Maternal Deaths from Induced Abortions

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Abstract

Context: Unsafe abortion has grave implications for the life of a woman and her future reproductive career. Efforts to find the reasons underlying how a woman gets to the point of having an unsafe abortion, and means of preventing and minimising complications arising thereby are highly desirable.
Objective: To find the extent to which unsafe abortion contributes to maternal mortality in our environment.
Study Design, Setting and Subjects: A descriptive study of patients who were admitted for complications arising from induced abortions between January 1988 and December 2000 at Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria with the data being obtained from case records.
Results: A total of 103 patients presented with complications arising from induced abortions. Twenty-one (20.4%) of these patients died as a result of complications arising thereby. During the same period, there were 71 deaths in the gynaecological ward. Thus, deaths from induced abortion accounted for 29.6% of all gynaecological deaths. There were 105 maternal deaths in the hospital during the period. Hence, induced abortions were responsible for 20% of all maternal deaths. The patients had various complications including 15 (71.4%) with septicaemia, 10 (47.6%) with anaemia, 7 (33.3%) each with jaundice and peritonitis.
Conclusion: Abortion-related maternal death is still a major contributor to maternal mortality in this environment. Women empowerment, easy access to good quality and cheap family planning methods and post abortion care and rationalisation of abortion law may help to halt this stream of deaths from unsafe abortions.

Key Words: Pregnancy, Unsafe Abortion, Maternal Mortality [Trop J Obstet Gynaecol, 2003, 20: 101-104]

Introduction

Unsafe abortion poses a grave threat to women's reproductive health in sub-Saharan Africa because in most parts of Africa abortion laws are highly restrictive and women therefore have limited access to safe methods for terminating unwanted pregnancies. Induced abortion as a means of terminating gestation for medical or eugenic reasons is practiced in virtually all societies [1]. The World Health Organization (WHO) in 1990 estimated that about 40-60 million abortions occurred around the world annually and half of these are unsafe, being performed outside authorised health services and or by unauthorised, often unskilled, providers [2, 3]. It is common knowledge that when abortion laws are restrictive, women often resort to clandestine means of terminating unwanted pregnancies.

It is estimated that unsafe abortion accounts for 3.5-50 percent of the over 600,000 maternal deaths that occur globally every year. Induced abortion is commonly practiced in Nigeria with a prevalence ranging from 25 to 53% amongst adolescents in schools and 88 to 94% amongst out-of-school single women [1, 2, 3]. Available statistics indicate that it is one of the leading causes of maternal mortality in Nigeria, accounting for between 11-40 percent of maternal deaths [4, 5, 6, 7, 8, 9, 10, 11]. Many women who escape death end up with serious chronic disabilities and health problems such as chronic pelvic pain, menstrual abnormalities, genital fistulae, ectopic pregnancies, infertility, recurrent spontaneous abortions and preterm labour [1, 12, 13, 14].

This study was undertaken to review the pattern of abortion-related maternal mortality at the Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria and to identify the factors that may be responsible for the high rate of maternal deaths from this procedure. It will also serve to bring into focus the ills of illegal abortion for open discussion and health policy enactment.

Materials and Methods

The clinical case records of all patients who died as a result of complications of induced abortion at the Olabisi Onabanjo University Teaching Hospital, Sagamu between January 1988 and December 2000 were retrieved. Data such as age, parity, marital status, mode of presentation, complications, causes of death, duration of pregnancy at the time abortion

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was induced, family planning experience and status of the abortionist were extracted from the records. The total number of gynaecological admissions, deaths on the gynaecological wards and all maternal deaths occurring in the hospital during the period were also ascertained from hospital records.

Results

During the study period there were 103 patients who presented with complications from induced abortion. Twenty-one of these patients died as a result of these complications, giving a case fatality rate of 20.4%. The total number of maternal deaths during the same period was 105. Hence, abortion-related complications accounted for 20% of maternal deaths during the period. The total number of gynaecological admissions during the period was 2,704 and induced abortion-related complications accounted for 3.8% of gynaecological admissions. There were 71 gynaecological deaths and abortion-related deaths accounted for 21 (29.6%) of these deaths. Fifteen (71.4%) of the patients had no surgical intervention after admission into our institution while 6(28.5%) had procedures ranging from uterine evacuation to laparotomy or both. The length of hospital admission ranged from 1 to 33 days (mean: 12.6; sd: 3.2 days).

Table 1

Socio-Demographic and Clinical Characteristics of Patients Dying from Abortion-Related Complications at Sagamu, Nigeria (1988-2000)

Variable	*Number of Patients N = 21*	*Proportion (%)*
Age ***(years)***		
15-19	3	14.3
20-24	8	38.1
25-29	5	23.8
30-34	5	23.8
Parity		
0	8	38.1
1	5	23.8
2	1	4.8
3	-	-
4	1	4.8
≥5	6	28.6
Marital Status		
Married	11	52.4
Single	9	42.8
Widow	1	4.8
Gestational Age ***(weeks)***		
8-12	1	4.8
13-14	10	47.6
15-16	1	4.8
≥ 17	9	42.8

Medically qualified personnel induced 7 (33.3%) of the abortions, 5(23.8%) were induced by nurses, 1 induced the abortion personally, while 8 (38.1%) patients refused to disclose who the operator was. None of the victims had ever used any method of contraception.

The demographic characteristics of the patients are summarised in Table 1. The ages of patients ranged between 16 and 34 years (mean: 24.8; sd: 4.5). The parity ranged from 1 to 8 (mean: 2.4; sd: 2.8). The gestational ages at the period of abortion ranged from 8 to 18 weeks with a mean of 14.6 (sd: 2.7) weeks. Twenty (95.3%) of the deaths followed second trimester termination of pregnancy.

Abdominal pains and vaginal bleeding were the leading presenting complaints. The other complaints and complications recorded are shown in Table 2.

Table 2

Presenting Complaints and Complications Seen in the Patients

Variable	*Number of Patients N = 21*	*Proportion (%)*
Complaints		
Abdominal Pain	13	61.9
Vaginal Bleeding	10	47.6
Fever	8	38.1
Offensive Vaginal Discharge	7	33.3
Vomiting	7	33.3
Abdominal Distension	5	23.8
Diarrhoea	3	14.3
Backache	1	4.8
Complications		
Septicaemia	15	71.4
Anaemia	10	47.6
Jaundice	7	33.3
Peritonitis	7	33.3
Haemorrhage	5	23.8
Uterine Perforation	4	19.0
Acute Renal Failure	2	9.5
Enterocutaneous Fistula	2	9.5
Vesico/Recto-Vaginal Fistula	1	4.8
Bowel Injury	1	4.8
Disseminated Intravascular Coagulopathy	1	4.8

Discussion

The frequency of induced abortion-related complication in this study was 3.8% of gynaecological admissions, with a case fatality rate of 20.4%. These findings are comparable to findings reported from other parts of the country [15, 16, 17]. These figures may not be an accurate reflection of the true incidence of unsafe abortion and its sequelae in the wider community, as many of the

victims fail to present in the hospital for fear of societal condemnation and shame [14]. During the same period, deaths from abortion accounted for 29.6% of gynaecological deaths similar to the findings in Benin [15].

The age groups most affected in the study were those in the third and fourth decades of life, a finding different from what had been reported from Benin where more than 60% of affected individuals were teenagers [15, 16]. High sexual activities amongst the adolescents and the young adults is well recognised in our environment and the likelihood of resolving unwanted pregnancies by seeking termination of such pregnancies is not in doubt. They may however be unable to present at the hospital with complications arising from this misadventures because of ignorance and poor financial status. The age distribution in this study is similar to that previously found in Lagos [1].

Complications arising from induced abortion are a significant cause of maternal mortality. In this study abortion related deaths accounted for 20% of all maternal deaths during the study period, falling in the middle of the range of 11-40% that had been reported previously [4, 5, 6, 7, 8, 9, 10, 11]. Complications are less common with first trimester termination of pregnancy compared to later attempts [7, 14, 15]. In this study, nearly all the pregnancies were second trimester pregnancies. This is not unexpected as the uterus become more vulnerable to trauma as the pregnancy advances because of its large size and softer consistency. Septicaemia, resulting in shock and acute renal failure remains the commonest major complication and the leading cause of death in these patients. It occurred in 90.9% of cases reported from Benin [15]. The use of unsterile instruments and the unhygienic environment where the abortions are performed set the stage for these problems.

Educating the populace on available methods of contraception would need to be intensified to improve awareness. Virtually all the patients studied had not used any method of contraception. Terminating unwanted pregnancies was the method of family planning adopted by the patients.

The management of these patients depends on the clinical state at presentation and the type of complication she presents with. Majority of them were managed conservatively either because the majority presented with septicaemia or that they were in poor clinical condition that made them unsuitable for surgical intervention.

The issue of abortion is a dilemma to modern medical practice. Abortion is illegal in this country as evident in section 228 of the criminal code of Nigeria [18]. The reality before us, however, is that the practice is rampant in our country. The incidence of procured or criminal abortion in any country is highly speculative because information is obviously withheld [15, 19]. That sexual intercourse and number of sexual partners among the young people of Nigeria are on the increase are in no doubt [20, 21]. At least two out of every five secondary school girls would admit to at least one previous pregnancy [21]. Most of these pregnancies result from the ignorance of these young women and their sexual partners about preventive devices, and in such circumstances termination of pregnancy becomes inevitable[22].

The complications and deaths resulting from abortion are no doubt significant. These are, however, preventable. If the goal of safe motherhood initiative in reducing maternal mortality is to be achieved then the problem of abortion deaths should be seriously addressed. At present 75% of the world's population live in countries that have liberalised their abortion laws and abortion complications are becoming a rarity in these countries. A good example is Singapore which has not experienced any abortion-related maternal death since abortion was legalised in 1980 [23, 24].

The crusade to bring into focus the ills of illegal abortion by means of facts and figures have been pioneered in the past by medical scientist in this country[1, 2, 19, 20, 21, 22, 25], but successive governments have either failed to address the issue or have pursued policies that have tended to escalate the problems. This campaign should be rejuvenated and efforts made to convince the government to either legalise abortion or, at the very least, liberalise the guidelines, to enable medically qualified personnel to perform the procedure in registered health institutions. This should be without prejudice to acceptable moral norms and medical ethics. In addition our social and political attitudes to sex education and family planning programmes should change and be oriented towards benefiting everyone, including the adolescent single population who the community should recognise are sexually active.

The provision of comprehensive post-abortion care services would contribute in no small measure in reducing mortality or alleviating morbidity associated with this procedure. Efforts should also be directed at preventing unwanted pregnancies. Promotion of moral values and contraceptive use among all adolescents and adults alike remain a potent weapon in this direction.

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