CASE REPORT

Barriers to safe abortion access: uterine rupture as complication of unsafe abortion in a Ugandan girl

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SUMMARY

A 15-year-old girl at 18 weeks gestation by the last menstrual period presented to a rural Ugandan healthcare facility for termination of her pregnancy as a result of rape by her uncle. Skilled healthcare workers at the facility refused to provide the abortion due to fear of legal repercussions. The patient subsequently obtained an unsafe abortion by vaginal insertion of local herbs and sharp objects. She developed profuse vaginal bleeding and haemorrhagic shock. She was found to have uterine rupture and emergent hysterectomy was performed. Young and poor women are at high risk of unplanned pregnancy and subsequent mortality during pregnancy and childbirth. Unsafe abortion is a leading and entirely preventable cause of maternal mortality worldwide. Multiple barriers restrict access to safe abortions including social and moral stigma, gender-based power imbalances, inadequate contraceptive use and sexual education, high cost and poor availability, and restrictive abortion laws.

CASE PRESENTATION

Uganda has one of the highest rates of maternal mortality in the world.¹ Since British occupation, Uganda has been a legislatively abortion-restricted area. The Ugandan Penal Code of 1950 states that anyone who has or is involved in the execution of an abortion can be criminally charged, except in the circumstance of saving the mother's life.² In 2006, the Ministry of Health's National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights outlined exceptions in cases of fetal anomaly, rape or incest, or if the mother is HIV positive.³ Unfortunately, laws and policies are interpreted inconsistently, and many healthcare personnel report fear of legal repercussions. In addition, many women report lack of awareness of the law's expansion.⁴

A 15-year-old female at 18 weeks gestation by the last menstrual period presented as a referral to our hospital from a rural community healthcare centre with a 12-hour history of severe vaginal bleeding and reduced level of consciousness.

Collateral history from the patient's relative reported that two days prior to her presentation at our hospital, she sought an abortion at the nearest community clinic in a rural town in Uganda. The pregnancy was undesired as it was a result of rape by the patient's paternal uncle. Since being orphaned at the age of 10, the patient's uncle had become her primary caretaker. Other relatives were

not aware of the sexual assault until the patient became pregnant. Although abortion is legal in Uganda in circumstances of rape, the skilled healthcare providers at her facility refused to provide the abortion out of fear of legal repercussions.

The next day, one day prior to presentation at our hospital, the patient visited a local herbalist. The herbalist provided substances that he claimed would terminate her pregnancy. Within hours of inserting the unknown herbs and sharp materials into her vagina, the patient developed vaginal bleeding. The bleeding was initially mild, but later became torrential. It was associated with severe, cramping lower abdominal pain that radiated to the back. Later that night, she returned to the local herbalist who vaginally introduced additional unknown herbs. The patient's condition worsened overnight and she became unresponsive. She was rushed to a nearby health centre. After several failed attempts to resuscitate her at the local health centre, she was transferred to our hospital's obstetrics unit.

On admission, she was hypotensive to 84/46 mmHg with a pulse of 130 beats per minute. Other vital signs were unremarkable. She was immediately treated with aggressive fluid resuscitation and her blood was taken for grouping and crossmatching.

Further history was obtained from the patient's medical records. This was the patient's first pregnancy and she had not received any antenatal care. She was of unknown HIV and hepatitis B serostatus. Besides sexual assault by her uncle, she was not sexually active with other partners. She was not using contraception. The patient had no prior history of gynaecological procedures or gynaecological illness. She had menarche at age 14 with regular and normal periods. She had no known chronic illnesses and was not on any medication.

The patient was still in poor general condition on secondary survey. Her Glasgow Coma Scale after fluid resuscitation was 11/15. She had severe conjunctival pallor. She had cold extremities with a thready radial pulse. Cardiac auscultation revealed normal S1 and S2 heart sounds with a S3 gallop rhythm. Her abdomen was moderately distended on inspection with visible striae and linea nigra. There were no visible scars. On palpation, the fundal height was at about 19 weeks. There was tenderness on superficial palpation of the abdomen, more marked on deep palpation, with guarding and rebound tenderness. There was an irregular protuberance on palpation of the lower abdomen suggestive of fetal parts. No fetal heart rate was detected.

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On inspection, the vulva was soiled with blood. Active bleeding was noted from the introitus. The cervical os was 4 cm dilated with the products of conception visible at the cervical os. The patient was then scheduled for emergent laparotomy.

The procedure was performed under general anaesthesia. Abdominal layers were opened by midline incision. Products of conception and gross blood were found in the peritoneal cavity. Multiple tears were discovered in the uterus, with the largest tear in the lower uterine segment. Products of conception were extracted, including the non-viable fetus. Attempts were made to salvage the uterus but haemostasis could not be achieved. A subtotal hysterectomy was then performed with good haemostasis, and the abdomen was closed in layers. The patient was discharged from surgery in stable postoperative condition.

Postoperative course was notable for transfusion with three units of blood due to persistent anaemia. The patient was continued on antibiotics and analgesia. The patient was discharged after 4 weeks in stable condition on oral antibiotics. She was connected with a community counsellor according to postabortion care guidelines.

GLOBAL HEALTH PROBLEM LIST

- ▶ Unsafe abortion is a leading global cause of maternal mortality.
- ▶ The vast majority of unsafe abortions occur in low/middle-income countries and abortion-restricted countries.
- ▶ Young and poor women are at particularly high risk.
- ▶ Death from unsafe abortion is entirely preventable.
- ▶ Barriers include abortion stigma, gender-based power imbalances, inadequate contraceptive use and sexual education, high cost and poor availability, and restrictive abortion laws.

GLOBAL HEALTH PROBLEM ANALYSIS

The World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating a pregnancy that is completed either by people who lack necessary skills or in an environment that does not meet basic health standards or both.⁵ The level of safety of an abortion exists on a spectrum, with certain mechanisms more dangerous than others. Common methods of unsafe abortions include vaginal insertion of dangerous objects such as herbs, twigs, or other sharp or caustic entities, as in our patient. Other methods include ingestion of hazardous materials, external force to the mother's uterus, or dilatation and curettage by an unskilled provider or in an unsafe environment.

It is estimated that each year, 22 million unsafe abortions occur worldwide. While there has been a global decline in total abortions, the proportion of unsafe abortions has increased from 44% in 1995, and 47% in 2003, to 49% in 2008.⁶ Almost all of the unsafe abortions occur in low/middle-income countries.⁷ Current estimates reveal that 4.7%–13.2% of all maternal deaths are caused by unsafe abortions.⁸

The burden of unsafe abortion and related maternal deaths are disproportionately higher for women in Africa than in any other developing region.⁹ Unsafe abortion is a central and well-established cause of maternal mortality in Uganda. One estimate found that there were an astonishing 294 000 primarily unsafe abortions performed in Uganda in 2003.¹⁰ In 2006, the Ugandan Ministry of Health estimated that abortion was the cause of maternal mortality in 26% of the cases, almost double the rate in neighbouring countries.¹¹

There is growing international awareness that unsafe abortion is a leading and preventable cause of maternal mortality and morbidity. In the year 2000, the Millennium Development Goals

identified the global imperative to reduce maternal mortality. In 2004, the World Health Assembly stated that, 'unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health'.¹²

Our patient noted that she delayed seeking immediate medical attention after her unsafe abortion due to fear of condemnation by her community. Because of abortion stigma, women like our patient may be reluctant to seek prompt medical care after postabortion complications. In 2015, a workshop was held in Kampala, Uganda, that examined the barriers to expanding safe abortion care in east Africa. Abortion stigma was consistently identified as restricting access and decreasing quality of current care.¹³ In countries around the world, moral and social judgement exists related to a woman's choice in pregnancy termination, contraceptive use and sexual intercourse.

To understand how this patient's rape and life-threatening abortion complications could occur requires a historical analysis of Uganda's social, religious and cultural landscape. Uganda has a long history of regulating women's sexuality and reproductive healthcare, similar to many countries around the world. In Ugandan society, men have traditionally been able to pursue careers in politics, engineering and medicine. Women's roles have been confined to the domestic arena as child bearer and caretaker, frequently justified as 'natural' and the consequence of having a womb. Many Ugandan men believe that it is their duty to decide if, how and when a woman will bear and raise children, whereas women have been left out of the discussion of control over their bodies.¹⁴ When the contraceptive pill/oral contraceptive was first introduced in 1957, Ugandan law made it available only to women who were married and not until the woman's husband granted written permission.¹⁴ These societal norms are exacerbated by economic disparities where men often have greater financial means and decision-making power.¹⁵ As a result, many young women are faced with limited ability to negotiate contraceptive use and safe abortion services even when available and accessible.

When women are denied the ability to plan their pregnancies and apportioned full childcare responsibilities, they are necessarily denied equal access to positions of power in civil society. Preventing women from having control over their bodies translates into a culture where deaths from unsafe abortions and rape are everyday realities. These patriarchal features of the sociopolitical landscape help to explain the environment that allowed our patient to be raped in her home by her uncle, denied safe abortion services and to suffer life-threatening abortion complications. Especially in situations of rape, where women have been denied control over their bodies, creating an option for safe abortion allows women to reclaim power over their bodies in the choice to continue a pregnancy or not.

This patriarchal sociocultural environment is intertwined with religious attitudes on contraception and abortion. The most widely practiced religions in Uganda include African traditional religions, Christianity and Islam. In African traditional religions, abortion is considered immoral; however, certain variations of contraception have been encouraged by African traditional religions with awareness of the benefits of family planning on maternal and infant health.¹⁴ The Catholic Church has considerable power and influence over society's view on abortion, and it is also the dominant Christian religion in Uganda. It teaches that human life and soul are present at conception, and thus termination of an embryo or fetus is viewed as murder. The Catholic Church is also opposed to almost all forms of contraception. Islamic religious views on abortion depend on the age of fetal development. The Qu'ran and some hadiths have stated that the

soul joins human life at approximately 120 days after conception, and so many believe that abortion afterwards is inexcusable.¹⁴ Understanding the moral stances of a society's major religions provides insight into the risk associated with contradicting these established value systems when a woman chooses to end a pregnancy.

The demographic and attitudes of providers often influence stigma surrounding abortion care. Historically, the majority of health providers in Uganda have been male, and many skilled health providers refuse to provide contraceptive services or abortion care on personal or political grounds, for example, because they believe the girl is too young to be sexually active.¹⁶ Furthermore, a restrictive legal environment reinforces the acceptability of the social stigma. There is an urgent need for stigma reduction and education strategies that challenge moral and social judgement surrounding abortion.

The use of modern contraception has resulted in a decreased incidence and prevalence of abortion worldwide.¹⁷ Unfortunately, it remains low in Africa, at 28% for all methods and 22% for modern methods.¹⁸ Only 30% of Ugandan women of reproductive age use contraception.¹⁹ This heavy burden of unwanted pregnancies leads to more than 300 000 induced abortions a year in Uganda, and 1200 deaths from unsafe abortion.²⁰ Barriers to contraceptive use among young people include false beliefs about contraception, cultural and social expectations regarding fertility, gender-based power imbalances, limited availability of contraceptives and provider bias.²¹ There is an unmet global need to expand comprehensive contraceptive services. Increased access to contraception would reduce unintended pregnancy and subsequent abortion-related maternal mortality.

Restrictive and ambiguous abortion laws prevented our patient from promptly receiving safe abortion services. When providers refused her abortion for fear of legal consequences, she turned to unsafe measures that resulted in life-threatening complications. She also experienced significant morbidity associated with hysterectomy at a young age, including infertility. It is estimated that 40% of women live in areas with highly restrictive abortion legislation or where lawful, have poor access such that legal abortion has little practical utility.²² In countries where abortion is legal and accessible, maternal mortality from abortion is minimal.²³ Restricted abortion legislation is likely to increase the number of unsafe abortions, and consequently, maternal deaths. In countries where laws and policies governing abortion are unclear, such as Uganda, skilled abortion providers may misinterpret the law and be less likely to provide safe abortion services. Accordingly, decriminalisation of abortion is likely to promote maternal health and safety. In countries with restrictive abortion legislation, there is a pressing need to update laws and policies to increase access to comprehensive safe abortion care.

Cost may prohibit a woman from accessing comprehensive safe abortion services. Many countries do not have national insurance systems or ones that do not cover abortion services. An individual fee often finances abortions in these settings. For poor women especially, user fees may be prohibitively expensive.²⁴ Additional costs of an abortion can include cost of travel and other social costs, such as unmet family responsibilities or lost time from work. Thus, poor women are more likely faced with the decision to self-induce an abortion or obtain an abortion from an unskilled provider or in an unhygienic setting.

Complications resulting from unsafe abortions are much more expensive for healthcare systems than providing safe abortions. This is especially true in low/middle-income countries where most unsafe abortions occur.²⁴ There is minimal additional staff, equipment and training needed to provide comprehensive safe

abortion services, as they coincide with the needs of most facilities that provide maternal health services.²⁴ Thus, in countries with high numbers of unsafe abortions, investing in comprehensive abortion services is likely to decrease maternal mortality and reduce overall healthcare costs. Health authorities should prioritise comprehensive abortion training, equipment and care that are available and affordable for all women.

Learning points

- ▶ Unsafe abortion is a leading cause of maternal mortality globally.
- ▶ The overwhelming majority of unsafe abortions occur in low/middle-income countries.
- ▶ Poor and young women are at a uniquely high risk.
- ▶ Death from unsafe abortion could be entirely prevented.
- ▶ Eliminating unsafe abortion will require a multifaceted approach aimed at stigma reduction, gender equality, increased contraception use and sexual education, and provision of safe, affordable and legal abortion care.

Contributors The patient initially presented to SK, who understood the importance of this case report and assisted in writing the case presentation. RO developed the concept, performed the literature review and was the main writer.

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