COMMENTARY

Post-Abortion Care: A Neglected Aspect of Reproductive Health Services in Nigeria

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Each year an estimated 20 million unsafe abortions take place worldwide, 95% of which occur in the developing world.[1] Of the 1.1 billion adolescents aged 10–19 years, 85% live in developing countries.[2] These boys and girls face multiple sexual and reproductive health risks. The young women, however, are especially vulnerable because of intersections between three conditions: unwanted pregnancy, unsafe abortion, and infection with HIV and other STDs. Unfortunately, post-abortion care is the least emphasised aspect of reproductive health in these areas where unsafe abortion contributes significantly to maternal morbidity and mortality.

In Nigeria, increased unprotected sexual activity among male and female adolescents leading to unwanted pregnancies and illegal abortion is posing serious health problems. Approximately 610,000 abortions are performed in Nigeria annually, 60% of which are thought to be unsafe.[3] The maternal mortality ratio in Nigeria is 1,500 deaths per 100,000 live births.[4] Of these, 12% are estimated to be due to unsafe abortion.[3,5] In some series, unsafe abortion accounted for up to 40% of maternal mortality.[6] The average unsafe abortion mortality ratio in Africa is 110 deaths per 100,000 live births.[7] Additionally, the high incidence of serious complications and mortality following unsafe abortion in Nigeria is worrisome. Many authors[8-13] have severally emphasised these complications.

In view of the above concerns, post-abortion care, an unfortunately neglected vital tool of the reproductive health care package of our women, should be seriously revisited, revitalised and promoted. The international community has long recognised unsafe abortion as a major public health problem and has called on health systems to take specific steps to provide safe and accessible services. In Nigeria, despite the restrictive abortion law, unsafe induced abortion has assumed a major reproductive health problem. Post-abortion care, therefore, should receive serious emphasis as an important intervention to address problems of unsafe abortion, not only in Nigeria but also in most developing countries where there are still deficient quality standards for post-abortion care. There are several areas that need emphasis in this regard.

Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Post-abortion counselling is non-existent in most African countries.[12] The psychosocial consequences of unwanted pregnancy in our women are varied but more profound among our adolescent girls undergoing formal education. As many schools dismiss pregnant girls, the pregnant

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adolescent is likely to be found to abandon her education unless some other solution is found; that solution is illegal abortion with its attendant risks of regret, remorse and varying degrees of emotional crisis, especially if there is no provision of pre and post-abortion counselling. Counselling sessions should also include sex education, encouragement of responsible attitudes towards sexual behaviours, information on the risks and consequences of procured abortion and information on contraceptive services. Counselling should also include providing emotional and physical support for the young girls, as many of them develop psychosexual problems subsequently. It has been shown that some of the reasons given by some women for delay before seeking abortion services include inexperience in recognising pregnancy.[11] Proper education on reproductive physiology will not only help in preventing unintended pregnancy but will also make these women to present early for medical attention.

In all cases, women should have access to quality services for the management of complications arising from abortion. Where the law permits, there should be provision of quality standards for abortion providers. A variety of life-threatening complications occurs in women following induced unsafe abortion. Thus, there should be provision of emergency care for abortion complications, which must be accessible, affordable, available and user friendly. The manual vacuum aspiration (MVA) method, which can be used by mid level providers such as midwives permits treatment of incomplete abortions in an outpatient setting. This emergency care should also include prevention and treatment of post-abortion sepsis and testing and treatment of sexually transmitted diseases and reproductive tract infections.

Adequate arrangements should be made for appropriate referrals for any services that are not available on-site. Referral networks exist in various health systems where health service providers can refer clients either up or down the ladder depending on need, availability and accessibility. Also, in order to improve efficiency, communities can liaise with post-abortion care (PAC) service providers to identify those that need PAC services and make appropriate contacts so that these vulnerable groups can have access to quality care. This is called community and service provider partnership. Enlightenment seminars and symposia on problems of abortion and unwanted pregnancy for students, with a social and gender perspective, should be made part of available post-abortion services. Government, non-governmental organi-sations and donor agencies should sponsor such enlightenment campaigns.

Family planning services, advice and counselling should be emphasised as a centre point of post-abortion care for our women, especially the teenage girls. In no case should abortion be promoted as a method of family planning. Knowledge and practice of modern family planning methods are generally low in Nigeria,[14] as only 3.5% of married Nigerian women actively use a modern contraceptive method.[15] Also, in most sub-Saharan African countries contraceptive prevalence rates below 5% for the 15–19-year age group have been recorded.[16] One of the main reasons for this low contraceptive prevalence is that adolescents lack access to contraception, and existing institutional service delivery points do not provide encouraging atmosphere for dialogue. Adolescent friendly reproductive health services do not exist in many places and free family planning services are often limited to adult or married women so that single adolescents do not easily obtain contraceptives.

Ovulation has been shown to occur within one month of first trimester abortion in over 90% of women.[17] It is essential, therefore, that contraception be commenced immediately following abortion. The best place to encourage this is the post-abortion clinic. Immediate post-abortion family planning advice has been shown to improve significantly the number of contraceptive acceptors after an unintended pregnancy,[18] and the provision of these family planning advice and methods on the gynaecological ward by ward staff was found to be the preferred and most effective model. Institutions can adopt such model so that those treated for abortion complications will have access to prompt family planning services. This will also help to avoid repeat abortions.

Family planning service providers should be enlightened to be more sympathetic and more receptive and helpful to women or single girls who

come to them for help. Government and other concerned organisations should help by making available reliable information and services on family planning, and by developing more effective contraceptive methods.

In addition to issues discussed above, women's right on reproduction should be preserved and promoted. Rights to education, career pursuits and rights to autonomy should be protected and promoted through advocacy. Abrogation of obnoxious traditional laws that are inimical to the protection and promotion of women's reproductive health is vital especially in Africa where traditional laws are sacred. Appropriate measures should be taken to deal with unplanned and/or unwanted adolescent pregnancy. Laws and regulations prohibiting pregnant teenagers from attending school should be revoked so that the young women can continue their education. Non-government organisations or donor agencies and religious groups can organise free support groups for unmarried pregnant girls and encourage their early and regular attendance at antenatal care to minimise the chances of pregnancy-related complications.

In conclusion, unsafe abortion is a clear contributor to poor maternal health and significant maternal deaths; hence, it should become a priority for donors and governments interested in improving reproductive health. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion through pervasive family programme. In circumstances that abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion care should be emphasised to all health care providers and such services as post-abortion counselling, education and family planning services should be offered promptly. There is urgent need to integrate PAC and related services into the overall reproductive health care and as a part of the broader safe motherhood initiative in Nigeria, as has been advocated in Kenya.[19] Governments, policymakers and donor agencies should create the enabling environment for the establishment of efficient, effective and functional post-abortion services in all health institutions in Nigeria, and indeed in all sub-Saharan African countries.

References

1. World Health Organization. *Unsafe Abortion*. Geneva: WHO, 1998.
2. WHO. Programming for adolescent health and development. Technical Report Series 886, 1998.
3. The Incidence of Induced Abortion in Nigeria. *Inter Fam Plann Persp* 1998; 24(4): 156–164.
4. Chukudebelu W.O. Maternal mortality. *Trop J Obstet Gynaecol* 1995; 12(Suppl. 1): 1–3.
5. Ujah IAO, Aisien OA, Uguru VE, et al. The contribution of unsafe abortion to maternal mortality in Jos, Nigeria. *Trop J Obstet Gynaecol* 2001; 81(Suppl.1): 56.
6. Okonofua FE and Ilumoka A. Prevention of morbidity and mortality from unsafe abortion in Nigeria. In: *Critical Issues in Reproductive health*. New York: The Population Council, 1992.
7. WHO. Unsafe Abortion: Global and Regional Estimates. Geneva: WHO, 1997.
8. Anate M. Adolescent fertility: a panoramic view of the problems. *Nig Med Pract* 1993; 25: 3–9.
9. Okojie SE. Induced illegal abortion in Benin City, Nigeria. *Int J Gynaecol Obstet* 1994; 46: 173–179.
10. Oronsaye AU, Ogbeide O and Unuigbe E. Pregnancy among school girls in Nigeria. *Int J Gynaecol Obstet* 1982; 20: 409–412.
11. Anate M, Awoyemi O, Petu O, et al. The continuing problem of procured abortion in Ilorin, Nigeria. *Nig J Med* 1997; 6(4): 106–111.
12. Ladipo OA. Adolescent sexuality and fertility problems. *Trop J Obstet Gynaecol* 1994; 11(suppl. 1): 1–7.
13. Ladipo OA. Preventing and managing complications of induced abortion in the third world countries. *Int J Obstet Gynaecol* 1989; 3: 21–28.
14. Adeleye JA and Adeleye GA. Knowledge, attitude and practice of family planning amongst women in Ibadan, Nigeria. *Trop J Obstet Gynaecol* 1985; 5: 19–26.
15. Emuveyan EE and Dixon AA. Family planning clinics in Lagos, Nigeria: clients, method accepted and continuation rates. *Nig Med J* 1995; 28: 19–23.

16. Ross J, Rich M, Molzan J and Pensak M. Family planning and child survival in 180 developing countries. New York Centre for Population and Family Health, Columbia University, 1988.

17. Cameron IT and Baird DT. The return of ovulation following early abortion: a comparism between vacuum aspiration and prostaglandin. *Acta Endocrinol* 1988; 188(2): 161–167.

18. Solo J, Billings DL, Aloo-Obunga C, et al. Creating linkages between incomplete abortion treatment and family planning services in Kenya. *Stud Fam Plann* 1999; 30(1): 17–27.

19. Lema VM, Rogo KO and Kamau RK. Induced abortion in Kenya: its determinants and associated factors. *E Afr Med J* 1996; 73(3): 164–8.