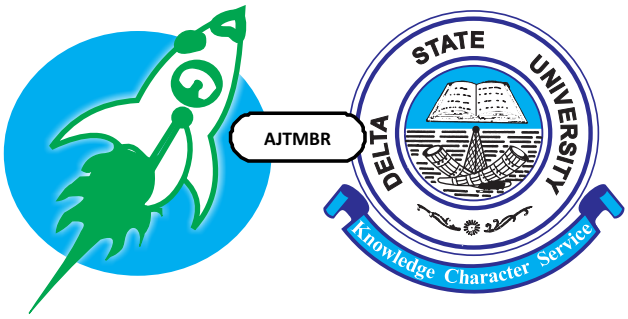
African Journal of Tropical Medicine and Biomedical Research (AJTMBR)



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The African Journal of Tropical Medicine and Biomedical Research is a multidisciplinary and international journal published by the College of Health Sciences, Delta State University of Abraka, Nigeria. It provides a forum for Authors working in Africa to share their research findings on all aspects of Tropical Medicine and Biomedical Sciences and to disseminate innovative, relevant and useful information on tropical medicine and biomedical sciences throughout the continent. The journal will publish original research articles, reviews, editorials, commentaries, short reports, case reports and letters to the editor. Articles are welcome in all branches of medicine and dentistry including basic sciences (Anatomy, Biochemistry, Physiology, Pharmacology, Psychology, Nursing etc) and clinical sciences (Internal Medicine, Surgery, Obstetrics and Gynaecology, Dental surgery, Child Health, Laboratory Sciences, Radiology, Community Medicine, etc). Articles are also welcome from social science researchers that document the intermediating and background social factors influencing health in countries of Africa. Priority will be given to publication of articles that describe the application of the principles of primary health care in the prevention and treatment of diseases.

Editorial Notices

The journal will be published biannually in the months of March and September. Annual subscription fee in Nigeria is two thousand naira (N2,000) per volume (2issues); One-thousand-naira single copy (N1000). The annual subscription rate for other parts of the world is as follows: United Kingdom £60 (post free). West Africa $60 (post free). The rest of the World and the United States of America $120 (post free). A charge of $60 is made for reprints inclusive of postage. Cheques should made payable to the African Journal of Tropical Medicine and Biomedical Research and addressed to the Editor-in-Chief.

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Original Research- The journal welcomes articles reporting on original research, including both quantitative and qualitative studies. Full-length articles should generally not exceed 3000 words, excluding abstract, tables, figures, and references. The subject matter should be organised under appropriate headings and sub-headings as itemized above.

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Editorial

Quantification of Unsafe Abortion in Nigeria and *Possible Panacea*

Omo-Aghoja LO

(Largely culled from an earlier publication by the author: Omo-Aghoja LO. Unsafe Abortion and miscarriages: Quantification and public health related perspectives. Port Harcourt Medical Journal 2013; 7:219-231).

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Introduction

Induced abortion continues to be a major public health issue that evokes social, political, legal, ethical, cultural, religious sentiments and debates in all societies.[1] And existing data indicates that unsafe abortion is a leading cause of maternal morbidity and mortality in developing countries.[1]

Discussion

About 53 million pregnancies are estimated to be terminated each year worldwide, over 20 million of these are unsafe.[2] Worldwide, 38% of the estimated 210 million pregnancies yearly are unplanned and 22% of these end up aborted, while 36% of the 182 million pregnancies occurring in developing countries including Nigeria are unplanned and 20% of these end up aborted. Many of these abortions are unsafe and Nigeria accounts for 20% of global estimates of abortion related deaths.[2] Of the 67,800 women that die from abortion each year, only 300 of these occur in developed countries and others in developing countries.[3] In developing countries, there are 330/100,000 abortion related deaths and 0.7/100,000 in developed countries.[4] Africa has the highest mortality ratio of 680/100,000. Indeed, the risk of dying from unsafe abortion in Africa is 1 in 150 and 1 in 1,900 in Europe.[4] These deaths occur in young adolescents, poor women and largely rural women with unmet contraceptive needs which is largely responsible for why they undertake abortion.[1-5] These abortions are rendered unsafe because of the restrictive abortion laws in Nigeria that have driven the practice underground and undertaken by backstreet professionals.

It is instructive to note that not only do large numbers of women require medical care because of unsafe abortion, but some of these women are likely to suffer long-term health consequences, while others will die as a result. In 1996, an estimated 610,000 abortions occurred (25 per 1,000 women of childbearing age), of which 142,000 resulted in complications severe enough to require hospitalizations.[1-5] The number of abortions was estimated to have risen to 760,000 in

2006. In 2012, an estimated 1.25 million induced abortions occurred in Nigeria, equivalent to a rate of 33 abortions per 1,000 women aged 15–49.[6] The estimated unintended pregnancy rate was 59 per 1,000 women aged 15–49. Fifty-six percent of unintended pregnancies were resolved by abortion. About 212,000 women were treated for complications of unsafe abortion, representing a treatment rate of 5.6 per 1,000 women of reproductive age, and an additional 285,000 experienced serious health consequences but did not receive the treatment they needed. Unsafe abortions are major reason Nigeria's maternal mortality rate is one of the world's highest. According to conservative estimates, more than 3,000 women die annually in Nigeria because of unsafe abortion.[1]

The World Health Organization estimates that each year, 12,000 deaths in West Africa result from unsafe abortion.[2] Henshaw et al in 1998 revealed that the rate of abortion is much lower in the poor, rural regions of northern Nigeria than in the more economically developed southern regions.[2] Regional differences in the level of abortion are considerable. Based on the best estimates from the work, the abortion rate is highest in the Southwest (46 abortions per 1,000 women), somewhat lower in the Southeast (32 abortions per 1,000) and much lower in the two northern regions (10-13 per 1,000). In the Southwest, the ratio of treatment for complications from abortions to that for miscarriages is higher than in any other region about 65,000 complications compared with nearly 46,000 miscarriages; in the Northwest, some 12,000 cases of abortion complications are treated annually, compared with about 28,000 miscarriages (not shown). Additionally, an estimated 40% of abortions were reported to be performed by physicians in established health facilities, while the rest are performed by nonphysician providers.

Of all hospitals and clinics that provide abortions, 87% are privately owned, and abortions are provided by non-specialist general practitioners at 73%. Three-quarters of physician providers use manual vacuum aspiration to perform abortions, and 51% of providers who treat abortion complications use this method. Physician respondents believe that the main methods used by nurses, midwives and other nonphysicians to induce abortions are dilation and curettage, hormonal or synthetic drugs and insertion of solid or sharp objects. Finally, the proportion of abortions performed by nonphysicians is highest in the Northeast (72% of procedures, compared with a national average of 60%).[2]

Possible panacea

Clearly unsafe abortion remains a major challenge and significant contributor to maternal morbidity and mortality. If the set sustainable development goal of maternal mortality reduction is to be achieved and the ICPD programme of action realizable in Nigeria, then concerted efforts must be made and geared towards addressing the key reasons and all intermediating factors why women undertake unsafe abortion. It is against this backdrop that the following recommendations are proffered as relevant interventions that will help.

Firstly, it is necessary to advocate for a review of the existing restrictive laws in Nigeria and other developing countries in order to reduce the high morbidity and mortality from unsafe abortion.[7] Advocacy and public health education that would increase the women's and provider's knowledge of the revised law,

help deal with the issue of religious and socio-cultural stigmatization of abortion, would certainly increase the benefits of liberalization in reducing mortality associated with unsafe abortion and this is advocated for priority attention. Secondly, is making available and creating access to comprehensivee contraceptive services. The fact that contraception is a necessary step to reducing the incidence of unwanted pregnancy (the real reason women will procure abortion) has been very well captured in the consensus statement by the International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Council of Nurses (ICN), and the United States Agency for International Development (USAID) on 25 September 2009*: "If the woman we treat for post abortion complications is there because she could not get contraception, we have failed her. If she leaves without family planning, we have failed her twice."* (1994, Postabortion Care (PAC) Consortium, International Conference on Population and Development (ICPD), Cairo). Additionally, a comprehensive sexual and reproductive health education must be put in place in our schools and in the community. Extensive advocacy activities and programs should be instituted to ensure wide coverage and dissemination of the facts. Barriers to obtaining a safe abortion by a trained provider could be reduced by publicizing the availability of such services and by making abortion available at low cost in more facilities, including public hospitals and clinics. More training in the safest abortion methods could be provided to physicians and others who perform abortions, and more physicians could be encouraged to offer the service. Women empowerment and gender equity is also advocated for.

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