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Study of Knowledge, Attitude and Practices Regarding Septic Abortion and Its associated factors in and around Muzaffarpur, Bihar

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Abstract

Objective: *Abortion is sought by women for a variety of reasons including birth control. Any pregnancy which is unwanted predisposes a woman to an additional risk; if she seeks abortion and safe service are not available to them. Lack of awareness regarding contraception and MTP Act and non-availability of trained health personnel are important causes of septic abortion in India. Present study was conducted to evaluate the knowledge, attitude and practices regarding septic abortion and its associated factors.*

Materials and Methods: *A total of 100 patients presented with septic abortion were selected through simple randomization were included in the study. Information of these cases regarding their knowledge, attitude and practices of septic abortion and other related factors was obtained by conducting interview. Result were studied and analyzed statistically.*

Result: *Among 100 cases studied, majority (46%) were having no knowledge about contraceptive device. Rural women had lesser knowledge regarding of contraception than female who were resides in town. Majority of the cases got the knowledge of contraception through media and health care providers like radio (22.22%), PHC (22.22%), television (18.52%), ASHA/ANM (18.52%). Urban Population of women had a greater knowledge of MPT Act than rural population, in majority of the cases (52%), abortion was done by dais. Among 100 cases studied, in 60 cases (60%), instrumentation was used for procuring the septic abortion.*

Conclusion: *Present study shows that less knowledge regarding contraception and MTP Act in rural women and conduction of abortion by untrained personnel like dais, quacks, and local practitioners are important cause for high incidence of septic abortion in India. So, there is the need to strengthen the health system for better quality abortion services and provision of comprehensive and safe abortion service centers.*

Keywords: *Attitude, Contraception, Knowledge, Practice, Septic abortion.*

Introduction

Abortion is theoretically defined as termination of pregnancy before fetus becomes viable (capable of living independently).[1] Any type of abortion when complicated with infection is called septic abortion.[2] WHO has defined septic abortion as "A procedure for the termination of unwanted pregnancy either by untrained or in an hospital

with the minimum medical standards or both."[3] Abortion is sought by women for a variety of reasons including birth control.[1] In spite of liberalization of voluntary abortion by the Medical Termination of Pregnancy Act (MTP-Act), 1971,[4] illegal abortions are frequently performed in India by untrained persons like traditional birth attendants or dais placing the pregnant women at an additional risk of life. MTP act deals with the conditions under which a pregnancy can be terminated, the person or persons who can perform abortion and where abortion can be done.[5] It is estimated that of the 210 million pregnancies that occur each year, about 80 million are unintended[1]. In India, an ICMR study documented that the rates of safe (legal) and unsafe (illegal) abortions were 6.1 and 13.5 per 1000 pregnancies respectively.[1] The high unsafe abortion rate exists in parallel to low overall contraceptive use.[6] Septic abortion is a paradigm of preventive medicine , relating to all levels of prevention- primary, secondary, and tertiary.[7] It is evident that perhaps two thirds of all abortion take place outside authorized health service by an unauthorized and often unskilled persons. [8] The incidence of abortions in cases attending ante natal clinics is lower than other quoted rates because firstly, booking is usually done after documenting fetal viability, secondly, the patient who takes the trouble to book early at an ante natal clinic is presumably interested in the pregnancy.[9] Viewed in all this context, the present study was undertaken to evaluate the knowledge and practices of women under study regarding septic abortion

Materials and Methods

The present study was a longitudinal study, conducted in the Department of obstetrics and gynecology, S.K. Medical College and Hospital, Muzaffarpur, during the period of January 2017 to July 2017. A total of 100 patients of septic abortion were selected for the study by simple randomization. Although clinical criteria vary, abortion is usually considered septic when there are rise of temperature of at least 100.4F for 24 hours or more, offensive or purulent vaginal discharge and other evidences of pelvic infection such as lower abdominal pain and tenderness. Women having features of septic abortion and registered in the indoor for treatment were considered as study subjects. Diagnosis of septic abortion was done on the basis of per abdominal and per vaginal examinations, investigations and per operative findings. Verbal consent was obtained from each women and confidentiality of the cases were maintained. All the personal information's of the cases were collected by conducting a personal interview of each woman using a pre-designed questionnaire.

Results

Table 1 shows Age and Septic Abortion

AGE	No. of cases	Percentage
<20	14	14%
20-29	66	66%
30-40	13	13%
>40	7	7%

Out of 100 cases of septic abortions, majority (66%) of patients were in the age group of 20-29 years, followed by 14% to age group <20 years and 13% to age groups 30-40 years.

Table 2 shows Knowledge about contraception

Knowledge about Contraception	No. of cases	Percentage
No Knowledge	46	46%
Pills	22	22%
Tubectomy	19	19%
Barrier method	07	7%
I UCD	06	6%
Foam/Jelly	0	0%

Out of the 100 cases studied, majority of the cases (i.e. 46%) had no knowledge of contraceptive devices. Out of the remaining, 22% knew about pills, 19% cases knew about tubectomy, 7% knew about barrier methods and 6% knew about IUCD.

Table 3 shows Knowledge of contraception (Rural, Urban)

Place	Total number of cases	Knowledge of Contraception	Percentage	No Knowledge of contraception contraception	Percentage
Rural	82	38	46.34%	44	53.66%
Urban	18	16	88.89%	2	11.11%

Out of the 100 cases studied, rural Women comprised of 82 cases in which Maximum number of cases (53.66%) had no knowledge about contraception, While 46.34% had some knowledge. Urban women comprised of 22 cases in which 88.89% had knowledge about contraception and 11.11% had no knowledge.

Table 4 shows Source of knowledge about contraception

Source of Knowledge	No. of cases	Percentage of cases
Primary health centre	12	22.22%
ANM/ASHA	10	18.52%
Media: Television Radio Stage Drama/Nautankee Others	 10 12 06 04	 18.52% 22.22% 11.11% 7.4%

Out of the 100 cases interviewed, only 54 cases could respond regarding their source of knowledge regarding contraception. Majority of the cases got the knowledge of contraception through media and health personnel. (PHC-22.22%, Radio 22.22%, ANMs/ASHAs-18.52%, Television (18.52%). 11.11% got the knowledge through stage drama/ nautankee. 7.4% learnt from friends, relatives and others sources of communications.

Table 5 shows Knowledge of MTP act

Place	Total no. of case	Knowledge of MTP Act			
		Yes	Percentage	No	Percentage
Rural	82	08	9.75%	74	90.25%
Urban	18	15	83.3%	03	16.7%

Out of the 100 cases studied, the majority of women had no knowledge of MTP Act. Among 82 rural women 90.25% had no knowledge about MTP Act and only 9.75% had knowledge. Out of 18 urban women 83.3% had knowledge about MTP Act, while 16.7% had no knowledge. Urban population had greater knowledge of MTP Act than rural population.

Table 6 shows Type of person conducting abortion

Conducting persons	No of cases	Percentage of cases
Dai	52	52%
Sister/Paramedical staff	42	42%
General Practitioner(MBBS)	6	6%

Out of 100 cases studied, the following distribution been observed in the incidence of persons conducting septic abortion: In 52 cases (52%), there was of history of intervention by dais. In 42 cases (42%), there was a history of sisters/ paramedical staff intervention and in 6 cases (6%), general practitioners (MBBS) intervention was there.

Table 7 shows Devices used for abortion

Device	No. of cases	Percentage of cases
Instrumentation	60	60%
Laminaria tent	16	16%
Abortion stick	10	10%
Laminaria tent with instrumentation	03	03%
Thin rod	0	0%
Suction	02	02%
Broom stick	01	01%
Not clear	08	8%

Out of the 100 cases of septic abortion, in 60 cases (60%), instrumentation was used, in 16 cases (16%) laminariatent was used, in 10 cases (10%) abortion stick was used, in 3 cases (3%) laminariatent with instrumentation was used, in 2 cases (2%) suction was used, in 1 case (1%), broomstick was used, and in 8 cases (8%), device used was not clear.

Table 8 shows Parity and septic abortion

Gravida	No. of cases	Percentage
Primigravidae	34	34%
Multiparate	66	66%

Out of 100 cases, Multipara constituted the major part with 66 cases (66%). Total number of cases, who were primigravida, was 34(34%).

Table 9 shows Period of gestation and septic abortion

Period of gestation	No. of cases	Percentage
<12 weeks	30	30%
12-20 weeks	55	55%
>20 weeks	15	15%

Out of 100 cases, in 55 cases (55%) abortion was induced within 12-20 weeks of gestation. This was followed by 30 cases (30%) who undergone abortion at gestation period less than 12 weeks. 15 cases (15%) undergone abortion after 20 weeks of gestation.

Discussion

MTP is a quite safe and easy procedure for specialized persons and trained hands, but becomes life threatening when performed by unauthorized and untrained persons. In our study, majority of patients were in age group of 20-29 years similar to the findings of Kore et al.[10] in our study, the termination of pregnancy was conducted mostly by dais in 52% cases, followed by paramedical staffs (42%) and general practitioners (MBBS). Sharma et al[11] had similar observations, in which 67.7% of cases were induced by dais and other untrained persons at home or other unhygienic places. Various other authors have made similar observations.[12-14] Our study shows that instrumentation remained the commonest method of interference constituting 60%, followed by laminaria tent (16%) and stick insertion (10%). Other methods used were suction and evacuation, broom stick, medicine etc. Sood et al[15] reported that termination method included instrumentation by untrained midwives (62%), foreign body insertion (7.5%) and dilatation and curettage or suction by unqualified personnel.

Conclusion

Our present study confirms that, septic abortion is one of the important neglected health problems, particularly in rural areas of our country. This is

mainly due to lack of awareness regarding contraception uses, lack of appropriate health education and communication, lack of adequately trained abortion service provider and freely available confidential and quality abortion service centers. These all situations lead to very high maternal mortality and morbidity. Thus, there is a serious unmet need for easy availability of safe and effective methods of contraception and abortion survey.

Increase the educational, social level and mental status of female so that they can avoid coercive sexual relationships and use contraceptive methods that they regard as safe and free of side effects.[16] There is high demand to spread awareness regarding safe MTP. There should be increased access of confidential counseling for safe MTP by trained ANMs, AWWs and ASHAs. There is need of confidential and comprehensive MTP service centers. Private and NGO sector should be encouraged to establish quality MTP services centers and commitment from all the health professionals for prevention of unsafe abortion is needed. Early diagnosis of complication and prompt referral to tertiary centers will save many lives.

References

1. Park K. Abortion: Demography and Family Planning.In: Park's Textbook of Preventive and Social Medicine.24th edn. Jabalpur: Banarsidas Bhanot 2017:p.539.
2. Jeffcoate's Principles of Gynaecology, 7th ed. New Delhi, India: Jaypee Brothers Medical Publishers (p) Ltd; 2008; 131-138.
3. Ahman E, Seth I. Unsafe abortion. In: Battler P. Global and regional estimates of the incidence of unsafe abortion and assoc-iated mortality. WHO, Geneva. 2004:1.
4. Ministry of Health & Family Planning, Government of India, Medical Termination of Pregnancy Act, 1971, 34 of 1971,31-6 (iii) Amended 1972, New Delhi.
5. Park K. Abortion: Demography and Family Planning. In: Park's Textbook of Preventive and Social Medicine.24th edn. Jabalpur: Banarsidas Bhanot 2017:p.540.
6. WHO (2011). Unsafe Abortion, Incidence and Mortality, Global and Regional Levels in 2008 and Trends During 1990-2008, Information Sheet.
7. Last JM: Scope and methods of prevention. In Last JM(ed): Maxy-Rosenan Public Health and Preventive Medicine.pp3,4 11th ed. New York, Applenton-century-crofts,1980
8. Govt. of India (2010). Annual Report 2011-2012,Ministry of Health and Family Welfare, New Delhi
9. Ian Donalds Practical Obstetric Problems. 6th edn. New Delhi: BI Publication Limited: p.
10. Kore S, Rao S, Pandole A, Rudrawawr R, Kamath S, Ambiye V. Outcome of septic abortions: impact of tertiary care. J Obstet Gynecol India. 2004;53(3):289-92
11. Sharma M, Malhotra P, Jain P et al. 'Rote of early active management in patients of septic abortion. J Obstet & Gynaecol. Today. 2008; 13: 459-61.
12. Jain V, Saha SC Bagga R, Gopalan S, Unsafe abortion: A neglected tragedy. Review from a tertiary care hospital in India. J Obstet. Gynaecol, 2004; 30(3): 197-201.
13. Padubidri V, Kotwani BG, Septic Abortions-5 Years review. J Obstet & Gynecol. India.1978; 11: 593-97.
14. Naib M, Siddiqui MI, Afridi B. A review of septic induced abortion cases in one year at Khyber
    Teaching Hospital, Peshawar. JAyub Med Coll Abbottabad. 2004; 16(3): 59-62.
15. Sood M, Juneja Y, goyai U. Maternal mortality and morbidity associated with clandestime abortions. Journal of Indian Medical Association. 1995; 93(2): 77.
16. Sai FT, Nassim J: The need for a reproductive health approach. Int J Gynecol Obstet 3(Suppl):103,1989.