

Unsafe Abortion: A Tragic Saga of Maternal Suffering

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ABSTRACT

Introduction: Unsafe abortion is a significant cause of maternal morbidity and mortality in developing countries despite provision of adequate care and legalization of abortion. The aim of this study was to find out the contribution of unsafe abortion in maternal mortality and its other consequences.

Methods: A retrospective study was carried out in the Department of Obstetrics and Gynecology in BPKIHS between 2005 April to 2008 September analyzing all the unsafe abortion related admissions.

Results: There were 70 unsafe abortion patients. Majority of them (52.8%) were of high grade. Most of them recovered but there were total 8 maternal deaths.

Conclusions: Unsafe abortion is still a significant medical and social problem even in post legalization era of this country.

Key Words: *abortion, legalization, maternal death, unsafe*

INTRODUCTION

WHO defines unsafe abortion as procedure of terminating an unintended pregnancy either by individuals without skills or in an environment that does not conform to minimum medical standards or both.¹ Unsafe abortion mainly endangers women in countries where abortion is highly restricted. Legal abortion has emerged as a safe procedure in contemporary medical practice.²

Worldwide 20 million illegal abortions take place every year.³ It is estimated that globally unsafe abortions are responsible for around 68000 death annually, accounting for 13% of total maternal mortality.⁴ Death due to unsafe abortion constitute only tip of the iceberg, often other serious complications such as sepsis, hemorrhage, genital and abdominal trauma and perforated uterus and other reproductive complications are more prevalent.⁵ In some

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low income setting, up to 50% of hospital budgets of obstetrics and gynecology are spent treating complications of unsafe abortion.⁶ This study evaluated abortion related admission in post legalization era.

METHODS

This is a retrospective study which analyzed all the abortion related admissions between 2005 April to 2008 September (3.5 years) in gynecology unit in BPKIHS. Unsafe abortion were identified using the classification developed by The South African National Incomplete Abortion Study conducted in 1994.⁷ This is useful tool for defining unsafe abortion in terms of morbidity severity categories (Table 1). The records were searched for different variables. The parity of the patient, marital status, reason for termination, mode of presentation, severity of systemic affects was noted. The records were also searched for the treatment that patient received in the center with postoperative complications and aspects of recovery. We retrieved total number of maternal death at the same period and calculated the contribution of unsafe abortion in maternal mortality rate.

Table 1. Unsafe abortion defined by morbidity severity categories

Severity categories	Definition
Low	Temperature $\leq 37.2^{\circ}\text{C}$ and No clinical signs of infection and No system or organ failure and No suspicious finding in evacuation
Moderate	Temperature $37.3-37.9^{\circ}\text{C}$ or Offensive products or Localized peritonitis
High	Temperature $\geq 38^{\circ}\text{C}$ or Organ failure or Peritonitis or Pulse ≥ 120 or Death or Foreign body/ Mechanical injury

RESULTS

Between 2005 April to 2008 September (3.5 years) there were 1071 abortion related admissions in gynecology unit of BPKIHS, out of which 70 were unsafe abortions out of which 16 (22.8%) were of low grade, 17 (24.2%) were of moderate grade and 37 (52.8%) were of high

grade. The number of unsafe abortion patients increased progressively each year, with the 3rd year of study accounting about half of the admissions.

The average age of patients was 29.3 years with age ranging from 16 years to 45 years, majority (57%) of patients were between of 16-35 years. As for parity majority 61(85.7%) were multipara ($P \geq 2$), only 9(4.3%) were primigravida. Among the patients studied 2 (2.9%) were unmarried and 68(97.1%) were married. The gestation period at termination of pregnancy for majority of patients was 6-12 weeks (47.7%), six were unsure of dates, 17.1% had gestation period less than six weeks .

Table 2. The modes of attempted abortion

Outside instrumentation /attempted curettage	5
Herbal twigs /sticks	13
Oral/ vaginal medications	7
Spontaneous expulsion	3
History not revealed by patient	42

Reason for termination of pregnancy was unwanted pregnancy in 68(97.1%) and in two patients (2.9%) reason was unmarried pregnancy. Place of termination of pregnancy was undisclosed by majority 24(34.2%) patients due to patient unwillingness, while 30% had abortion attempted at home either self or by paramedics, 8% had abortion attempted at hospital, 12.8% had attempted at private clinics and 14.2% had abortion attempted at health posts.

At the time of presentation to hospital 6(5.5%) patients were in state of shock, 32 (45%) had evidence of sepsis in form of fever and tachycardia, 40 patients had respiratory abnormality in form of consolidation/crepitations /wheeze, 37 patients had signs of peritonitis/ileus. Abnormality of renal function was present in 15 patients, deranged liver function in two, coagulation function abnormality in 11.

Ultrasonographic evidence of pyoperitoneum was present in four patients, 17 patients had evidence of retained products of conception, five patients had features suggestive of uterine perforation, two had live fetus of more than 12 weeks, one had fundal fibroid. After admission to hospital 42 (60%) required a repeat check curettage and 13 (18.5%) required surgical intervention.

Table 3. Details of surgical intervention

Laparotomy for peritoneal lavage for pyoperitoneum	5
Laparotomy for ruptured ectopic	1
Laparotomy for intestinal injury repair	5
Laparotomy for ovarian pregnancy	1
Laparotomy followed by hysterectomy	4
Laparotomy followed by removal of ovary	2

Blood transfusion was given for 29(41.1%) patients. Mean duration of hospital stay was 7.4 days with longest stay of 49 days and shortest stay of three days. Intensive care unit admissions were required for 20 patients out of which 13 required ventilatory and ionotropic support and rest seven for observation only.

At the time of discharge from hospital majority 58(82%) had recovered from illness, 8(11.1%) patients had expired. The causes attributed were: sepsis, renal failure, respiratory complications and multiorgan dysfunction. Four patients (5.7%) were taken against medical advice by visitors. They were in critical condition and presumed to have expired.

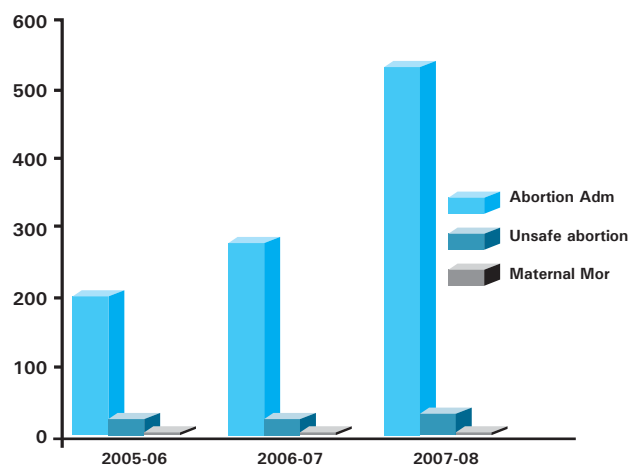
Table 4. Outcome of patients

Recovery	58(82%)
Left against medical advice	4(6%)
Death	8(12%)

There were total 55 maternal deaths in the study duration, unsafe abortion accounting 14.5% of it.

DISCUSSION

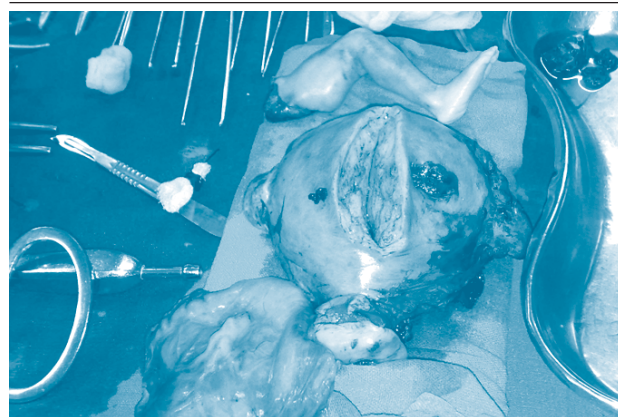
Unsafe abortion still accounted a large share in maternal morbidities and mortality in the study duration. Prior to legalization of abortion, unsafe abortion was cause behind about 25% of maternal death in this centre. After legalization of abortion, there was not even a single maternal death attributed to unsafe abortion in this centre for next two years.⁸ That was surprising on its own, considering its magnitude few years earlier. After initial years, the contribution of unsafe abortion in maternal mortality regained its ominous pattern; it is increasing in trend even now days. So, it could be presumed that mothers are still dying due to this horrific problem, some make it to the centre before last breath, many do not considering the access to health in the grief stricken country, which is in general, difficult.

**Figure 1. Admissions related to abortion and mortality (Adm = admissions, Mor = mortality)**

The other reason of increase in abortion related admissions is probably women depending more on paramedics outside the reliable facilities for the clandestine procedures. This study showed that majority of the patient refused to disclose the mode of abortion and it was found that most of them (70%) were carried out by health professional.

The main reason for termination of pregnancy was unwanted pregnancy. The cause behind unwanted pregnancy ranged from contraceptive failure to polygamous relationship. The majority of women had high grade of unsafe abortion with about 11 patients having coagulation abnormality. This was probably due to delay in arrival hence delay in initiation of the treatment.

Intensive care was required in 20 patients; most of the mortalities were after admission in intensive care unit and having exhausted already the limited resources. This added significantly to healthcare burden of the institute which caters need of the poorest patients of the whole eastern region of the country with limited resources available

**Figure 2. Uterine injury with injured bowel segment with fetal limb**

Safe and efficient services can usually be offered or improved by adaptations of existing healthcare facilities, in most cases by relatively minor changes. Whether facilities are public, private and nongovernmental, safe abortion services may be provided or upgraded by acquisition of minimal additional equipment and/or provision of basic training to service provider so that improvement in the quality, safety, efficiency and capacity of services are achieved.⁹ Nepal has already liberalized her law of abortion and in the past decade maternal mortality has significantly decreased from 539 to 281 per 100000 live births. The reduction was largely due to women receiving better antenatal care, more assisted deliveries and better postnatal care.¹⁰ But women needing abortion continue to fall in unskilled hands outside health care facilities, endangering their health and lives, owing to the social stigmas associated with it.

The consequences of unsafe abortion to women and society depend on the progress achieved in improving the legal situation and access to safe abortion. It depends as much as on the attitude of health care providers and health system organization as on the actual legal regulation.¹¹

Generally, abortion related mortality is highest in the country where it is legally restricted and reproductive health services are insufficient, in a country where abortion is legal and services are adequate, no women needs to risk her health. Although the chances poor women have access to safe abortion is much greater in the country where it is legal, liberalization of abortion are not always a guarantee that abortion services will be available. Countries like Zambia and India are good example to show that legality means little if health system and physicians are not prepared to provide safe abortion services. In India, Medical Termination of Pregnancy (MTP) Act legalizing abortion was approved in 1972. Since then the reported MTP cases have been relatively few, although slowly increasing. Khan et al. concluded that despite abortion being legal in India for more than

two decades, services are not accessible to majority of women. Consequently, 90% of the estimated 6.7 million induced abortions are conducted by untrained practitioners under conditions that lack hygiene.¹¹ It's probable that Nepal would become another example.

The abortion rate will drop and safety of the procedure will improve relative to the position women occupy in their society, and to the level of recognition of their sexual and reproductive rights. Greater political progress has been achieved in the country during last few years towards greater recognition of women's rights and in particular to women reproductive rights. The legalization of abortion was just the first step. It was not long back those tragic stories of mother languishing in prisons because the new abortion law did not bring any justice to them were in air. They were imprisoned for the charge of infanticide: however many of them had miscarriage or still birth.¹² So, to prevent Nepal becoming another example as mentioned above, concrete effort and firm stance on the part of government and the major stakeholders are required to improve the awareness of health, to provide access of healthcare facilities in the remote area, thus a giant step to reduce unsafe abortion related consequences.

CONCLUSIONS

Unsafe abortion is still prevalent and it continues to add to maternal mortality and morbidity. Mere legalization of abortion is not enough. In addition, the number and quality of abortion providing health centers should be increased and people should be encouraged to seek abortion services.

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