Archives of Reproductive Medicine and Sexual Health

Volume 1, Issue 1, 2018, PP: 1-3

Acceptance of Contraception after Illegal Abortion in Antananarivo, Madagascar

Hary Fanambinantsoa Rabarikoto[1], Romuald Randriamahavonjy[2], Tolora Marie Myriame Tovone[3] Hery Rakotovao Andrianampanalinarivo[4]

department of Obstetrics and Gynecology, Military Hospital Antsiranana, Madagascar.
department of Obstetrics and Gynecology, Soavinandriana Hospital Center Antananarivo (CENHOSOA), Madagascar.
department of emergency, Soavinandriana Hospital Center Antananarivo, Madagascar.
Departement of Obstetrics and Gynecology,University Hospital Center GOB, Antananarivo, Madagascar.
hrabarikoto@yahoo.com

***Corresponding Author:** Dr. Hary Fanambinantsoa Rabarikoto, Department of Obstetrics and Gynecology, Military Hospital Antsiranana 1, Boulevard Sakaramy, Madagascar.*

Abstract

***Introduction:** Abortion is a crime in Madagascar, it is realized clandestinely. Our objectives were to determine the acceptance rate of contraception and the reason for refusal in hospitalized patients for complications of illegal abortion.*

***Materials and Methods:** This is a descriptive study of the cases of complication of illegal abortion admitted to CENHOSOA, Military Hospital of Antananarivo, Madagascar, from the first of June 2011 to the 31st of March 2013. We have included all the cases of abortion declared and cases whose abortion was found in the genital tract of the patient.*

***Results:** We collected 42 cases out of 1432 births. The most affected were women aged between 25 and 30 (52.39%), were married (57.14%) and without a profession (47.42%). Only 16.67% of the patients had accepted contraception at the exit of the hospital: 3 students, 3 housewives and an employee. In the majority of cases the reason for refusal was hearsay stating that contraception is bad for health (47.62%) followed by fear of husband (28.77%).*

***Conclusion:** Clandestine abortion is a national scourge. A major effort needs to be made in the «destigmatization» of contraception in population.*

Keywords: *Illegal abortion, Contraception, Antananarivo, Madagascar*

Introduction

In Madagascar, the termination of pregnancy is illegal except for a medical indication [1]. The abortion is used by women in the management of the number of children and to back the birth of the first-born [2]. We have proposed to conduct a descriptive study on the acceptance of contraception in patients hospitalized for complication of illegal abortion at the Soavinandriana Hospital Center (CENHOSOA), Military Hospital Antananarivo, Madagascar. Our objectives were to determine the acceptance rate and the reason for refusal.

Materials and Methods

This is a descriptive study of cases of complication of illegal abortion admitted to CENHOSOA, Military Hospital of Antananarivo, Madagascar, spread over a period of 22 months from June 1st, 2011 to March 31st, 2013. We included all the patients whose abortion was admitted by itself or the accompanying persons as well as in the case where the means of abortion were found in the genital tract of the patient. The presumptions of termination of pregnancy were excluded. The variables we studied were the social profile of patients who had been hospitalized following a clandestine abortion,

the acceptance of contraception, and the reason given by the patient in case of refusal. The data was collected from the patients, recorded on a pre-established form in the form of a questionnaire for each case. The number of births during the study period was counted in the birth register of the work room and the number of hospitalizations in the admission registers of the Gynecology Obstetrics Service. The data were analyzed with Excel 2007 and results presented as a percentage.

Results

We collected 42 cases of complication of illegal abortion on 1341 hospitalizations for gynecological pathologies and on 1432 births: one per 31 hospitalizations (3.14%) and one per 34 births (3.13%). The average age was 26.15 years with extremes of 15 to 41 years.

More than half of the patients were married (57.14%) at the time of the act. In 47.62% of the cases, the patients were without profession (Table 1).

Table 1. *Distribution of patients according to their professional situations and acceptance of contraception.*

Occupational status	Number of cases	Percentage %	Yes to contraception
Without profession (housewife)	20	47,62	3
Students	11	26,19	3
Employees	10	23,28	1
Farmer	1	2, 38	0
Total	42	100	

Seven patients (16, 67%) had accepted contraception at the hospital exit including 3 students, 3 housewives and one employee (Table 1). In the majority of cases (47.62%), the reason for their refusal was «it is said to be bad for health» (Table 2).

Table 2. *Distribution of patients who refused contraception by reason.*

Reason for refusal	Number of cases	Percentage %
“It is said to be bad for health”	20	47,62
Fear of husband	12	28,77
Afraid of side effects	1	2, 38
Without answers	2	4, 76
Total	35	83,53

Discussion

In our study, the frequency of 3.13% in relation to births is probably underestimated. Indeed, unconfirmed interruptions of pregnancy were not taken into account despite a strong clinical suspicion when the means of abortion is not found on the patient.

As in Africa, sexual activity starts very early in Madagascar. The minimum age we recorded was 15 years old. It was 12 years old in Brazzaville and 15 years old in Ouagadougou [3,4]. This young age would be due to a lack of discussion between mother and daughter [5]. In Madagascar, talking about sexuality with one’s children remains a taboo subject in the majority of families regardless of the level of maternal education. The role of social networks, school attendance and the fear of rejection by their group are significant in sex education among young people.

According to Carolyn C et al, starting contraception after abortion would help reduce abortion practice and possibly reduce maternal mortality [6]. In our study, only 16.67% of patients had accepted a contraceptive method upon discharge. Which is paradoxical compared to the clandestine abortion they had done. But this is not surprising since contraception is designated by the majority of Malagasy as a provider of disease, including infertility later. As a result, contraception is still poorly accepted. Indeed, its use is only 10% in young women aged 15 to 19 and 30% in 20 to 24 years [5].

Regarding marital status, 57.14% of our patients were married at the time of the act. Gastineau B and her team reported the same proportions: 52% of female couples, married or common-law patients in the 2005 APIA survey (Illegal Abortion in Antananarivo) [2]. A recent study in Befelatanana reported 60% of married women [7]. Nearly half (28.77%) reported «husband fear» when they refused contraception. Indeed, these patients reported having already discussed the use of contraception with their husband. This assumes a predominant place in the decision of the husband in the decision-making and assumes especially the misunderstanding of the contraception by him.

Of the 42 patients included in our study, 20 were unemployed (47.62%) and 11 were under study (26.19%). This large proportion of women «without direct financial resources» including housewives and students is a vulnerable group. Indeed, in

many Malagasy and African studies, these women constitute more than half of the patients who resort to the clandestine abortion [1-4]. But only 6 of them had accepted contraception after the procedure despite a complication that had led to hospitalization. At the basic health centers and clinics some types of contraceptive methods are completely free. Consultations and poses are also free for implants and intrauterine contraception when they are available.

Conclusion

Clandestine abortion is a national scourge in Madagascar. To hope to reduce its incidence and thus the rate of its complications, significant efforts must be made in the «destigmatization» of contraception in the population.

References

[1] Rakotondraisoa JM, Andrianampy HA, Rajaonarison JJC, Randriambelomanana JA. Les complications des avortements clandestins vus à l'Hôpital Universitaire de Gynécologie et Obstétrique de Befelatanana, Antananarivo RevmédMadag. 2013; 3(2): 273-277.

[2] Gastineau B, Rajaonarisoa S. Santé de la reproduction et avortement à Antananarivo Madagascar. Résultats d'une recherche originale. African J ReprodHealth 2010 ; 14(3) : 223-32.

[3] Ouattara A, Ouédraogo A, Ouédraogo CM, Lankoande J. L'avortement clandestin dans les pays à restriction légale sur les avortements Aspects épidémiologiques, cliniques et pronostiques au CHU Yalgado-Ouédraogo de Ouagadougou. Médecine et Santé Tropicales 2015 ; 25 : 210-214.

[4] Iloki LH,Zakouloulou-Massala A, Gbala-Sapoulou MV. Complications des avortements clandestins : à propos de 221 cas observés au CHU De Brazzaville (Congo). Médecine d'Afrique Noire 1997, 44 (5) :262-264.

[5] Boure P. Madagascar, Fréquence des avortements clandestins. Médecine et Santé Tropicales 2013 ; 23 (84) : 384.

[6] Carolyn C, Douglas H, Tamarah M. Postabortion family planning: addressing the cycle of repeat unintendedpregnancyandabortion.International perspectives on sexual and reproductive health. March 2010; 36 (1): 44- 48.

[7] Andriamifidison NZR, Rafamatanantsoa JF, Andriantoky VB et al. Déterminants de l'avortement provoqué au centre hospitalier universitaire de gynécologie obstétrique de Befelatanana, Madagascar.Journal Malgache de Gynécologie-Obstétrique 2016; 1:19-23.

Citation: **Hary Fanambinantsoa Rabarikoto, Romuald Randriamahavonjy, Tolora Marie Myriame Tovone, Hery Rakotovao Andrianampanalinarivo.** *Acceptance of Contraception after Illegal Abortion in Antananarivo, Madagascar. Archives of Reproductive Medicine and Sexual Health. 2018; 1(1): 1-3.*

Copyright: © *2018* **Hary Fanambinantsoa Rabarikoto, Romuald Randriamahavonjy, Tolora Marie Myriame Tovone, Hery Rakotovao Andrianampanalinarivo.** *This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.*