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(Research Article)

Unsafe abortion and its complications: A silent and unprecedented catastrophe happening in our society

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Abstract

The term abortion often connotes criminal induced abortion in the context of our local setting. The socio-cultural and religious perceptions associated with having an abortion make the practice almost a taboo such that the procedure is often performed clandestinely with unimaginable and sometimes fatal consequences. The restrictive abortion laws in Nigeria, unmet needs for contraceptives, widening poverty and illiteracy, paved the way for unskilled personnel and quacks to dominate abortion services making the practice quite unsafe. In this editorial, we x-ray some reported abortion cases and how these challenges impact the health and reproductive careers of young women in Nigeria.

Keywords: Unsafe; Abortions; Unprecedented; Catastrophe; Nigeria

1. Introduction

The World Health Organization (WHO) defined unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment that did not conform to minimal medical standards, or both [1]. Unsafe abortion has become a public health issue even as it is largely preventable. Recent statistics showed that around 73 million induced abortions take place worldwide each year, with 6 out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies, ending in induced abortion [2]. In Africa, approximately 3 out of 4 of all abortions are unsafe whereas nearly half of all abortions occur under the least safe circumstances [3].

In Nigeria, an estimated 1.25 million induced abortions occurred in 2012 alone. This was equivalent to a rate of 33 abortions per 1,000 women aged 15–49. The estimated unintended pregnancy rate was 59 per 1,000 women aged 15–49. Fifty-six percent of unintended pregnancies were resolved by induced abortions. About 285,000 women experienced serious health consequences undergoing abortion but did not receive the treatment they needed [4]. These figures are more than double from the estimates reported 10 years earlier. A survey by Okonufua et al, in the late 1990s had reported that about 610, 000 unsafe abortions a year were carried out in Nigeria, while about half of the 20, 000 women who died from the complications of unsafe abortion were adolescents. The death rate from unsafe abortions in Nigeria was thought to be one of the highest in Africa [5].

The purpose of this editorial is to highlight how unsafe abortions have been destroying the lives of our young women and the conspiracy of silence there from. The article will share the outcomes of just a few documented cases of unsafe abortions and the legal, socio-cultural, religious, and ethical challenges of assessing safe abortion care in this part of the world.

While it may be difficult from the above definition of unsafe abortion to correctly determine who a safe abortion provider is, or what constitutes the correct skill for safe abortion, it is even more difficult to clearly stipulate what

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environment met the minimal medical standards. The complications of unsafe abortion appear to be highest when self-medication is resorted to, or when obsolete method like dilatation with sharp curettage is used even by a skilled healthcare giver, and much more with the employment of dangerous methods such as the use of corrosive substances orally or more often vaginally, or the insertion of sticks into the uterus, employed often clandestinely to terminate an advanced pregnancy [6]. Unsafe abortion when poorly managed may lead to grave consequences and even when the patient survives, the morbidities are often lifelong with severe socioeconomic implications.

Here are a few of our documented experiences in a teaching hospital setting.

Miss E.O was a 25-year-old salesgirl with a private company. She stopped formal education after secondary school due to financial constraints. About 6 months into the job, she had unintended pregnancy and after a futile attempt at terminating the pregnancy, she had a baby boy that was left to the care of her mother. She lost her job as a consequence and struggled to support her mother to raise the baby to an extent. Fast forward, 6 years later she became pregnant again which was denied by her boyfriend. She swore never to have a second child out of wedlock and decided to do everything humanly possible to terminate the pregnancy. She visited a private hospital manned by a specialist but was denied access to abortion. She then resorted to a patent medicine shop where she was sedated and vaginal instrumentation performed at about 14 weeks gestational age. She bled profusely for days and continued to pass foul-smelling vaginal discharges until she started getting weak and feverish. She managed to confide in her girlfriend shortly before she became unconscious. She was rushed to the teaching hospital where a diagnosis of septic abortion with shock was made. Despite all efforts with intravenous fluids, antibiotics, and blood transfusion she died within 48 hours of admission.

Miss N.O was a 17-year-old Senior Secondary 2 student who lived with her aunty where she also doubled as a house-help. She got pregnant by one of the boys living next door who was also a secondary school student. She was taken to procure an abortion at almost 16 weeks gestational age from a patent medicine dealer. She ingested 800ug of misoprostol and inserted another 800ug per vaginam. This was followed by vaginal instrumentation a week later when the products of conception could not be completely expelled. She was diagnosed with septic abortion and uterine perforation and died just before arriving to the teaching hospital.

Miss F.O was a 26-year-old known Sickle Cell Disease patient who just finished her National Youth Service after graduating from a university. She had been crises-free for quite some time until she presented with fever, weakness and generalized body pains. Examination revealed a temperature of 38.9^0C with severe deepening jaundice. A diagnosis of acute haemolytic crisis with septicaemia of unclear origin was entertained. Further probing following investigations led to her confessing that she had had a dilatation and curettage for an induced abortion and had been bleeding for two weeks prior to presentation. Every effort made to treat, transfuse, and resuscitate her failed as she died within 24 hours of presentation.

Miss S.O was a 26-year-old business woman who deals on foodstuffs. She presented with 3-year history of cessation of menstrual flow and 6-months history of inability to conceive. Three years earlier she had unintended pregnancy and decided to terminate it. She procured an abortion via vaginal instrumentation by a doctor at a private hospital. This resulted in septic abortion and subsequent secondary amenorrhoea due to complete uterine synechia. She hid this medical history from a new consort and got married to him 6 months prior to presentation. Fast forward, her marriage was dissolved due to deceit and childlessness following her confession.

Miss I.U was an 18-year-old secondary school leaver who was awaiting her university entrance examination result. She had unintended pregnancy and claimed that she was not aware that she was pregnant and had thought it was infection that stopped her menstrual flow. By the time her parents found out that she was pregnant, the pregnancy was already 5 months old. He father initially chased her away from home but later took her to a private hospital where several attempts were made to terminate the pregnancy using a combination of oral, parenteral, and vaginal suppository drugs to no avail even after it had been confirmed with ultrasound scan that the baby had died in utero. The said doctor then decided on surgical removal of the dead baby. Open hysterotomy was performed and patient developed post operative wound infection with pelvic abscess. After prolonged treatment with antibiotics, patient was referred to the teaching hospital where a gangrenous mass that was later found to be the uterus fell off from the open operation wound site. Fast forward, the young girl survived but lost her uterus which apparently was de-vascularized during the hysterotomy.

And the list continues.

The above pathetic cases clearly illustrated the complications and the challenges of managing unsafe abortion in our environment. The question that readily comes to mind is why didn't these patients present to the tertiary hospitals first

hand to obtain 'safe abortion' instead of presenting in critical conditions after procuring unsafe abortion? This can only pass for a rhetorical question given that our people are very religious and places high premium on the sanctity of human life. The mere mention of the word abortion even if it is spontaneous connotes criminal abortion and is fraught with a lot of stigmata both for the patient and the health care provider. Moreso, Nigeria operates restrictive abortion laws making it difficult if not impossible to access safe abortions when an unwanted pregnancy occurs.

Worldwide, issues concerning abortion have always been delicate and often generate complex moral, ethical, and religious debates and dilemma. It has been reported that notwithstanding the legal, moral, or cultural status of abortion, there are women who will seek to terminate an unwanted pregnancy [7]. Evidence showed that restricting access to abortion services does not reduce the number of abortions, instead it does affect the safety of these women along with a barrage of psycho-social trauma. The punitive nature of our laws that allow abortion only when the mother's life is in jeopardy means that women especially the young unmarried girls resort to all manners of clandestine options as exemplified the cases presented above. Studies have confirmed that the proportion of unsafe abortions are significantly higher in countries with restrictive abortion laws like Nigeria, than in countries with less restrictive laws [6]. This was evident from the study by Chigbu et al, in 2018 from South-eastern Nigeria. The study showed that while 57.7% of women were aware of the abortion laws in Nigeria and 59.2% had previously done abortion for unwanted pregnancies, as high as 78.3% reported that abortion laws will not influence their choices of abortion service providers in cases of unwanted pregnancies [8].

The factors fuelling unsafe abortion in our environment are multifaceted. They include stigma associated with having a baby out of wedlock, the fear of disappointing ones' parents and relatives with unwanted pregnancies, the refusal of health workers to provide abortion services based on personal conscience or religious belief, the sociocultural beliefs and indeed the financial constraints needed to procure safe abortion. These are worsened by the restrictive abortion laws and requirements that are not medically justified, including criminalization of abortion, mandatory waiting periods, provision of biased information or counselling, third-party authorization and restrictions regarding the type of health care providers or facilities that can provide abortion services [6]. Another major contributor to unsafe abortion practice is none-use of or poor accessibility to contraceptives. Most unwanted pregnancies will be prevented and the need for an abortion drastically reduced with correct and consistent use of an effective contraception. This however, does not entirely eliminate the need for abortion.

There is urgent need for massive reorientation of the people on issues surrounding abortion. Comprehensive sexual education should be a basic component of the academic curriculum especially from the junior secondary school level. Here, evidence-based information on abortion and contraception should be provided to prevent unwanted pregnancy. A thorough review of the restrictive abortion laws in Nigeria is long overdue and has become inevitable. I agreed with Prof. Adimma's recommendations of a combination of advocacy, liberalization of restrictive abortion law, training of health workers on Post Abortion Care(PAC) services, inter-organizational collaboration, development of right based code of ethics, inclusion into medical training curriculum, socio-economic empowerment of women, provision of PAC services in every health facility, and improvement of access to quality family planning services to reduce the prevalence and complications of unsafe abortion[9]. It is rather ironical that a 'skilled' health provider denies a young unmarried girl an abortion in a seemingly 'safe environment' for whatever idiosyncratic reasons only to quickly accept and manage the same patient when she returns with emergency complications following an unsafe abortion of the same pregnancy.

2. Conclusion

Unsafe abortion has catastrophic consequences and those for who survive it, the sequalae often lasts for a lifetime. A holistic plan of action is needed starting with a review and amendment of the current restrictive abortion laws. We can no longer continue to turn a blind eye on the devastating effects of unsafe abortion on the lives and the reproductive carriers of our girls and young women. A stitch in time, they say, saves nine.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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