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MEDICAL ABORTION: COMPARATIVE STUDY BETWEEN KYRGYZSTAN AND INDIA

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Abstract:

Although more than one method of abortion has been available for many years, in most countries the provider chooses the method and may be skilled in one method only. This paper discusses choice and acceptability of medical abortion from the perspective of both women and abortion providers and argues that choice of method is important for both. Safety, efficacy, number of visits, how the method works, how long it takes for the abortion to be complete and cost all affect acceptability. Medical abortion is considered more natural because it happens in women's own bodies and can take place at home before nine weeks of pregnancy; surgical abortion with vacuum aspiration is simple and over quickly. Unless the costs of both methods are similar, however, women and providers will tend towards whichever is the cheaper option, limiting choice. Medical abortion is effective from when a woman misses her period through 24 weeks of pregnancy, and more women and providers need to be made aware of this. In legally restricted situations, complications tend to be less serious and easier to treat with early medical abortion than after unsafe invasive methods. Ideally, both medical and surgical methods should be available, but each can be provided without the other.

Keywords:

medical abortion, abnormal vaginal bleeding, advantage and disadvantage of abortion, pregnancy

Introduction:

Medical abortion is a procedure in which medication is used to end a pregnancy. It does not require surgery and is performed through the ninth week of pregnancy, Access to contraception and safe comprehensive abortion care remains uneven around the world and complications due to unsafe abortion are still significant causes of maternal morbidity and mortality. More than half of all pregnancies globally are Unplanned, and one in every four, or 56 million pregnancies per year, ends in abortion. Of these, an estimated 25.2 million are unsafe abortions. The vast majority of these unsafe abortions – 97 per cent – occur in low- or middle-income countries, which are more likely to have restrictive abortion laws, high unmet need for contraception, shortages of trained healthcare providers and limited access to quality health care. A large body of evidence, practice internationally, and recommendations by the World Health Organization(WHO) supports the efficacy of a 200 mg dose of mifepristone, followed by 800 mcg of misoprostol in pregnancies up to 63 days' gestational age [9,10] and recent data supports extending its use to 70 days' gestation [11]. These protocols are highly effective, with treatment failure occurring in approximately 2–5% of cases [3,9]. Gestational age is known to affect the efficacy of all regimens, with decreasing efficacy after nine weeks' gestation [12], which is why regimens recommend routinely repeating misoprostol doses starting in the late first trimester. Home administration of misoprostol has similar effectiveness as clinic administration up to 63 days' gestation and is endorsed as a safe and acceptable practice in the WHO guidance [9,10]. Studies of later gestational age ranges would need also to demonstrate similar efficacy, acceptability and rates of adverse events with home administration of medical abortion drugs.

Objective:

The aim of the article is to know the modern method, current evidence and advantage disadvantage of medical abortion in India and Kyrgyzstan

Methods:

We searched PubMed and Cochrane databases for articles in any language that examined the success of medical abortion at gestational ages (>63 to≤84 days' gestation). We sought articles that compared: medical abortion with surgical abortion at this gestational age, combination mifepristone and misoprostol and/or misoprostol alone); different dosages of misoprostol; different routes of misoprostol administration; frequency of dosing; and location of medical abortion (in health care facility vs. outpatient management). Our primary outcome was complete abortion. Data was independently abstracted by two authors, graded for evidence quality, and assessed for risk of bias.

Medical management of incomplete abortion at <13weeks of gestation

Recommendation	Combination regimen	Misoprostol Only
Incomplete abortion <13weeks of gestation	**Mifeprostone >>1-2days >misoprostol**	**Misoprostol Po /SL**
		600 ug PO or 400ug SL

For the treatment of incomplete abortion at <13 week of uterine size , We suggest the use of 600ug misoprostol administration orally or 400 ug misoprostol administer sublIngually

Reference no:7

Advantage and disadvantage of medical abortion

Advantage are: less invasive, does not require anesthesia, prevent physical trauma, less expensive. Disadvantage are: high failure rate, more side effect, bleeding and pain nay be greater.

Kyrgyzstan steps for medical abortion

1)Between August 2014 and September 2015, midwives provided medical abortion to 554 women with a complete abortion rate of 97.8%, of whom 62% chose to use misoprostol at home 99% indicated a high level of satisfaction

2) According to the service in Kyrgyzstan, 20,172 abortions were registered in 2019. Every year the number of abortions increases by 1.6%. This is most likely due to the steady decline in the proportion of women of reproductive age using contraception

3)One of our biggest achievements was to register the drug "MEDABON" in the countryThis has increased women's choice and access to safe abortion methods in Kyrgyzstan (1) (2)

India steps for medical abortion

In India due to easy availability of this drugs 112 women got side effects Majority (101; 90%) took two drugs (Mifepristone and Misoprostol), 28 (25%) used correct dosage. Drugs were consumed beyond 9 weeks of gestation by 25 (22.4%) women. Abnormal vaginal bleeding was commonest 105 (93.75%) presentation. Hemorrhagic shock was noted in 21 (18.75%) women, while 21 (18.7%) women required blood transfusion. (3) (4)

Scoping and formulation of guideline questions

:###Preliminary PICO questions were identified, discussed, reviewed, modified and finalized during the scoping meeting.PICO question: For an unsensitized Rh-negative individual seeking abortion at < 12 weeks of gestation, is no administration of anti-D a safe and effective alternative to routine anti-D administration?

P: Unsensitized Rh-negative individuals seeking abortion at < 12 weeks (undergoing either medical or surgical abortion)

I: No anti-D administration

C: Routine anti-D administration

O:

Rate of isoimmunization in subsequent pregnancy

Rate of antibody formation after initial pregnancy.

Example ::

For a pregnant person seeking medical abortion at < 14 weeks of gestation, is pain control with any particular (i) pharmacological method (given prophylactically or after onset of pain) or (ii) non-pharmacological method safer, more effective and/or more satisfactory/acceptable compared with any other such method or no treatment/placebo?

P: Pregnant persons seeking medical abortion at < 14 weeks of gestation

I:

Pharmacological methods (Timing: prophylactic or after onset of pain)

Ibuprofen

Acetaminophen plus codeine

Anti-emetics

Loperamide

Tramadol

Non-pharmacological methods (music, acupuncture, “verbicaine”, etc.)

C:

Pharmacological methods (Timing: prophylactic or after onset of pain)

Ibuprofen

Acetaminophen plus codeine

Anti-emetics

Loperamide

Tramadol

Non-pharmacological methods (music, acupuncture, “verbicaine”, etc.)

No treatment/placebo

O:

Effectiveness (maximum pain as measured by VAS)

Safety (complications related to pain-control methods, use of any supplemental narcotic, use of any additional analgesic medication), side-effects

Effectiveness of medical abortion regimen, defined as successful completion without additional surgical intervention

Time to expulsion

Satisfaction/acceptability

###The finalized priority PICO questions covered the following thematic areas: medical management of incomplete abortion at ≥ 13 weeks of gestation; medical management of intrauterine fetal demise (IUFD)

at ≥ 14 to ≤ 28 weeks of gestation; medical management of induced abortion at 9–12 weeks of gestation;

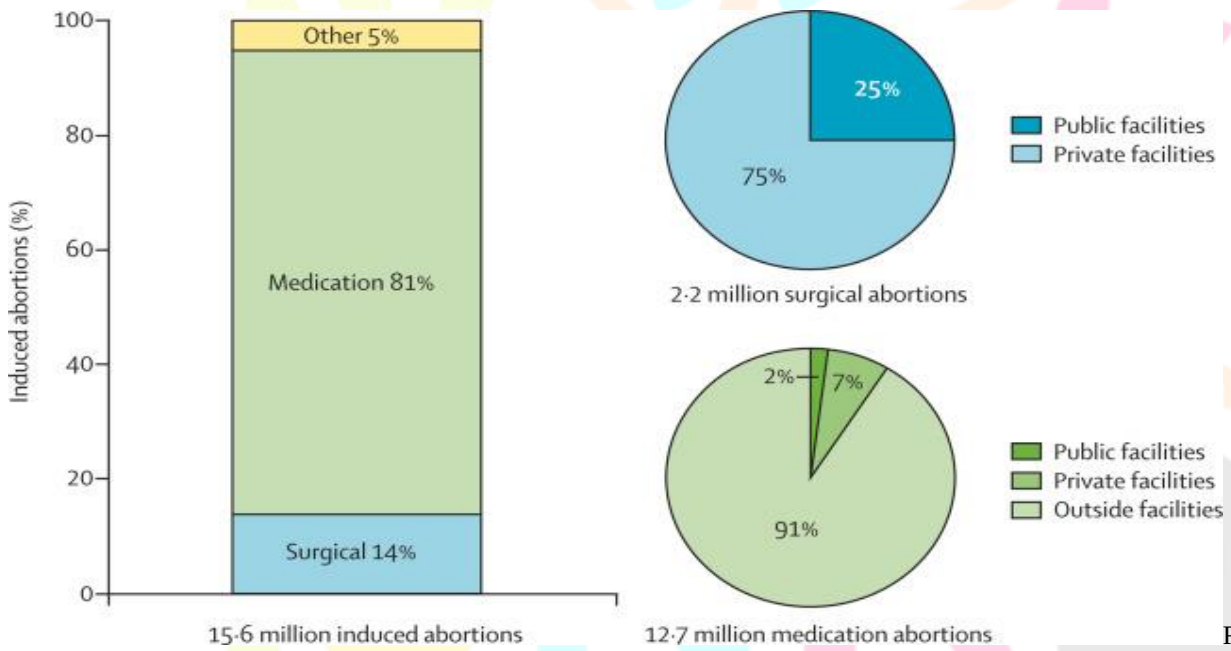
medical management of induced abortion at ≥ 12 weeks of gestation; timing of initiation of contraception after medical abortion.

Reference no : 6

Risk for medical abortion

Potential risks of medical abortion include:

- Incomplete abortion, which may need to be followed by surgical abortion
- An ongoing pregnancy if the procedure doesn't work
- Heavy and prolonged bleeding
- Infection
- Fever
- Digestive system discomfort



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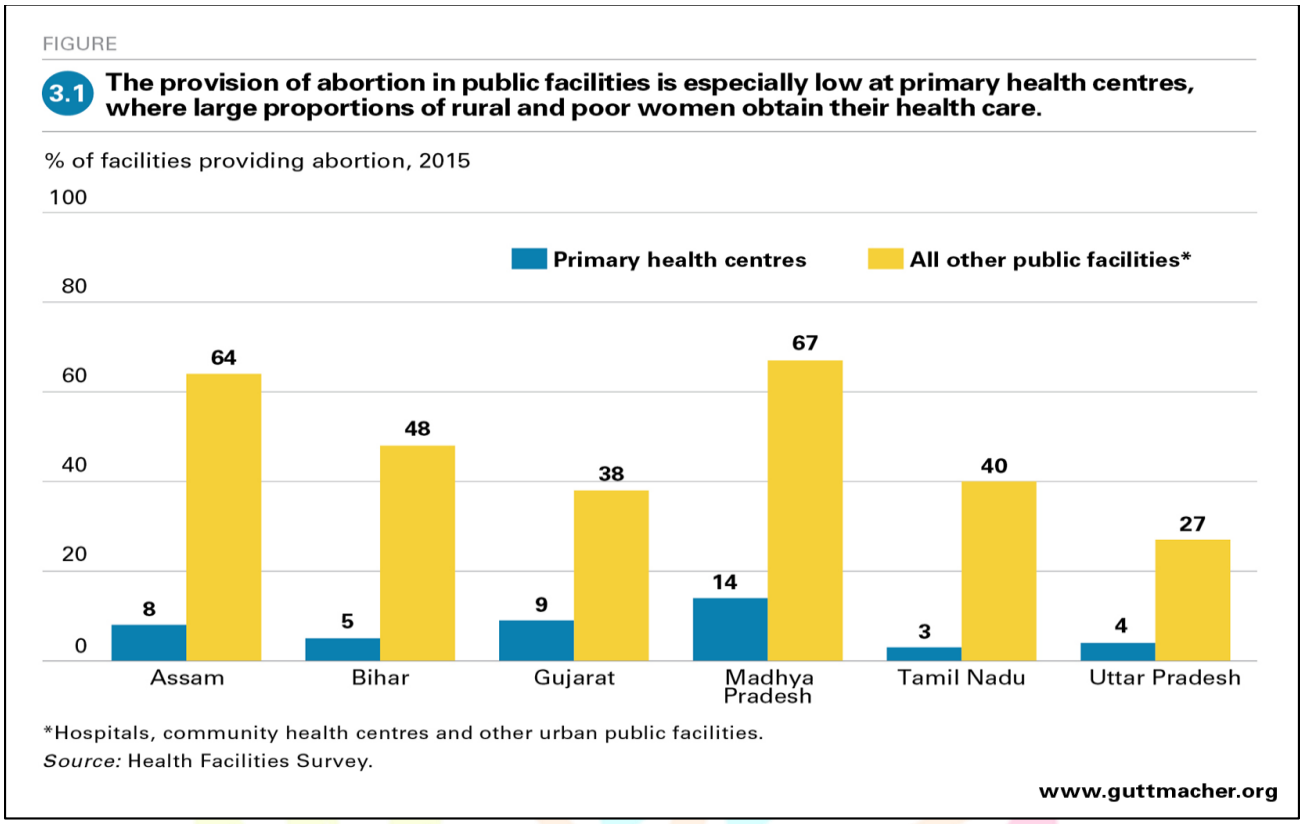


Reference No 18 (table)

Slightly more Indians say it is very important for a family to have at least one son than at least one daughter

General population.	Son.	Daughter.	Differences
Hindus	94%	90%	+3
Muslims	94%	91 %	+3
Christians	95%	86%	+9
Sikhs	90 %	87%	+3
Buddhists	90%	95%	+5
Jains	90 %	92%	+2
Men	93%	93%	0
Women.	94%	90%	.-4
Age-18-34.	93 %	91%	-2
Age 35+	94%	90%	-4
Less than clg.	94%	90%	-4
Clg graduates.	93%	90%	-3
General category.	93%	92%	-1
Lower category.	94%	90%	-4
Religion is very important.	95%	92%	-3

Religion is less important.	**86%**	**82%**	**-4**

Reference no -16

Awareness of legal gestational limit

State wise percentage of chemist aware of 20 weeks gestational limit for abortion

1) Uttar Pradesh -9.5%

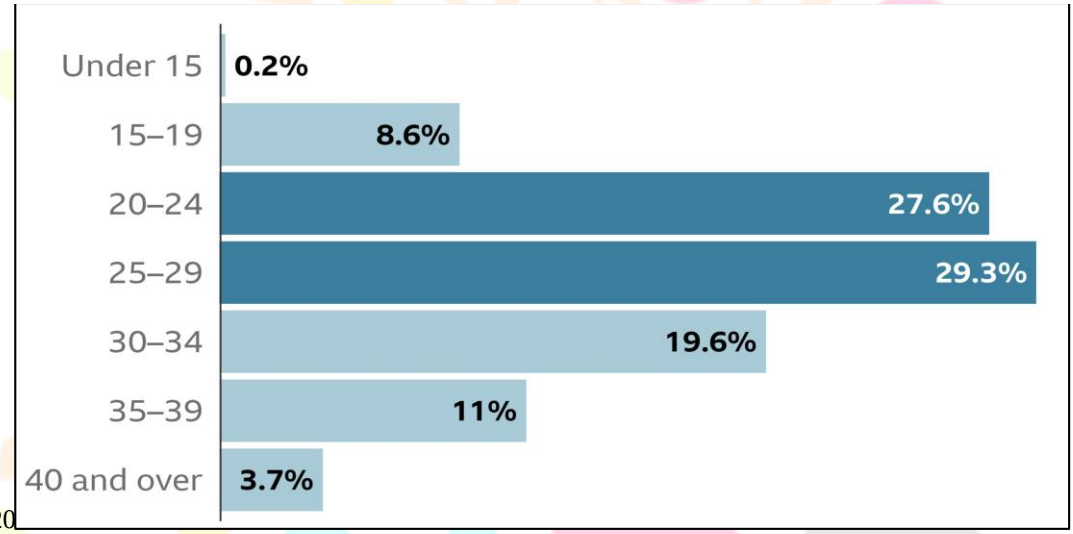
2) Bihar -26.3%

3) Rajasthan -28.6%

4) Maharashtra -41.3%

Reference no 15

Women's in their 20s have more abortion:



Reference no :20

Complication of medical abortion:

1) Injury to cervix

2) hemorrhage

3) uterine perforation

4)thrombosis or embolism

Gynecological complication includes:

1) menstrual disturbance

2) chronic pelvic inflammation

3) scar endometriosis

Obstetric complication includes:

1) ectopic pregnancy

2) preterm labor

3) Rupture uterus

Safe and legal means MTP in Mumbai

1) 2014-2015 = 30742 cases for MTP

2) 2015-2016= 34,790cases for MTP

3) 2016-2017=33,526 cases of MTP

4) 2017-2018=35,358cases for MTP

5) 2018-2019=36,315cases for MTP

6)20,886 women undergoing abortion and medical termination of pregnancy between April 2020 and March 2021

##Failure of contraceptive : 32,124

##Danger of life :1,558

##Injury to physical health Of woman:1,059

##Injury to mental health of women: 547

##Pregnancy cause by rape :43

##Child would suffer physical and mental

Abnormality :864

Reference : 12 and 13

Medical abortion regimen

	FDA Approved	**Evidence based alternative**
Mifeprostone dosage	**600mg**	**200mg**
Home administration of mifoprostol	**No**	**Yes**
Number of clinic visit required	**Three or more**	**Two or more**
Gestational limit	**Up to 49 days (7 weeks)**	**Up to 63days (9 weeks**

Reference no :17

Post abortion medical eligibility recommendation for contraceptive methods (contraceptive method post abortion condition)

Contraceptive methods	1st trimester.	2nd trimester	Immediate Post septic Abortion
1) combine oral . Contraceptive	1. 1	1. 1	1 .
2) combine injectable Contraceptive	1	. 1	. 1
3)patch and vaginal ring	1	1	1
4) progesterone only pills	1	1	1
5)progesterone only injectable	1	1	1
6)progesterone Only Implant	1	1	1
7) copper bearing iud	1	2	4
8)LNG-releasing Iud	1.	2	4
9) condoms	1	1.	1
10) spermicide	1.	1	1
11) diaphragm	1	1	1

Reference no :7

Benefits of medical abortion:

- Medical abortion is a safe, effective, highly accepted and affordable method of abortion.
- Contraindications to treatment are rare and side effects are usually self-limiting.
- Medical abortion can be safely and effectively self-administered at home up to 10 gestational weeks.
- 49 Having an abortion in the privacy of their own home increases women's autonomy in abortion care and reduces the stigma associated with induced abortions.
- Medical abortion is a less costly and less invasive method than surgical methods of abortion and does not require surgical training.
- The assessment of abortion completion

  following a medical abortion can be done by women themselves using a low-sensitivity Test

Result:

Amongst 233,805 medical abortions cases significant adverse events or outcomes were reported in 1,530 cases (0.65%) one patient death occurred due to undiagnosed ectopic pregnancy (3-4)

Conclusion: the drugs should be taken after consulting to physician because it contains lots of side effects. Review of this large dataset reinforces the safety of the evidence-based medical abortion regimen

Discussion :

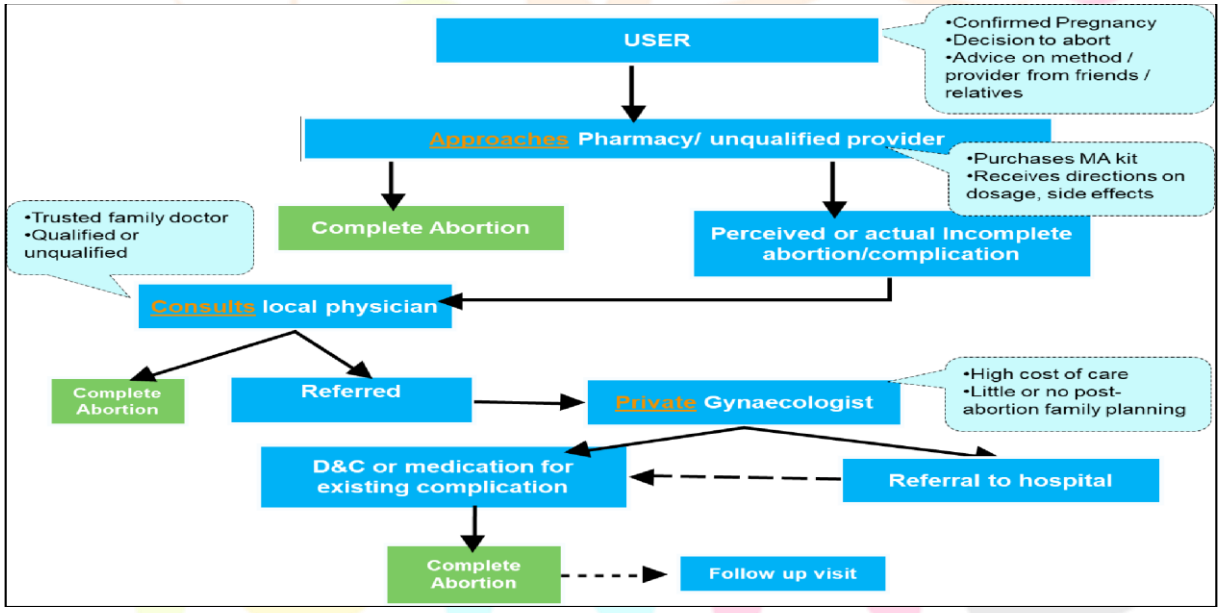
###What are the different types of abortion?.

There are two kinds of abortion — the abortion pill and in-clinic abortion. Medication abortion (also known as the abortion pill) consists of using two different medicines called mifepristone and misoprostol to end a pregnancy. This medicine causes cramping and bleeding to empty your uterus. It's kind of like having a very heavy and crampy period, and the process is very similar to an early miscarriage.

You can take the abortion pill 11 weeks after the first day of your last period. If you're past 11 weeks, you may be able to get an in-clinic abortion. Your doctor or nurse will give you detailed directions about where, when, and how to take the medicines. You may also get some antibiotics to prevent infection.

In-clinic abortion (also called a surgical abortion) is a medical procedure. It works by using suction to empty your uterus. How late you can get an abortion depends on the laws in your state and what doctor, abortion clinic, or Planned Parenthood health center you go to. It may be harder to find a doctor or nurse who will do an abortion after the 12th week of pregnancy, so it's best to try to have your abortion as soon as possible.

###what are the method for abortion?



Reference no :8

Methods of abortion

1) Non-surgical (Medical Abortion)
2) Vacuum Aspiration
3) Dilation & Curettage (D&C)
4) Dilation and Evacuation (D&E)
5) Labor Induction (also called induction abortion)
6) Hysterotomy (similar to a C-Section)

What kind of assessment is recommended after medication abortion?

Routine in-person follow-up is not necessary after uncomplicated medication abortion. Clinicians should offer patients the choice of self-assessment or clinical follow-up evaluation to assess medication abortion success. If medically indicated or preferred by the patient, follow-up evaluation can be performed by medical history, clinical examination, serum human chorionic gonadotropin (hCG) testing, or ultrasonographymifepristone FDA label includes recommendations for follow up 23. However, some patients choose not to return for follow-up; this likely is due to the high success rates and becauspatientsare able to self-assess abortioncompletion

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