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Case Report

Practice of Illegal Abortion in India: With Reference to a Case Report

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Abstract

Abortion is an important health concern of women but it is increasingly being governed by patriarchal interests which often curb the freedom of women who seek abortion as a right. Consequently, illegal unsafe ways of abortion practices remains as the only alternative for these helpless women; especially the poor, widows and the unmarried. Lack of awareness, ignorance and illiteracy are some of the major factors making rural women unreachable to the safe abortion services. The present case is a hand-pick illustration of the existing status of abortion/MTP service in rural India. How and what are the circumstances compel an average Indian woman to adopt illegal and unhygienic ways of abortion is the prime focus of this case report. A 40 year old married woman becomes pregnant outside marriage; and attends a local quack for abortion. The quack gave her a medicinal twig and some crude herbal abortifacient. She was told to introduce the twig into her vaginal canal and pills to eat. She developed excessive vaginal discharge, lower abdominal cramp, fever and skin rashes. She was diagnosed as a case of septic abortion with co-morbid uterine perforation and Disseminated Intravascular Coagulation (DIC); and subjected to emergency exploratory laparotomy. However, she succumbs to the complications. With this case report, we have tried to put forth a reasonable insight in to the existing inadequacy of abortion laws and apparent failure of Medical Termination of Pregnancy (MTP) services.

Keywords: Illegal abortion; Uterine perforation; Disseminated intravascular coagulation; Septicemia; Herbal abortifacient.

Introduction

As per abortion laws of India, only those doctors who have qualified in Medical Termination of Pregnancy (MTP), approved Government Hospitals (MTP centers), and MTP-license holder clinics can perform MTP.[1] MTP Act was enacted in the year 1971 and came into effect from 1st April 1972; and was subsequently amended in 1975. It has different sections and subsections which define the conditions under which pregnancy can be legally aborted, the beneficiaries, the qualification required to perform MTP and the places where it can be performed.[2] This Act was framed with an intention to reduce the incidence of illegal, unsafe abortion and consequent maternal morbidity and mortality rate. Therefore, this act has been armed with liberalized clauses in order to meet the demands of most needy ones. However, forty years after this ground breaking legislation, majority of women seeking abortion still turn to the uncertified service providers e.g., quacks, mid-wives, medicine shop keepers etc; because of their easy accessibility and door step service facility.[3] Contrary to it, the qualified or government health providers are usually not available in the rural areas; or if available, the

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beneficiaries have to face many official and legal intricacies.[4] In most of the occasions the patient confidentiality is breached. Besides, it has been alleged that, the workers at public hospitals and government MTP centers often have disrespectful attitude towards the women seeking MTP service. On many occasions, it has been seen that these centers lack adequate infrastructure to provide immediate, hassle free services. Consequently, the illegal ways of procuring abortion services from the spurious providers remains the only alternative for those helpless women. A study on illegal abortion in rural areas, conducted by the Indian Council of Medical Research (ICMR) revealed that the extent of illegal abortion (13.5 per 1,000 pregnancies) in comparison with legal abortion (6.1 per 1,000 pregnancies) was still quite high and the trend in the past 17 years (1972-1989) could not show a tendency for illegal abortion to decline.[5] In fact, the official report fails to record the unregistered cases of abortion. Because, these estimates mainly depend on the ratio of induced abortions to live births, ill timed and unwanted pregnancies, age specific fertility rates. Others according to some estimates there are 3 illegal abortions for every one legal abortion in rural area and 4-5 illegal abortions for every MTP in urban area. Gupta gave a higher estimate of illegal abortions 8 for every one legal MTP.[6] This highlights the degree of jeopardy of MTP service in India. Hopefully, the present case report may aptly highlight the status of abortion practice in rural India.

Case Report

Body of a 40 year old woman was brought to the mortuary of our hospital with alleged history of death following a gynecological operation. External examination revealed multiple confluent, sub-cutaneous and submucosal hemorrhagic patches all over the body (Fig 1). She had a pale and dehydrated look. A vertical laparotomy stapled wound surrounded by in-situ drainage wounds was found over the anterior abdomen (Fig 1). Examination of perineum revealed dry blood stains with surgical gauge packing in and around the vaginal canal. On removing the gauge pack, foul smelling serosanguinous discharge mixed in clot and gauge piece was oozing out of the vaginal orifice. Exploration of abdomino-pelvic cavity revealed generalised peritonitis. Peritoneal cavity contained about 350 ml of blood tinged transudate. A part of omentum was surgically resected. Stomach contained about 20 ml of mucoid fluid without any specific odour. Multiple, confluent patches of sub-mucosal hemorrhages were found almost all over the gastric mucosa. A dark-

Fig I: (i) Multiple Confluent Patches of Subcutaneous Hemorrhage (Thin Arrows) (ii) Surgically Stapled Wound (15.7cm long) over Anterior Abdomen (Thick Arrow) (iii) Peritoneal Drainage Wound (Spearhead Arrow)

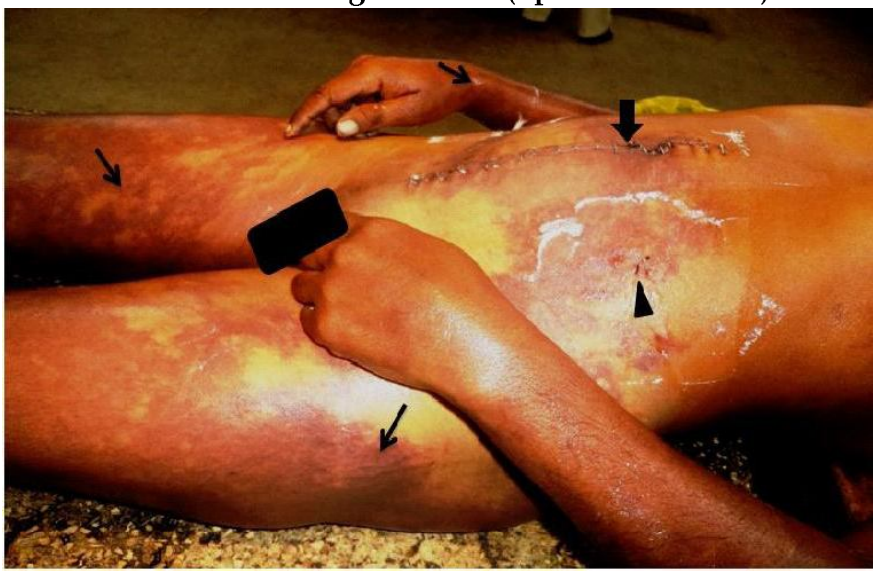
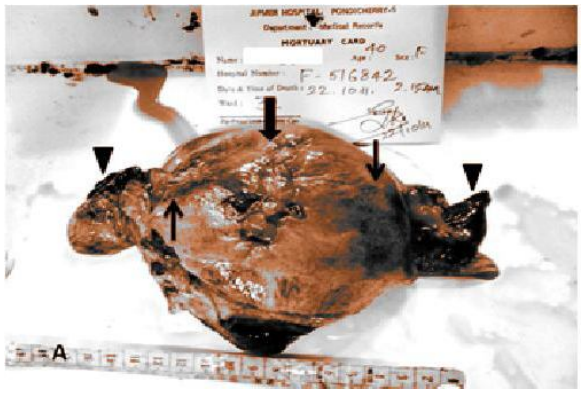
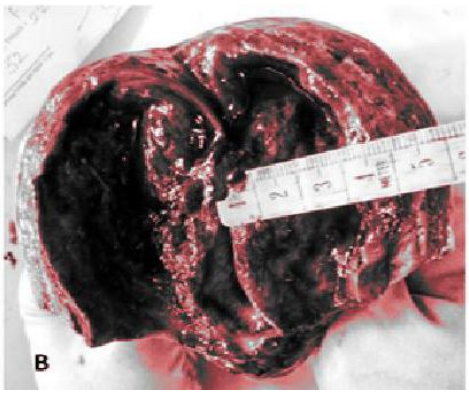


Fig IIA: Posterior View of Uterus & Adenexa. Uterus Bulky (Size-16cmX9.8cmX2cm, wt. 475 gm) (i) Surgical Repair Wound (5cm) of Uterine Perforation on Posterior Wall of Uterine Fundus (Thick Arrow) (ii) Ovaries Enlarged, Congested and Hemorrhagic (Spearhead Arrows) (iv) Multiple Patches of Sub-serosal Hemorrhage (Thin Arrows)



brown submucosal hemorrhagic patch of size 4.5 cm diameter, ulcerated at the center was found over the greater curvature close to the pylorus. A part of mesentery along the distal loops of ileum was surgically removed. The adjacent part of small intestine was hemorrhagic and edematous; multiple petechial hemorrhages were found on both serosal and mucosal surfaces. All major abdomino-pelvic blood vessels were intact. Liver was congested. Cut section revealed multiple patchy areas of hemorrhage. Hemorrhagic changes were noticed in adrenals and in pancreas. Both kidneys were congested. Cut-sections revealed diffuse sub-cortical hemorrhages. Diffuse, mottled sub-capsular hemorrhage was seen over the surface of the spleen. Examination of pelvic viscera revealed enlarged, bulky, dusky brown appearing uterus (Fig 2A). A vertical sutured wound was found on the posterior wall of uterine fundus. Cervix was surgically repaired. Uterine adnexa were congested and had multiple confluent patches of sub-serosal hemorrhage. Both side ovaries were enlarged, hemorrhagic and congested (Fig 2A). Cut-sections revealed stromal hemorrhage and necrosis. On opening the uterine cavity, endometrium was congested, hemorrhagic and necrosed with multiple areas of sloughing (Fig 2B). Heart showed multiple patches of sub-epicardial and sub-endocardial hemorrhages. Both lungs showed multiple sub-pleural hemorrhagic patches and blood tinged edema fluid came out on cut section. Scalp, skull and membranes were intact. Brain was congested and edematous. A subcortical necrosed cavity (2 cm diameter) was found over the lateral surface of the left parietal lobe. On dissection, diffuse sub-cortical micro-hemorrhages were found within the substance of brain.

Fig IIB: Showing Uterine Cavity-Endometrium Congested, Thickened, Hemorrhagic and Necrosed with Areas of Sloughing



Perusal of hospital records revealed, the deceased was admitted in a critical condition with complaints of excessive vaginal bleeding, lower abdominal pain, fever and skin rashes for 1-2 days accompanied with chill and rigor, giddiness. Vitals were, pulse-122/min/ low volume, BP-90/50mm Hg, Respiratory rate-34/min. Investigation reports revealed low hematocrit values (Hb-7gm% improved to 10.8gm%, Hematocrit- 38%). Blood urea level-101 mg/dl, creatinine 2.2 mg/dl, total bilirubin 2.2 mg/dl, total protein 5.3g/dl, and albumin 2.5 g/dl. Arterial Blood Gas analysis showed-pH 6.97, pCO_2 19 mmHg and $pO_2$130 mmHg. Liver enzymes were within normal limits. Emergency explorative abdominal sonography was done and it showed enlarged uterus with thick, irregular endometrial echo-texture, and cavity contained disorganized mass of products of conception (POC). There was perforation of posterior wall of uterine fundus,

laceration of endocervix and edematous bowel loops. The provisional clinical diagnosis was 'Septic abortion with co-morbid uterine-perforation, bowel necrosis, renal failure and DIC'. Therefore, she was shifted for emergency laparotomy after conservative stabilization and blood transfusion. Post operative notes of gynecologist recorded repair of perforation of posterior wall of fundus, and surgical resection of gangrenous cervix and mesentery of distal ileum. She was died on the first post-operative day.

Further history from the attendants and police disclosed the inherent cause of abortion. The deceased was from a remote village of Tamil Nadu. She was married for 21 years and had 2 children. The husband was an alcoholic and used to abuse her physically. Allegedly, she became pregnant out of an illicit affair with a fellow villager and to have abortion surreptitiously, she approached a village quack. The quack gave her some pills of crude herbal extracts to eat, and a twig of some herb to keep inside the vaginal canal. However, in order to achieve rapid abortion, she vigorously manipulated the twig inside her vagina; and the very next day she had abdominal cramp and profuse vaginal bleeding. She was shifted to a nearby primary health center, from where she was referred to our hospital.

Discussion

Illegal abortion is a major cause of maternal morbidity and mortality in India. Singh *et al* observed, about 98% of illegal abortions take place in developing countries like India.[7] Data from 67 studies in 17 countries, indicate that, in some areas, up to 50% of maternal deaths occurring in hospital are due to complications of unsafely induced abortion. In many countries this proportion averages about one-quarter of all maternal deaths in hospital.[8] Nevertheless, the practice of safety-less abortion is not uncommon in developed countries too. Practicing abortion in many catholic European countries is not legal, because of certain religious public sentiments against abortion. A recent incident of death from complicated abortion at Ireland kindled public ire and huge protest to legalise abortion.[9] One in two people in India don't know that abortions are legal. The result: Mortality rate as high as 8% among women who are compulsively approach ill-trained clandestine practitioners for abortions. According some eminent health economist of India 15,000-20,000 women die every year due to lack of access to safe abortion practices.[10]

Safe abortion (MTP) services remains inaccessible to the rural underprivileged parts of India despite such services being provided free by the government. Most of the government and private MTP facilities exist in cities rather than in the underdeveloped rural areas.[11]A wide variety of uncertified and/ or self trained abortion service providers are available in the country side like the informal, alternate system of medicine (ayurvedic, homeopathic, unani etc.) practitioners, Auxillary Nurse Midwives (ANMs), nurses, pharmacists, Traditional Birth Attendants (TBA) and even medicine shopkeepers.[3] In developing countries like India, most of the abortions are performed by local unqualified quacks who use orthodox and unscientific methods like inserting foreign bodies into uterine cavities, oral administration of crude abortifacients, and sometimes inserting poisonous herbal products or substances into the uterus. Therefore, the chances of an induced abortion getting septic is very high in these procedures.[12,13,14] A retrospective study on septic abortion cases revealed that about 58% percent of the complicated abortions were done by self-trained quacks or clandestine service providers; only 9.7% were attended by trained doctors.[15] A study by Singh *et al* (2011), in 62% cases the untrained local quacks were involved in committing the abortion; and midwifery, nurses were involved in 26% of cases, while the patient herself tried in 8% cases. The commonest method employed for inducing abortion was local trauma, i.e. insertion of foreign body into the uterus (70%), followed by ingestion of poisonous substance (14%). Unknown poisonous substances were

introduced into the uterine cavity in 12% of cases.[7] Similar results were recorded by other authors, where 60% of the cases of abortion were dealt by clandestine, unqualified service-providers and, the methods used were oral medications e.g. ayurvedic preparations, chloroquine tablets, high-dose progesterone, high dose estrogen plus progesterone etc, with or without intra-vaginal interventions like use of sticks, roots, iodine-benzoin paste, decoctions of papaya and custard apple seeds etc. Injections (Carboprost or Ayurvedic preparations) used in 36%, and surgical methods (D&C, catheters, intra-amniotic saline or glycerin)were adopted in rest 4% of the cases.[3,4] In the present case the deceased had taken service from a village quack and was treated with a combined method of ayurvedic pills and intra-vaginal insertion of some herb-twig.

Confidentiality and rapid service are two major priorities for most women who seek abortion. Local providers, though uncertified or unqualified are preferred for several reasons. Because, they are familiar and stay close to the community; secondly, they are believed to be trustworthy as regard to the professional secrecy. Nevertheless, most often they lure by waiving-off of their fee amount. The major concern for most women seeking abortion is to get in and out of the clinic as quickly as possible, preferably on the same day, before any neighbour or acquaintance find out the truth. The burden of domestic work and family responsibilities often restrain them to have a longer hospital stay (which may be required for a safe abortion). Therefore, they tend to resort to trusted providers despite their ineligibility. Abortion in adolescents are more likely to be performed by the uncertified, clandestine-service providers and contribute to 20% of all abortion-related deaths among adolescents.[3,11] The reasons Indian women terminate unwanted pregnancies are many and varied; and it may be due to financial burden, pregnancy related health hazards, old age pregnancy, pregnant out of illicit relationship or rape etc. Nevertheless, not so commonly reported reasons for seeking abortion are pregnancy occurring outside marriage or adolescent pregnancies. However, female feticide has taken the front among surreptitious abortions. Not only the untrained/self-trained service providers but also the trained doctors are providing service to this group of women; because, now it is a lucrative gray-business in India. Government sponsored MTP-centers or certified MTP centers have low case loads due to their apathy to maintain confidentiality, may incur high costs due to compulsive bribing practice by the workers in government centers, cringing formalities and pressure to accept sterilization or IUD etc. In many government MTP-centers, especially in rural areas, the services are not available due to lack of doctors, functional equipments and other infra-structures. The MTP training facilities in those areas are also sparingly available. Given such a situation, where safe abortion services are not easily accessible, the problem of abortion is of great magnitude and makes a major contribution to maternal deaths.[16] In the present case, deceased had pregnancy out of extra-marital sexual contact with a fellow villager. Hence, she sought a secret way of procuring abortion from a known village quack, so that she can get an immediate, hassle free and confidential service at door step. The disadvantages with the unqualified service providers are, their inability to attend the complications of abortion or ancillary medical needs and failure to do a timely referral etc. Hence, illegal ways of abortion practices are prone to land up in to complications e.g. shock, uterine perforation, cervical laceration, bowel injuries, peritonitis, septicemia, septic shock, acute renal failure and DIC etc. However, commonly encountered complications include incomplete abortion, haemorrhage and uterine or cervical injury.[17] Study by Agrawal *et al* (2008), it revealed that about 63% cases of complicated abortion brought to the hospital are subjected to emergency explorative laporatomy. Out of those uterine perforation were seen in 40% of cases, bowel injury in 34% of cases, blood/pus or faecal peritonitis in 18% cases, and death in 8% cases.[18] The major killers among the complicated abortion, in descending order are hemorrhagic shock,

septicemia (together accounts 58%), disseminated intravascular coagulation (28%), acute renal failure (9%) and adult respiratory distress syndrome (5%).[19,20] In present case, the deceased had suffered from uterine perforation, cervical laceration and multiple bowel injuries. She was died of complications of incomplete abortion *i.e.* refractory shock, disseminated intravascular coagulation and acute renal failure.

Conclusion

This case report legibly projects a clear picture of the prevailing abortion practice in India. Therefore, it requires a considerable attention in order to transform the theoretical right to a practically feasible safe abortion practice into service. The current situation warrant reforms in the trend of abortion practice; and need to initiate a campaign to raise public awareness with a special attention to the unreachable, rural sectors. Appropriate redistribution of resources in critical sectors, and reduction of the extraneous paperwork that discourages proper reporting by the service providers should be considered. Legal stakeholders should contemplate for reforms in existing MTP Act in order to educate and trained the uncertified or unqualified abortion service-providers; so that the clandestine practice of unsafe abortion may be prevented and simultaneously, they can be mobilized as a resource at unreachable rural areas.

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