

PILL AND ABORTION PROBLEMS.

Two interesting questions about family planning in Nepal were raised at the recent medical conference in Kathmandu attended by many doctors and by Dr. Louis Hellman, Professor of Obstetrics and Gynaecology at a prominent U.S. Medical Center and Chairman of Association for Abortion Reform in the U.S. These were (a) How can oral contraceptive steroids best be distributed? (b) What about abortion?

Pill Problems

First, in regard to oral steroids, there are three systems in Nepal, namely, the clinical system (the individual patient that comes to a doctor), the national system for the population of married fertile women who want and really, need the "pills" but have no doctor to whom they can go for help, and the pharmacy system (where anybody can simply buy the pills over the counter).

The clinical system is that a patient should have a medical history, a complete physical examination by a qualified obstetrician and gynaecologist to include examination, internal pelvic examination, a Pap. Smear, urinalysis, blood analysis, and possibly a glucose tolerance test and liver function tests before taking an oral steroid contraceptive. The patient then should see a doctor every 6 months for repeat examinations and tests and to study her physical and mental reaction to the oral steroid. Before stopping the pill for purpose of conception she should have all physical examinations and biologic tests repeated. Her husband also should be examined including his spermatazoa to assure that the father is healthy. Both parents should then have mental health screening tests and be interviewed to be sure both are emotionally stable and mutually agreed on wanting the child. The mother then should be given vitamins, high quality diet and gammaglobulin to prevent virus disease so that her health will be optimum at the instant of conception and that the extremely critical first three months of fetal development are as safe as possible. She should be warned to take no other medications than the doctor prescribes and stop smoking during pregnancy. She should have monthly visits to the doctor throughout pregnancy for close antenatal care. Following her delivery, supervised and conducted by a qualified obstetrician, she should be carefully counselled on the method of contraception to either space her children or limit total family size i.e. either male or female surgical sterilisation.

The national system is based on the impressive facts that Nepal has one of the highest birth rates in the world, high maternal mortality, and high infant mortality. Despite these high mortality rates there are almost twice as many births as deaths in the country. Thus population is growing much too fast. The population will double in 30 years. Who will provide twice as many jobs, twice as many schools, twice as much food, and enough doctors and nurses and facilities for all these new dependent children being born?

The risk of death to the mother on the average during child-birth in Nepal is probably between 400 and 700 deaths per 100,000 deliveries. The estimated annual risk of death from thromboembolism while taking oral steroids (England) is 3 per 100,000. There is also

no evidence that the clinical examination described above will reduce this hazard at all. Other hazards such as possible carcinogenic factors, liver toxicity, and hormonal effects are suspected but not proven to be actually true of the oral steroids in humans. It would also be impossibly difficult to do extensive screening on all the women who want to take the pills in Nepal, England, or the USA.

The conclusion is that with present knowledge it would be both unwise and impossible to use only the clinical system of distribution of oral steroids in Nepal at this time. The present national strategy is to provide oral steroids to as many women who want them. The Maternity Hospital in Kathmandu established such a policy a few months ago with the result that within two months ten times as many women came each day to start taking the pills. The clinical system was replaced by the national system. The national system includes these policies:

1. All women who deliver a baby or have an abortion in a hospital are visited by a F. P. worker for instruction on pills, IUD, and sterilisation.
2. The pills are available every working day—all day to make it easy for the woman to get them at all FP and MCH clinics, Department of Health facilities, and FPA clinics.
3. The pills are given at any time during the menstrual cycle to new patients with instructions to start the pill the first day of the next menstrual period. (Previously the women could receive the pills only during her menstrual period which discouraged some women who never returned).
4. Three to six cycles of pill are given to patients depending on distance from the clinic.
5. A medical and menstrual history is taken by a nurse or trained FP worker to rule out history of major illness, jaundice, thrombophlebitis, cardio-renal disease, and pregnancy before giving the oral steroids. Patients with a positive history are referred to a doctor before giving pills. No routine internal pelvic examination is required.
6. Pills are provided to husbands for the wife on the basis of his report of the wife's medical history.
7. A lengthy (15-20 minute) instruction is given on how to take the pills, expected side effects, and what to do in case of problems.
8. A system of reporting details of first and missed visits is being used to evaluate the national pill programme. Surveys will also be used to determine continuation rates.
9. Women who return with problems are first seen by the nurse or F.P. worker who are trained to answer most questions and when to refer to a doctor.
10. Clients are gradually being asked to pay 50 paisa per cycle for the pills.

The above national system is a compromise between the clinical system and the open availability, at a high cost, through pharmacies which is now being used. Neither the clinical system nor pharmacy system have succeeded in satisfying the latent national demand for pills. Will the national system be able to do it? That is for the FP & MCH project to prove.

The long range strategy for the FP & MCH project is:

- a) to improve and expand maternity delivery services and link post-natal family planning services to them.

- b) to establish extensive clinical screening and follow-up studies on a sample of women using the oral steroids. (This will include what is described under the clinical system).
- c) to introduce new and improved oral contraceptives (or injections) as they are developed. It is likely that the programme will soon use mini-dose pure progestins (megesterol acetate, Chlormadinone or Depo-provera) which contain no oestrogen (the component suspected as being hazardous). These also have no effect on lactation but are not quite as effective in preventing pregnancy as the combined pills with oestrogen.

Abortion

Medically induced termination of pregnancy (abortion) is of course a complex problem. at the recent conference on Family Planning at the Nepal Medical Association Building. It is made so not only by myths and ignorance but also by dedicated religious opposition, medical conservative tradition, and political fears. There are several interesting things that can be said about abortion based on recent studies and collected information.

a) Induced abortion (self, doctor or by others) is very common in most countries whether legal or illegal. In some countries (e.g. Catholic countries) where artificial family planning methods are illegal, there are as many abortions as livebirths. (Long ago Catholics approved abortion in the first three months of pregnancy). Thus there is a great natural demand by women who can't tolerate pregnancy, who seek and obtain (if they have money) abortion despite legal, social, and conscience disapproval.

b) Medical termination of pregnancy especially using the vacuum or suction method in the first three months is very safe. Mortality risk is about the same as for one year's use of pills i.e. 3 per 100,000 operations.

c) Women in other countries have organized and demanded changes in abortion laws against opposition from men who never experienced personally the difficulties and hazards of pregnancy and delivery.

d) Developed countries: are generally more liberal about abortion than under-developed countries: e.g. Japan, England, Russia, Sweden. several States in USA have liberal laws. India, Nepal, Pakistan, South America, Malaysia, Taiwan, Korea have restrictive laws but there is much abortion for those who can afford it or through self-inducement.

e) Developed countries find it necessary to have liberal and legal abortion because present family planning methods often fail or are not used properly or certain people refuse to use them. Thus medical doctors in all countries face a demand and need for medical termination of pregnancy.

f) It will be impossible for Nepal to control its birth rate with present methods of contraception unless medical termination of pregnancy is used along with tubal ligation, vasectomy, pills, IUD, and condoms.

g) There has never been legal or court action against a medical doctor in Nepal for medically terminating a pregnancy.

Ralph Tenhave