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Original Research Article

Demography, clinical profile and outcomes of self-prescribed abortion pills among women, experience from a tertiary care teaching hospital in central India

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ABSTRACT

Background: Medical abortion pills have revolutionised the freedom of woman in her decision for abortion. Due to self-medication of these drugs by pregnant women without any medical consultation or supervision has become very common. This study was carried out to study the analyse the effect of unsupervised self-prescription abortion pill in women attending tertiary care centre.

Methods: This prospective observational study was conducted among patients with history of unsupervised intake of medical abortion pill. After written and informed consent socio-epidemiological factors like age, marital status, education status, residence and family were counselled. Obstetric history was noted, source of procurement, reason behind the pill intake, time duration since the pill intake to presentation, gestational age at time of pill consumption, the regime followed and complaint at presentation to health care facility were noted. Final outcome in the form of any medical measures and treatment or surgical intervention done was noted.

Results: In present study, most of the patients (52%) belongs to 18-24 years of age group. Based on ultrasonography (USG) findings and clinical examination 70% of patient had incomplete abortion, 22% had complete abortion, 1.3% had incomplete abortion with shock, 3.3% ectopic pregnancy had incomplete abortion with sepsis and 1.3% had incomplete abortion with shock.

Conclusions: When abortion performed under medical supervision, medical abortion is both effective and safe. To regulate and restrict the over-the-counter sale of abortion pills, strict law is essential, and public access to abortion pills should be limited to MTP-licensed centres.

Keywords: Abortion, Pills, MTP, Self-prescription

INTRODUCTION

Medical abortion pills have revolutionised the freedom of woman in her decision for abortion.¹ According to World Health Organization (WHO) unsafe abortion is that which is not provided through approved facilities and or person.⁴ According to WHO, 19 million women worldwide undergo unsafe abortion annually and 18.5 million of these cases occur in developing nations. Mortality attributed to unsafe abortion is about 68,000 per year.² In India, around

6.4 million abortions occur annually and among these 56% are unsafe which accounts for 8-20% of all maternal deaths.³ The use of abortion pills is governed by clear guidelines developed by organisations such as the WHO and Federation of Obstetrics and Gynaecological Societies of India (FOGSI). This guideline advocates the use of combo-pack of 1 tablet mifepristone (200 mg) plus 4 tablets of misoprostol (200 µgm each) for termination of pregnancy up to 63 days of gestation.³ Medical abortions is a safer option than surgical abortion because it avoids problems such as infection, uterine perforation, cervical

trauma, and incompetence. However, it is only a blessing if it is used according to standard procedure and under adequate medical supervision.⁴ When a patient, her husband, a family, or a friend buys an abortion pill over the counter without medical supervision or prescription, it is referred to as "self-medication".⁵ Complications such as excessive haemorrhage, sepsis, and deaths from untreated ectopic pregnancies are not uncommon among women who self-administer these medications.⁶ The aim of the study to analyse the effect of unsupervised self-prescription abortion pill in women attending tertiary care centre.

METHODS

This prospective observational study conducted among patients attending to OPD and emergency department of obstetrics and gynaecology, Gandhi Medical College, Bhopal. During January 2020 to July 2021, 200 patients were included in the study. By self-medication we mean these pregnant women had no medical consultation with a registered medical practitioner and has taken the abortion pills which was purchased from the pharmacy without any prescription by herself or by some close relative. After written and informed consent Socio-epidemiological factors like age, marital status, education status, residence and family was counselled. Obstetric history was noted, source of procurement, reason behind the pill intake, time duration since the pill intake to presentation, gestational age at time of pill consumption, the regime followed and complaint at presentation to health care facility were noted. Final outcome in the form of any medical measures and treatment or surgical intervention done was noted. All patients were inspected and examined completely.

Data was collected and entered simultaneously in statistical package for social sciences (SPSS) version 23 and coded appropriately. Descriptive statistics were calculated to summarize the sample characteristics in terms of frequency and percentage. Graphs and charts were made. Analytical and inferential analysis was applied between dependent variable and other independent variables. Significance was set at standard 0.05.

RESULTS

In present study, most of the patients (52%) belongs to 18-24 years of age group and 40.3% of participants belongs to 25-30 years of age group. Only 1.7% of participants were graduated and majority of the women were educated up to higher secondary level (28.7%). It was found that according to modified Kuppaswamy scale most of the participants (33% and 32.3%) belongs to upper lower and lower socioeconomic status. Only 8% of participants belongs to upper class. Majority of the women belonged to rural areas (63.3%).

In present study most of the patients (57%) were primi, 37.3% were multi gravida and only 5.7% patients were grand multi. It was found that most of the patients (32%

each) had taken pills in the gestation period of 9-12 weeks and 7 weeks, 28% of patients had taken pills in 7-9 weeks of gestation, and 8% of patients had taken pills after 12 weeks of gestation. 29% of participants herself brought the medicine, 36.7% of patients husbands brought medicines and 34.3% of patients' other relatives brought medicines.

Table 1: Distribution of women according to socio-demographic variables.

Socio-demographic variables	Frequency	Percentage
Age groups (years)		
18-24	156	52.0
25-30	121	40.3
31-36	10	3.3
37-42	13	4.3
Education		
Uneducated	30	10.0
Primary	70	23.3
Middle	54	18.0
High school	55	18.3
Secondary	86	28.7
Graduate and above	5	1.7
Occupation		
Upper class	24	8.0
Upper middle	25	8.3
Lower middle	55	18.3
Upper lower	99	33.0
Lower	97	32.3
Residence		
Rural	190	63.3
Urban	110	36.7

Table 2: Distribution of clinical profile among study participants.

Clinical variables	Frequency	Percentage
Gravida status		
Primigravida	171	57.0
Multigravida	112	37.3
Grand multi-para	17	5.7
Gestational age (weeks)		
Early pregnancy <7	96	32.0
7-9	84	28.0
9-12	96	32.0
>12	24	8.0
Interval between pill intake and hospital visit (days)		
1-10	52	17.3
11-20	172	57.3
21-30	44	14.7
>1 month	32	10.7
Sources of procurement		
Self	87	29.0
Husband	110	36.7
Relatives	103	34.3

It was found that majority (46.6%) of patients reported with bleeding and abdominal pain as their complaints (Table 3).

Table 3: Distribution of patient according to their chief complaints.

Chief complaints	Frequency	Percentage
Excessive bleeding per vagina	70	23.3
Irregular bleeding per vagina	26	8.7
Bleeding with abdominal pain	140	46.6
Abdominal pain	43	14.3
Fever with abdominal pain and irregular bleeding	10	3.3
Non expulsion product of conception	11	3.6

Based on ultrasonography (USG) findings and clinical examination 70% of patient had incomplete abortion, 22% had complete abortion, 1.3% had incomplete abortion with shock, 3.3% ectopic pregnancy had incomplete abortion with sepsis and 1.3% had incomplete abortion with shock (Table 4).

Table 4: Distribution of patient according to their diagnosis.

Diagnosis	Frequency	Percentage
Incomplete abortion	210	70
Complete abortion	66	22.0
Incomplete abortion with sepsis	10	3.3
Incomplete abortion with shock	04	1.3
Ectopic pregnancy	10	3.3

Based on procedure/method used for management of patients, 65% of patients managed through MVA only.

Women were counselled for use of regular contraception at the time of discharge (Table 5).

Table 5: Distribution of patient according to treatment received by the patients.

Management of complications	Frequency	Percentage
MVA only	204	68
MVA and BT	52	17.3
Treatment not required	24	8.0
Laparotomy for ectopic pregnancy	10	3.3
Sepsis management	10	3.3

DISCUSSION

MTP Act legalised abortion so as to reduce maternal deaths due to unsafe abortions. But still the burden of unsafe abortion in developing countries India is too high.⁷ Unsafe abortion include self-induced abortion or those performed by persons lacking necessary skills or in the environment without minimal medical standards or both.⁸ But still 8-11% maternal mortality in low and middle income countries are due to unsafe abortions.⁹

In present study, majority of the patients (52%) were in the age group of 18-24 years, followed by 40% in 25-30 years, 4.3% on 37-42 years and 3.3% in 31-36 years. Majority of participants were educated (28.7%) till higher secondary school, 23.3% were educated up to primary level and only 1.7% were graduate. Yadav et al reported, majority (87.4%) of women was in the 20-35-year age group and 70.2% women had education up to secondary school or higher.¹⁰ In our study according to modified Kuppaswami classification, pill misuse was mostly widespread among upper lower (33%) and lower category (32%) followed by 8% in upper class. Similar results were reported by Bhalla et al where pill misuse was more widespread among low socio-economic strata women (87%).⁴ In present study majority of the participants were living in rural area (63.3%) and 36.7% were residing in urban areas. Majority of the study participants were primigravida (57%), 37.3% were multi gravida and 5.7% were grand multipara. In this study the % of Primigravida patients were higher in comparison to other studies. Thapa et al reported, 37.8% were primigravida and 62.2% were multigravida.¹¹ This demonstrates that women rely on medical abortion and see it as a better way to space out their pregnancies than taking contraception and preventing undesired pregnancies in the first place. The safe upper gestational age limit for pill intake is seven weeks, according to the MTP Act of India. Even if performed under ideal conditions, the risk of complications associated with all types of abortion increases with gestational age, rising exponentially after the first trimester. In present study it was found in this study that most of the patients (32%) had taken pills in the gestation period of 9-12 weeks, 28% of patients had taken pills in 7-9 weeks of gestation, 32% of patients had taken pills before 7 weeks of gestation and 8.0% of patients had taken pills after 12 weeks of gestation. Similar to our findings Giri et al reported that, 19% of the patients used the pills between 9 and 12 weeks of pregnancy, and another 21% used it after 12 weeks, which is pretty concerning.¹² Most of the participants (57.3%) reported after 11-20 days of pills intake, 17.3% of patients reported after 1-10 days of pills intake and 10.7% of patients reported after 1 month of pills intake. Munshi et al reported that majority of women 30 (75%) had consumed the abortion pills 1-10 days before coming to the hospital.¹³ In present study, it was found that 29% of participants herself brought the medicines from chemists, 36.7% of patients husbands brought medicines and 34.3% of patients' other relatives brought medicines. Thakur et al reported that source of information regarding pills was Husband

(28.57%) in most of the cases, followed by chemist, friend or relatives (14% each).¹⁴ This depicts that despite the legal ban on over-the-counter supply of this drug and the rigorous guidelines of the MTP Act, the drug is commonly misused. In this study it was found that 46.6% of patients reported with bleeding with abdominal pain as their complaints, followed by 23.3% of participants reported with excessive bleeding per vagina, irregular bleeding with per vagina, abdominal pain, fever with abdominal pain and non-expelled product is presented by 8.7%, 14.3%, 3.3% and 3.6% respectively. Side effects reported by Thakur et al were heavy bleeding (42.86%), weakness and giddiness (35.71%), pain abdomen (21.43%) and irregular periods (14.29%).¹⁴ In present study, based on USG findings and clinical examination 70% of patient were diagnosed as incomplete abortion, 22% as complete abortion, 1.3% as incomplete abortion with shock, 3.3% ectopic pregnancy and 3.3 % incomplete abortion with sepsis. Similar to our findings, Giri et al reported, 60% of the patients had an incomplete abortion, 13% had a viable pregnancy, 6% had a septic incomplete abortion, and 6.5% had an ectopic pregnancy.¹²

The high prevalence of incomplete and unsuccessful abortions in this study is due to the unsupervised pill intake. In present study 65% of patients managed through MVA only, 17.3% of patient were managed through MVA and BT, 8% of patient did not require any treatment, and 3.3% of patient required laparotomy for ectopic pregnancy 3.3% of patient required sepsis management. In a study done by Munshi et al, authors reported that instrumental evacuation was required in 28 (87.5%) patients. Laparotomy for ruptured ectopic and rupture uterus was performed in 1 (2.5%) of each patient. 6 (15%) patients were severely anaemic. Transfusion of blood was required in 9 (22.5%) of patients.¹³

Limitations

The study's sample size was limited; larger sample sizes would provide more robust insights. The research was conducted at a single tertiary care center, which may not capture variations in self-prescription practices in different regions or healthcare settings. The study did not delve deeply into the reasons why women chose self-prescription of abortion pills. Understanding the motivations and barriers would be valuable for designing interventions

CONCLUSION

Unsupervised self-prescription of abortion pills poses serious risks, including incomplete abortions and life-threatening complications. This study, conducted in a tertiary care center, revealed a predominantly young, rural demographic seeking abortion outside recommended gestational limits. Addressing these issues requires greater awareness, accessibility to safe abortion services, and stricter regulations on over-the-counter abortion pill sales.

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