Case history on incomplete abortion presented at Toli health post Achham, Nepal.

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Abstract

Background: Among sorts of abortions, incomplete abortion is one of them in which there is open cervical os with vaginal bleeding but there is not complete expulsion of all products of conception from the uterus. Haemorrhage and infection are common complications associated with abortion. Infection is the leading cause of death due to abortion. The government of Nepal made abortion legal in September 2002. However the law prohibits abortions done without the consent of women, sex-selective abortions and abortions performed without the legally permissible criteria. The history of this study is among the rare history. Which encourages brought out this case history in front of you.

Objectives: The chief objective of this case history was to rule out factors associated with incomplete abortion, its consequences and preventive measures.

Evaluation of the case history: A woman aged 29 years old presented at Toli health post dated on 29th September 2015 with principal complained of P/V bleeding. On physical examination, she was looking very weak, ill and anaemic. She couldn't walk freely without other people's support. She was 14 weeks of pregnancy. She already had three children. She did not want any more children, so she attempted to abort her pregnancy by taking medicine from a local medical hall as a result of incomplete abortion occurred. Again, she kept a wooden stick on her uterus to abort her pregnancy but she for a second time failed to abort her pregnancy. After that, the case was presented at Toli health post. The case was promptly referred to higher centre after primary treatment for further management due to unavailability of human resources and other facilities.

Lesson learned from the case: Women seek medical abortion through local illegalized medical hall if no health facility provides safe abortion services located near them or there are no trained safe abortion service providers in their local community.

Proposed solution: Women empowerment on reproductive health and socio-economic issues should be aroused at the community.

Keywords: Incomplete abortion, Toli, Health post, Achham, Case history.

Abbreviations: CAC: Comprehensive Abortion Care; DMPA: Depot-Medroxy Progesterone Acetate; Hb: Hemoglobin; I/V: Intra Venous; MA: Medical Abortion; NDHS: National Demographic Health Survey; OPD: Out Patient Department; R/L: Ringers Lactate; VDC: Village Development Committee; WHO: World Health Organization

Introduction

An incomplete abortion is defined by the clinical presentation of open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus. Common symptoms include vaginal bleeding and abdominal pain. The main reasons for having an abortion are wanted no more children, delay childbearing, health issues, birth spacing and sex of child which accounts for 50%, 12%, 10%, 9% and 7% respectively. Abortion falls into three categories *i.e.* safe, less safe and least safe. When an abortion takes place by using a safe method and performed by an appropriately trained health care providers *i.e.* as per WHO health worker guidelines are known as safe abortion, the abortion takes place by using a safe method with untrained health care providers and vice versa is known as less safe abortion and the abortion takes place by using an unsafe method with untrained health care providers is known as least safe abortion. It is estimated that among all abortion, 55% are safe, 31% are less safe and 14% are least safe. Haemorrhage and infection are common complications associated with abortion. The most frequent cause of all potentially life-threatening conditions is haemorrhage; however, infection is the leading cause of death [1].

As of 2010-2014, it is estimated that 55.9 million abortions occur each year in the world in which 49.3 million abortions occur in developing regions and only 6.6 million in developed

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regions. Overall, 35 abortions occur each year per 1,000 women aged 15-44 years worldwide. The abortion rate is lower in developed regions (27 per 1,000 women) as compared to developing regions (36 per 1,000 women) [2]. An annual rate of abortion of 35 per 1,000 women shows that, on average, a woman would have one abortion in her lifetime. The abortion rate in Africa is 34 per 1,000 women which are very close to that of Asia where abortion rate is 36 per 1,000 women. The total abortion occurring worldwide each year between 2010 and 2014 is estimated nearly 25.1 million were unsafe among them 24.3 million or 97% of unsafe abortions occurring in a developing country. The complication resulting from unsafe abortions are common in a developing country [3].

Literature Review

The abortion rate among women of reproductive age (15-49 years) in Nepal is 42 per 1000 women of reproductive age. Only 42 per cent of women were provided legal abortion at government-approved service site among total abortion in Nepal. Lots of female face unwanted pregnancy due to lack of accessible family planning knowledge and services [4]. Women who lack access to safe abortion services as per their desire time fall under higher risk of developing complications due to unsafe abortions, or in the worst case, suicide due to social pressure [4].

Evidence from NDHS report 2016 showed that in this 21st century only 48% of women age 15-49 years have knowledge where a safe abortion service can be obtained. Data from the same report also revealed that only 41% of women age 15-49 years known that abortion is legal in Nepal among them people from urban areas & rural areas are 43% and 36% respectively. Before 2002, abortion was illegal in Nepal, unsafe abortion was common and deaths from abortion-related complications attributed to more than half of maternal deaths occurring in major hospitals. In Nepal, more than half abortions *i.e.* 58% are clandestine procedures performed by untrained or unapproved health care providers or induced by the pregnant woman herself. About five million women and girls are admitted in the hospital each year for seeking treatment of abortion-related complications due to result of unsafe abortion. These problems cause 220,000 children motherless [5].

A study done by Axel I. Mundigo showed that if an unmarried woman can secure clinic or private abortion services, she is often asked to pay four times as much as married women. Consequently, many resort to unqualified practitioners or to traditional birth attendants to terminate their pregnancy. The methods used by these traditional practitioners include abdominal massage, ingestion of quinine, or the insertion of instruments into the uterus by the attendant [6].

Although the government of Nepal made abortion legal in September 2002, the implementation of comprehensive abortion care services started from March 2004. The abortion law allows women to terminate their pregnancy under the following conditions: Pregnancies of 12 weeks' gestation or less for any woman according to her own decision, pregnancies of 18 weeks' gestation if the pregnancy is a result of rape or incest and pregnancies of any duration with the recommendation of an authorized medical practitioner if the life of the mother is at risk, if her physical or mental health is at risk or if the fetus is deformed. However, the law prohibits abortions done without the consent of the woman, sex-selective abortions and abortions performed outside the legally permissible criteria [7]. The abortion service providers and the health facilities where abortion services are provided should be certified and approved by family health division of ministry of health of Nepal as per the current policy and guidelines of ministry of health before they start providing safe abortion services [8].

Discussion

Objectives

- To find out the factor associated with an incomplete abortion.
- To rule out the consequences of incomplete abortion.
- To identify the preventive measures of incomplete abortion [9].

Location of case

Panchadewal Binayak municipality is located in Achham district of Sudurpashchim province of Nepal which falls under the hilly region of Nepal. This municipality is surrounded by Kalikot district in the east, Kamalbazar in the west, Ramaroshan in the North and Dailekh district in the South. It is divided into 9 wards. Toli is one of them. There is one health post located in that ward where an incident of this case history happened [10].

Evaluation of the case history

Around 8:00 pm, I was just taken my dinner and had started reading 'Rich Dad Poor Dad' book at my bedroom which was located on top of my serving place *i.e.* Toli health post. Nearly 10 people came at the same time at the health post. Among them, one man, aged of about 32 years shouted hurriedly-"Doctor, Doctor." Immediately I went out of my room and looked outside. There were gathering of nearly 10 people. They were whispering each other. I reached there to know what was happening [11]. There was a lady of 29 years old brought by them. She was carried out on a basket from the village at three hours walking distance because the health post was located in the remote mountain region of Achham district of Nepal. She was looking lethargic and anxious. Her clothes were wet due to blood. Seeing her worsen the condition, without delay I opened the door of OPD and asked them to take her on the bed. Our health post staff ANM named Bhumisara Rawal was also with them. We asked other people to stay outside of the examination room. After that, I requested to Bhumisara Rawal mam for taking vital sing and I started to take history and physical examination promptly. On physical examination, she was looking very weak, ill and anaemic. She couldn't walk freely without other people's support. She had three children. She had refused to take DMPA for birth control

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due to bleeding and menstrual irregularities after taking two dose of DMPA as a result she became pregnant. At the time when she brought to health post, she was 14 wks pregnancy. She didn't want any more children, so, first of all, she went to the local medical hall to abort her pregnancy. She had taken medicine from there but couldn't get success to abort her pregnancy. After that, she kept a wooden stick on her uterus to abort her pregnancy. But again she failed to abort her pregnancy. After that, she was brought to health post due to heavy per vaginal bleeding [12].

As a result of heavy bleeding, her BP was very low and pulse was rapid and feeble. So immediately we opened I/V line with R/L and provided her primary treatment available at health post. After that without making a delay, we have counselled her husband to take his wife to district hospital Mangalsen, Achham for blood transfusion and CAC service. Initially, her husband was not agreeing to take his wife to the district hospital for further management. "We don't have enough money to take her district hospital for further management. Please save her life. We don't have any option to save her life her husband replied in a very sad mood by bending his head down when we counselled her husband to take her wife to the district hospital for further management. After that, I provided all the information about her condition to Dr. Sharad Chandra Baral who was serving at district hospital Mangalsen, Achham as a medical officer. I also requested him to provide all the available services free of cost at the district hospital due to her poor economic condition. He became agreed with me and said it's ok, don't make late. Refer her as soon as possible with I/V line open with R/L. I forwarded this information with her husband and again counselled him to take his wife to the district hospital for further treatment. Finally, he convinced. Thereafter, we called the Ambulance driver. One hour later an ambulance arrived. Afterwards, that lady was referred to district hospital Mangalsen Achham with open I/V line with R/L. From case arrival to first aid management and referral it took three hours time period. Next day around 10:30 am I called to Dr. Sharad Chandra Baral to know about the condition of the patient whom we had referred yesterday night. "Thank you, Chaudhari, jee for your contribution to save her life on timely referral. She is now out of risk zone" Dr. Sharad Chandra Baral replied. Her Hb was 4.3 gm/dl and there was a wooden stick on her uterus Dr. Sharad Chandra Baral added. The sound "she is now out of risk zone" dispersed smile on my face. At 2 pm after finishing the OPD, I held a staff meeting with all health post staff to discuss the cause, consequences and preventive measures of cases like the previous day's case [13].

Lesson learn from the case history

Following was the lesson learned from the case:

- Although we disseminated the health education on abortion in the community, we were failure to disseminate health education on abortion to all target groups.
- Women don't want to explore their health conditions at the government health service centre, for example, health post until it becomes very critical.
- One co-ordination with higher level can save one's life even though he/she is from a poor socio-economic background.
- Women seek MA through local illegalized medical hall if no health facility provides safe abortion services located near them or there are no trained safe abortion service providers in their local community.

Proposed solutions/changes

- Health education and awareness program on the legalization of abortion in Nepal and where to get those safe abortion services for young women, women from rural or remote regions and for women from the lower socio-economic background through radio, television, street drama should be conducted regularly.
- Negative thinking on family planning should be tearing out from the community through health education and street drama to increase CPR, decrease unwanted pregnancy and ultimately decrease maternal morbidity and mortality.
- Government of Nepal should provide training on safe abortion to the birthing centre staff at health post level for the expansion of safe abortion service.
- Health education should be disseminated widely at mother's group on reproductive health issues.
- Women empowerment on reproductive health and socio-economic issues should be aroused at the community.

Conclusion and Recommendations

- Collaboration with universities, medical training facilities and medical college to formulate strategies to increase the number of well-trained health care professionals on safe abortion choosing and continuing to work in rural and remote regions of Nepal.
- Training pharmacy staff on safe MA provision, post-abortion family planning and referral mechanism to minimize abortion related complications.
- Training opportunities on long-acting family planning methods like Implant, IUCD should be provided to community-level health service providers who are serving people of rural and remote regions of Nepal which will increase nation's CPR and decreases unwanted pregnancy.
- Government of Nepal should provide safe abortion services at each birthing centre too through providing training to ANM and staff nurse to minimize abortion-related complication and decrease maternal morbidity and mortality.
- An incentive should be provided to local medical for referral of abortion case at a registered abortion clinic where services are provided by trained authorized health personnel.
- Quack and quackery should be control from the community by strongly implementing rules and regulations.

Limitations

- As it is a case history, it provides little basis for generalization of the case to the wider population.

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- There may be recall bias.

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