timing were not included in multivariate models owing to correlation with participant education and parity, respectively. We compared the characteristics of participants who completed six-month interviews with those who did not using multivariate logistic regression. Analyses were conducted using Stata 12.1 (StataCorp, College Station, TX, USA). $P < 0.05$ was considered statistically significant.

3. Results

The mean age of the 838 participants was 26.3 ± 4.6 years. Almost all were married (97%), but 16% of married women were not currently living with their husband (Table 1). No unmarried women were cohabitating. Most participants had children (87%). A majority (59%) did not want another child; 36% wanted to delay childbirth for at least two years; and 5% wanted a child within two years.

Two-thirds of women reported receiving information on at least one effective method at their abortion visit, most commonly injectables (52%) or pills (45%) (Table 2). Approximately 31% received information about two methods, and 19% on three or more. Counseling was largely provided by nurses (69%) or counselors (20%). Half were told when they could become pregnant again.

Women not currently living with their husband or cohabitating were less likely to receive contraceptive information than women living with husbands (57% vs 68%, $P < 0.05$), and nulliparous women were less likely to receive information than parous women (53% vs 68%, $P < 0.01$). Women having MA were no less likely to receive information than those having aspiration abortions (62% vs 67%, $P = 0.24$). Facility was strongly associated with contraceptive services: patients at the nongovernmental clinics were more likely to receive contraceptive information (82% and 97%) than women at public hospitals (67% and 40%, overall $P < 0.001$).

In the multivariate analysis, receipt of effective contraceptive information did not vary by age, assets, education, or parity (Table 3). Non-cohabitating women were less likely to receive counseling (aOR =

Table 1
Participant characteristics among 838 abortion patients in Nepal.

Characteristics	No.	(%)
Marital status		
Currently married	810	(96.7)
Never married, separated, or divorced	28	(3.3)
Not living with husband or partner	134	(16.0)
Greater than primary education	579	(69.1)
Husband has greater than primary education (n = 830) ^a	702	(84.6)
Rural residence	345	(41.2)
Parity		
Nulliparous	111	(13.3)
Parous	727	(86.8)
Desired timing of next pregnancy		
Wants no more children	495	(59.1)
More than 2 years	301	(35.9)
Within 2 years	42	(5.0)
Happy if became pregnant in next 6 months	123	(14.7)
Husband happy if became pregnant in next 6 months (n = 832) ^a	203	(24.4)
Prior use, most effective contraceptive method (n = 832)		
None or condoms	307	(36.9)
Pills or injectable	475	(57.1)
IUD or implant	50	(6.0)
Abortion type		
Aspiration	671	(80.1)
Medication	167	(19.9)
Facility		
Clinic 1	164	(19.6)
Clinic 2	234	(27.9)
Hospital 1	66	(7.9)
Hospital 2	374	(44.6)

^a Includes only currently married women.

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