



Maternal mortality and morbidity post unsupervised consumption of abortion pills at a secondary hospital setting: a case series

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Abstract

Unsafe abortions contribute to approximately 8-11% of global maternal fatalities and predominantly occur in low- and middle-income nations. The Medical Termination of Pregnancy (MTP) Act enacted by the Indian Parliament in 1971, was aimed at regulating and ensuring the accessibility of safe abortion services. Following the enactment of this legislation, a legal framework was established for abortion in India. This act delineates the circumstances under which abortion may be performed, the locations suitable for such procedures, and the qualified personnel authorized to carry them out.

The World Health Organization (WHO) and the Federation of Obstetric and Gynecological Societies of India (FOGSI) have developed comprehensive guidelines for pre-abortion assessments, including the confirmation of pregnancy, accurate determination of gestational age, and validation of the intra-uterine location of the pregnancy.

In spite of the relatively progressive abortion care services available in India, a significant number of women resort to self-medication with unsupervised over-the-counter (OTC) abortion pills for MTP. This practice results in a considerable incidence of unsupervised abortions and potentially life-threatening complications.

We present, herein, a series of case reports documenting instances of OTC abortion pill consumption that led to morbidity and perilous situations, including near-miss cases that necessitated urgent medical and surgical interventions. Furthermore, we illustrate how our support and care have played a pivotal role in fostering resilience and faith in these women.

Keywords: Abortion, self-prescribed abortion pill, OTC abortion pill, Medical Termination of Pregnancy

Introduction

Unsafe abortion persists as a formidable public health dilemma, particularly in resource-limited settings where access to comprehensive reproductive healthcare is severely constrained. Although medical methods for abortion are legally sanctioned and can be safely administered under appropriate supervision, the unregulated consumption of abortion pills has become increasingly widespread. This phenomenon is often propelled by factors such as societal stigma, a lack of awareness, and insufficient access to trained healthcare professionals. When not utilized correctly, medical termination of pregnancy (MTP) can precipitate significant maternal morbidity and, in some instances, mortality—especially when complications remain unrecognized or untreated.

Secondary healthcare facilities frequently serve as the first point of referral for women experiencing adverse outcomes following unsupervised abortion attempts. These centers thus provide critical insights into the clinical and systemic consequences of this public health issue.

Annually, approximately 6.4 million abortions occur in India, with over half categorized as unsupervised. These unsupervised abortions are responsible for an estimated 8% to 20% of maternal deaths in our country.^{1,2}

Unsupervised utilization of abortion medication is associated with a myriad of complications as cited in various studies including those done by Sarojini and Ashakiran.² These complications encompass incomplete abortion, missed abortion, ruptured ectopic pregnancy, and uterine rupture. Management frequently necessitates emergency interventions such as surgical procedures, blood transfusions, admissions to intensive care units, and treatment for acute renal injury.^{2,3} Reports of maternal mortality have also emerged, highlighting the potentially fatal ramifications of unregulated and un-monitored medical termination of pregnancy pill usage.

Despite the existence of unequivocal legal stipulations under the Medical Termination of Pregnancy Act (1978), which dictate that abortion pills must be prescribed exclusively by

authorized medical personnel and administered under medical supervision, a considerable number of women continue to procure these medications directly from pharmacies without any prior consultation. Research has demonstrated that many women remain oblivious to the associated risks and often adhere to unverified, self-constructed, dosing regimens, thereby, heightening the probability of complications and treatment failures.³ Moreover, the decision to utilize MTP pills is frequently swayed by male partners, particularly husbands, as underscored by the findings of Ganatra B, Gerds C, Rossier C, et al.^{3,4}

Through this case series, we aim to examine and document the clinical presentations, management challenges, and outcomes among women presenting to a secondary healthcare facility following the unsupervised consumption of abortion pills. By highlighting these real-world experiences, this study seeks to inform public health strategies, support policy formulation, and enhance awareness regarding the safe and supervised use of medical abortion methods.

Case 1

A 28-year-old P1+1 presented at our emergency with complaints of spotting on and off and pain lower abdomen for nearly 40 days, which was gradually increasing in intensity. On detailed history taking, she revealed that she had a cesarean section a year back. Also, she said that she became pregnant again. When it was 8-10 weeks gestation, she herself induced abortion by taking medication bought over the counter, without the prescription of any registered medical practitioner. This was about 40 days previously. All her symptoms had begun after consuming the medicines.

On general examination her pulse rate was 126 per minute and temperature were raised to 100 F. Per-speculum examination revealed extremely foul-smelling pus discharge. On per vaginal examination, uterus was approximately 12 week's size and tender. Patient was further investigated, and it was found that her hemoglobin was 6 gm % with raised total leucocyte count and C- Reactive Protein levels.

Her liver function test, renal function test, urine microscopy, and coagulation profile were well within normal limits. Her ultrasound scanning revealed a bulky uterus, with a heterogeneously hyperechoic lesion in the lower uterine segment with presence of fluid in the endometrial cavity.

She was diagnosed with post abortion endometritis. Patient was started on broad spectrum antibiotics and one unit of packed red cells was transfused. Examination under anesthesia was done, and after dilatation of the cervical opening, approximately 30-40 cc of pus was drained that was sent for culture and sensitivity. Antibiotics were continued for seven days. The patient's condition improved. Contraceptive counselling was done, and patient opted for interval contraception with injection depot medroxyprogesterone acetate given after the treatment.

Case 2

A 26-year-old, (Gravida-5, Para-1, Living-1, Abortion-3) with a previous history of lower segment cesarean section (LSCS), presented to our hospital with painless bleeding per vagina 10 days previously, following 10 weeks of amenorrhea. She had a positive urine pregnancy test six weeks prior to presentation. There was no history of any contraceptives used. She gave a history of intake of medications for abortion three times in the past, all of which were uneventful. She experienced per-vaginal spotting initially, which made her assume that her pregnancy was non-viable, so she attempted self-induction of medical abortion with MTP kit 5 days prior to presentation at our hospital. All the above mentioned were self-induced abortion with medications, bought over the counter without any proper prescription of any registered medical practitioner.

At presentation to our emergency room, her general condition was poor with severe pallor, tachycardia (110-120/min) and blood pressure (BP) of 60/30 mm of Hg. Blood investigations done revealed haemoglobin level of 4.4 gm/dL and other parameters within normal limits. Furthermore, per speculum examination showed active vaginal bleeding and bi-manual

examination revealed a uterine size of 10 weeks. Ultrasound finding revealed a ruptured ectopic pregnancy with hemo-peritoneum. She was initially hemodynamically stabilized with I.V. fluids and ionotropic support and was taken up for emergency laparotomy surgery under the cover of blood. She received a total of three units of blood along with other medication, given over a period of one week. Patient recovered satisfactorily.

Case 3

A 24-year-old (Gravida-4, Para-2, Living-2, Abortion-1) with a prior history of an unremarkable vaginal delivery, presented to our hospital with an episode of painless vaginal bleeding persisting for one week, subsequent to 12 weeks of amenorrhoea. She had a positive urine pregnancy test 8 weeks previously. There was no history of any contraception used. She experienced per-vaginal spotting initially, which made her assume that her pregnancy was aborted, so she attempted self-induction of medical abortion with MTP kit one week prior to presentation to our hospital. This self-administered abortion was conducted utilizing medications procured over the counter, devoid of any appropriate prescription from a licensed medical practitioner.

At presentation, her general condition revealed severe pallor, tachycardia (140/min) with a blood pressure (BP) of 70/40 mm of Hg. Blood investigations showed haemoglobin 5.2 gm/dL, and other parameters were within normal limits. Furthermore, per speculum examination showed active vaginal bleeding and bi-manual examination revealed a uterine size of 16 weeks, ultrasound finding revealed molar pregnancy. She was initially stabilized with fluids and then taken up for suction evacuation under the cover of blood. She also received three units of blood along with other medication given over a period of one week. Patient recovered satisfactorily.

Discussion

Medical abortion with mifepristone and misoprostol is considered safe for women for termination of pregnancy up to 63 days

if practiced under medical supervision with followup.^{4,5} But self-induced abortion by self-administration of abortion pills has a higher complication rate.⁶ Such complications can include psychological and emotional consequences, whether supervised by a physician or self-administered.

The MTP Act of India, legalizing abortions, was passed with the aim of reducing the number of maternal deaths due to unsafe abortions.⁷ The MTP act of India permits that abortion pills be prescribed by only registered medical practitioners and not by non- allopathic doctors or by pharmacists. WHO recommends that the person or facility prescribing abortion pills should have a backup, health care facility in case of failed or incomplete abortion.⁸ In spite of such clear guidelines and recommendations, self-administration of these drugs by pregnant women without any medical consultation or supervision has become highly prevalent due to availability of these drugs over the counter without any prescription. Many women depend on medical abortion and consider it as a method of spacing between pregnancies.⁹ Some consider it as a method of birth spacing and depend on it without knowing its complications can include sepsis, severe haemorrhage, or even death.¹⁰

In our 1st case, the woman had spotting for about 40 days and had Pelvic Inflammatory Disease (PID). Even though studies have indicated that there were no long-term complications like increased risk of spontaneous abortions, ectopic pregnancies, low birth weight babies, or preterm babies following medical abortion¹¹ when undertaken under unsafe conditions without medical supervision, there is a risk of long-term sequelae like infertility secondary to PID.

In the 2nd case, the woman who had an LSCS, had had three abortions earlier by taking over the counter medications. When she took it for the 4th time, she presented with profuse bleeding. This is a clear-cut case of repeated misuse of medication. The major complaint at presentation was excessive bleeding (78%).¹³ This is similar to what is seen in the hospital. Self-administered abortion or abortion pill by

an unskilled person is considered to be unsafe abortion by WHO.

In the 3rd case, spotting which followed intake of abortifacient was considered to be abortion by the woman. However, when profuse bleeding took place, she was rushed to the hospital where blood transfusion and evacuation of vesicular mole saved her life. The level of awareness among the public seems to be limited. In child-bearing age, a period of amenorrhoea is thought to be pregnancy. Women tend not to access medical help in hospitals when they have amenorrhea. This could be due to financial constraints, hierarchical societies in which permission has to be sought from the elder in the family or, at times, just the fact that the hospital is too far away. However, bleeding prompts one to rush to hospitals.

A very important issue we see in all the three cases is that due to self-medication, these women did not have medical advice, medical back up facility, and follow up as recommended by WHO.⁹ On the other hand, if they had undergone abortion in a healthcare facility under direct medical supervision, there would have been close monitoring with regular follow up. This could have prevented life-threatening bleeding, rushing to the facility, anxiously waiting for a favourable outcome, and undue medical expenses. The purpose of the MTP Act, to make safe abortions accessible, has failed. The fact is that pregnancy kits and abortion pills are readily accessible over the counter even in rural areas, so one does not feel the need to get MTP done in a healthcare facility.

In our hospital, during a period of six months, there were 68 cases with complications of self -induced medical abortions. 76% cases required surgical evacuation of retained products of conception, 8% needed laparotomy to treat ruptured ectopic pregnancies, and about 22% needed ICU care as they had sepsis and extremely low haemoglobin levels. Other studies on unsupervised group showed similar results; study conducted by Mishra N, et al. concluded that 46.5% require surgical evacuation, medical management in 33.7%, and 2.3% patients underwent laparotomy.^{13,14}

Another study conducted by Thaker RV, et al. concluded that 75.6% require surgical evacuation, 5.4% required laparotomy, and 5.4% did not require any intervention.¹⁵ Ojha N, et al. reported 56% requiring surgical evacuation, and 13.3% required laparotomy.¹² ICU admissions accounted for the cases; among them, there was one case of acute kidney injury secondary to hemorrhage. Based on these, we interpret that unsupervised medical abortion can lead to life threatening complications. 8% of maternal deaths are attributed to unsafe abortions in India.¹³

Over-the-counter utilization of abortion pills devoid of medical oversight could engender women to a multitude of complications, including but not limited to, failed abortions, incomplete abortions, infertility, ruptured ectopic pregnancies, severe bleeding, sepsis, shock, and maternal mortality. Unsafe abortion mostly leads to complications like sepsis, uterine perforation, cervical trauma, ectopic pregnancy, and incomplete abortion. It is the major reason for maternal morbidity and mortality and has become a global health issue.¹³ Medical abortion is an alternative to surgical abortion but self-administration without professional consultation is a serious issue.¹⁴

Non-adherence to the recommended medical protocols is very commonly observed, reflecting broader systemic and educational gaps. These patterns point to an urgent need for improved community-level education, stronger enforcement of regulatory frameworks, and the expansion of accessible, non-judgmental, reproductive health services. Based on our observations, we recommend that medical abortion in the first trimester, when deemed necessary, should be conducted only after thorough medical evaluation and options counseling.

The right of a pregnant woman over her body is important, but people should be prevented from killing the unborn indiscriminately. Presently, the pregnant woman's body contains another human body and life that is in some stage of development. For this reason, the argument that she should have absolute right over her own body does not hold because, what

affects her body and life will also affect the body and life of another person. However, this does not mean that the woman forfeits her rights over her body and her life. What it means is that when she makes her decision, she has to consider that her body is carrying an actual human life.

The lax implementation of the Medical Termination of Pregnancy (MTP) Act does indeed contribute to the misuse of abortion pills. From a theological perspective, the view of human life as sacred and precious can shape one's stance on abortion.

Many religious traditions emphasize the sanctity of human life, considering it a gift from God, the author of life. Theological perspectives often emphasize the dignity and worth of every human being, regardless of circumstances. This can lead to a more nuanced understanding of the complexities surrounding abortion. Encouraging respectful dialogue between individuals with differing perspectives on abortion can help foster greater understanding and empathy.

In fact, in light of human nature, it might be concluded that accessibility and safety are at cross-purposes. Two of the three cases had had previous abortions. Free access of abortifacients appears to make abortion a trivial matter, and this kind of thinking is potentially dangerous. Ending a pregnancy is hardly a trivial matter as a *human* life is extinguished. Considering it trivial shows a low view of the value of human life.

Limitation of this study

This study has not researched why women of child bearing age are not using contraceptives to prevent pregnancy. Also, it has not found out why the women did not obtain MTP in a hospital but resorted to self-induced medical termination of pregnancies. It could be that women fear publicity if they access the hospital for MTP.

Recommendations

- Awareness about complications of unsafe abortions should be given to all women to prevent over-the counter usage of MTP pills.⁶



- Women should be educated about the availability of the various contraceptive methods to prevent unwanted pregnancies.⁶
- Strict legislative measures are needed to prevent over-the-counter usage of MTP pills.
- Advocate that medical abortion during the first trimester should be considered solely after a comprehensive medical evaluation and options counselling.
- Create awareness that threat to the lives of mothers is a very serious outcome of taking over the counter medications to have abortions.

Conclusion

Medical abortion has become a choice for women facing an unwanted or unexpected pregnancy. Abortifacients are freely available over the counter in India. Women in child-bearing age are susceptible to morbidity and mortality due to the consumption of abortifacients available over-the-counter, especially without medical supervision. Profuse vaginal hemorrhage could be life-threatening. When faced with complications after taking abortifacients, women tend to access medical help in hospitals where life-saving measures are employed to decrease morbidity and to prevent mortality. There is urgent need for supervision of legislation and restriction of drugs available over the counter for medical termination of pregnancy. If needed, MTP should only be carried out by healthcare professionals to prevent maternal mortality and morbidity due to indiscriminate use of these medications.

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