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Maternal Mortality in Unsafe Abortion

Renuka Sinha, Manju M. Bara

Dept of Obst & Gynae, RMCH, Ranchi

Summary:

Induced abortions often carried out by unqualified persons under unsafe conditions carry very high maternal mortality rate. In the present study, maternal mortality rate due to unsafe abortion is found to be 33.3% which is very high. To reduce the maternal death due to unsafe abortion does not only require the correction of defect in the present health system but important thing is spreading of awareness among the people regarding the death occurring due to unsafe abortion and so preventing the unwanted pregnancies by other means.

Introduction

Nearly 50-55 million induced abortions take place annually in the world today and half of these are still performed illegally. About 150,000 to 200,000 women die from complications arising out of illegal abortion, of them more than 50% are said to be in developing countries. The report of ICMR Task Force study during April 1993 to March 1994, shows maternal mortality among septic abortion is 16.8 per 100 cases. That shows that inspite of the liberalization of MTP Act, even today illegal abortions are performed more frequently in our country with their disastrous result.

The aim of the present study is to analyze and to evaluate the factors responsible for high maternal death due to unsafe abortion and to discuss the measures to prevent such avoidable gigantic problem.

Materials and Methods

The present work is prospective study of unsafe abortion admitted in the Department of Obstetrics and Gynaecology, RCMH, Ranchi during one year period from May 1997 to June 1998. This hospital mostly caters poor, illiterate adivasi and non-adivasi population coming from hilly rural areas with average 80% of emergency admission.

Observation

During one year time total abortion admissions were 720, there were 610 MTP, 96 spontaneous abortions and 24 septic abortions. Out of 24 septic abortions there were 8 deaths giving 33.3% maternal mortality death rate per 100 women among unsafe abortion.

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Table-I

Sl. No./Name/Age/ Adivasi-Non-Adivasi/Religion	Marital Status/ Present Pregnancy/Gestational period	Socio-Economic Status/Literacy/ Rural-Urban	History of Interference Done by/Place/ Method	No. of Shift to RMCH/Day of Admission after Induction	Clinical features at the time of Admission/ Degree of Sepsis	Management	Cause of Death	Hospital Stay in Hour
1. Indrani Devi/30 yrs/Adivasi/Hindu	Married/3rd preg/12 weeks	Poor/Illiterate/Rural	Yes/Untrained Doctor/Private clinic/D & C	Shift I/15th day	Fever, distension of abdomen, foul smelling discharge P/V III sepsis	Conservative	Septaecimia Anuria, shock	09 hrs
2. T.Tirkey/30 yrrs Adivasi/Hindu	Married/4th preg./16 weeks	Poor/Illiterate/Rural	Yes/Untrained Dai/Home/Stick	Shift II/13th day	Fever, distension of abdomen, foul smelling discharge P/V III sepsis	Conservative	Septaecimia, Severe anaemia, Anuria Shock	06 hrs
3. Z. Khatoon/ 30 yrs/ Muslim	Married/4th preg/12 weeks	Poor/Illiterate/Rural	Yes/Nurse/Private clinic/D & C	Shift III/12th day	Fever, distension of abdomen, foul smelling discharge P/V III sepsis	Conservative	Septaecimia Shock, Anuria	17 hrs.
4. U. Sahu/19 yrs/ Hindu	Unmarried/1st preg / 22 weeks	Poor/Illiterate/Rural	Yes/Untrained Doctor/Private clinic/First attempt D & C at 12 weeks Second attempt D & C at 22 weeks	Shift IV/13th day	Fever, distension of abdomen, foul smelling discharge P/V Crepitation ant. abd. Wall III sepsis	Conservative	Septaecimia and shock, gas gangrene, Anuria	18 hrs.
5. Birsi/15yrs/ Adivasi/Hindu	Unmarried/1st preg/ 12 weeks	Poor/School education/Rural	Yes/Untrained doctor/Private clinic/ D & C	Shift IV/13th day	Fever, distention of abdomen, foul smelling discharge P/V Scanty urine III sepsis	Conservative	Septaecimia shock, Anuria	40 hrs.
6. Punna/ 19 yrs Hindu	Separated/1st preg/ 12 weeks	Poor/Illiterate/Rural	Yes/Untrained doctor/Private clinic/ D & C	Shift II/7th day	Distention of abdomen, scanty urine III sepsis	Conservative	Septaecimia shock, Anuria	10 hrs.
7. Romila Linda/ 30 yrs Adivasi Christian	Married/3rd preg 12 weeks	Low middle class Graduate Urban	Yes MBBS Private clinic D&C	Shift II/ 6th day	Perforation of uterus and gut II sepsis	Laparotomy	Septaecimia, shock	72 Hrs
[illegible] Adivasi Hindu	Unmarried/1st preg 16 weeks	Poor/Illiterate Rural	Yes untrained Doctor Private clinic D & C	Shift [illegible] day	Fever, vomiting, Abdominal distension, PSD, P/V II sepsis	Conservative	Septaecimia Anuria, shock	[illegible] Hrs

From the table, it was observed that in 8 deaths, the incidence was equal in both adivasi and non-adivasi women, there were 7 patients coming from low socio-economic group, 6 were illiterate, one had lower school education, while one patient coming from city was graduate Christian. The three unmarried and one separated from husband were nullipara and below 20 years of age. In all 8 cases, there was history of interference done by untrained local doctor in 5 cases, by nurse in one case, by MBBS doctor in one case and application of root stick by local untrained dai in one case.

With the different shift from home to way upto final shift to RMCH, these cases were received between 6th to 15th day of induced abortion with septaecimia and shock and died within one to 72 hours of admission. There were 5 deaths within 10 hours. Along with septaecimia and shock in all cases, ARF was present in 7 cases, gas gangrene in one case and in one case there was perforation of uterus and gut (Table-I).

Discussion

Reviewing the literature and comparing mortality rate in unsafe abortion in different centres, it becomes evident that in the present series mortality rate is almost double than other centres Table no. – II. According to ICMR Task Force study survey maternal mortality is 16.8% when Chatterjee (1996) reported 15.9% and Meenakshi et al (1995) noted 13.3% of mortality rate, but in the present study, maternal mortality in unsafe abortion is 33.3%. Bhaskar Rao and Mallika (1977) have reported 25% death in unsafe abortion.

According to Reddi Rani et al (1996) and P. Chatterjee (1996) report, women in age group of 21-30 years constituted majority and so the married and multiparous women when in present study incidence was equal in all these groups. Septaecimia was the commonest cause of death accounting for 60-80% as observed by Agarwal and Chandrawati (1988) and 70% by Reddi Rani et al (1996). In the present observation, incidence of septaecimia was 100%. ARF was associated with 87.5% cases and 50% women died within 10 hours after admission in present series, when in Reddy Rani et al series (1996) 47% of these patients died 48 hours after admission.

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Table – II

	Total No. of Septic Abortion	Total No. of Death	Mortality Rate Per 100 Cases
Bhaskar Rao and Mallika 1977			25%
Reddi Rani et al (1996)	358	34	9.49%
Chatterjee 1996) Calcutta		40	15.9%
Meenakshi et al (1995) Rohtak	15	02	13.3%
Kambo et al (1998)	590	99	16.8%
Present Study, RMCH, Ranchi 1997-98	24	08	33.3%

Conclusion

Analyzing the factors responsible for maternal death due to unsafe abortion, we have to look for where the fault and defect was present.

- It is the ignorance and lack of awareness of the patient and relatives.
- Untrained personnel doing illegal and unsafe abortions under unsafe condition.
- Referring of the cases from one place to other till they reach the final shift in terminal stage to die.
- There is a series of defects and faults which needs to be corrected.
- To reduce the maternal death due to unsafe abortion is not only terminating the unwanted pregnancies by instituting safe abortion services but preventing the unwanted pregnancies by contraceptive services. The root cause of all the factors is unwanted pregnancy. It is better to prevent unwanted pregnancy than to treat unsafe abortion.
- There should be proper mass education for fertility control methods, only then we can reduce the maternal death due to unsafe abortion.

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