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THE IMPACT OF MEDICAL AND ILLEGAL ABORTIONS ON WOMEN'S REPRODUCTIVE HEALTH

Naimova Zulfiya Abror qizi

3rd-year student, Faculty of General Medicine.

E-mail: zulfiyanaimova576@gmail.com Tel: +998507941609

Bukhara University of Innovative Education and Medicine, Bukhara, Uzbekistan

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Abstract. This article analyzes the impact of medical and illegal (unsafe) abortions on women's reproductive health on the basis of the scientific literature. It covers the effectiveness and safety criteria of medical abortion, its indications and contraindications, and its possible complications. The article shows that the combination of mifepristone and misoprostol yields high success rates in the early weeks of pregnancy, whereas unsafe abortion increases the risk of hemorrhage, purulent-inflammatory diseases, and secondary infertility. A separate section is devoted to post-abortion rehabilitation measures and the principles of contraceptive method selection. The author argues that providing abortion services under qualified medical supervision, offering women counseling beforehand, and promptly providing modern contraception after the abortion are the main prerequisites for reducing the number of repeat abortions.

Keywords: abortion, medical abortion, mifepristone, misoprostol, reproductive health, contraception.

Introduction

Reproductive health is an integral part of a woman's overall health and quality of life. An unplanned pregnancy confronts many women with the question of whether to terminate it. According to international estimates, approximately 55.7 million abortions are performed worldwide each year, of which nearly 45% are classified as unsafe [5]. Unsafe abortion can lead to maternal death and long-term reproductive disorders through severe conditions such as hemorrhage, sepsis, and uterine injury [3].

In Uzbekistan, induced termination of pregnancy is carried out in licensed medical institutions, within the established time limits and in compliance with the prescribed conditions. An abortion performed outside a medical institution by an unqualified person is considered illegal and becomes the greatest source of risk to a woman's health.

The aim of this study is to analyze, on the basis of the literature, the effectiveness and safety criteria of medical abortion, the complications of medical and illegal abortions for reproductive health, and the principles of post-abortion rehabilitation and contraceptive selection.

Materials and Methods

The study involved a comparative analysis of national and international scientific publications, WHO clinical guidelines, systematic reviews, and the results of clinical studies. The data were grouped and summarized according to the two main areas of the topic.

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Medical Abortion in Modern Gynecology: Effectiveness and Safety Criteria

Mechanism and Effectiveness of the Method

Medical abortion is a method of terminating pregnancy by means of medications, without surgical intervention. The current standard regimen consists of two drugs: mifepristone, a progesterone receptor blocker, and misoprostol, a prostaglandin analogue that enhances uterine contractions. Mifepristone disrupts the structure of the decidual tissue in the uterine lining, preparing the way for detachment of the gestational sac. Misoprostol, in turn, softens the cervix and induces myometrial contractions, thereby accelerating the expulsion of the gestational sac [1, 3].

According to WHO recommendations, 200 mg of mifepristone is administered orally, followed 1–2 days later by 800 µg of misoprostol; this regimen can be used up to 12 weeks of gestation [4]. Clinical studies have shown that the 200 mg dose of mifepristone is not inferior in effectiveness to the 600 mg dose [1]; therefore, prescribing a higher dose is unjustified.

The systematic review by Raymond et al. covered more than 47,000 women in 87 studies. It reported ongoing pregnancy in 1.1% of cases, hospitalization due to complications in 0.3%, and blood transfusion in 0.1% [6]. The risk of failure increased when gestational age exceeded 8 weeks, when the interval between the two drugs was shorter than 24 hours, and when misoprostol was taken in a low dose or orally [6]. Winikoff et al. found that when 800 µg of misoprostol was administered buccally at gestational ages of 57–63 and 64–70 days, the effectiveness was 93.5% and 92.8%, respectively, with ongoing pregnancy accounting for about 3% [7]. Thus, the outcome declines slightly as gestational age increases, but the method remains highly effective in the outpatient setting as well.

An important practical question is whether the method can be used at home. A meta-analysis combining nine prospective cohort studies (4,522 women in total) found no significant difference in the rate of complete abortion between women who took misoprostol at home and those who took it in a clinic, and no serious complications were reported [1]. This approach brings the service closer to the woman, but she must know how to reach medical care quickly when needed. The date of the last menstrual period and a clinical examination are usually sufficient to determine gestational age; ultrasound is not mandatory for every woman [1].

Safety Criteria and Contraindications

The safety of the method is assessed using several indicators: (1) the rate of complete abortion without additional aspiration or curettage; (2) the frequency of ongoing pregnancy; (3) severe bleeding and the need for blood transfusion; (4) inflammatory complications; and (5) the woman's satisfaction and her willingness to choose the method again. Serious complications such as cervical injury and uterine rupture are very rare, and most of them occur in second-trimester abortions [1].

Before the procedure, a medical history is taken; gestational age is determined on the basis of the last menstrual period and clinical examination; and an ultrasound is performed if an ectopic pregnancy is suspected. Contraindications include ectopic pregnancy, chronic adrenal insufficiency, long-term glucocorticoid therapy, bleeding disorders or anticoagulant use, allergy to the drugs, severe anemia, and an intrauterine device in place. The procedure must be performed under the supervision of a qualified physician, and the woman must be warned about danger signs. These

signs include bleeding that soaks two or more sanitary pads per hour for two consecutive hours, a fever above 38 °C, worsening pain, and foul-smelling discharge.

Complications of Medical and Illegal Abortions

The complications of abortion depend on where and by whom it is performed. When abortion is carried out in qualified care settings, serious complications are rare, but they do not disappear entirely. Early complications include hemorrhage, incomplete abortion, endometritis, and cervical injury. In an observational study of 40 patients conducted at the Fergana Public Health Medical Institute, hemorrhage (22.5%), inflammation (17.5%), and psychological disorders (22%) predominated among early complications; complications were more severe with surgical and late-term methods [2]. Because the sample size was small, these results cannot be generalized to the entire population.

Illegal or unsafe abortion leads to far more severe consequences because it is performed under conditions in which aseptic rules are violated, by unqualified persons, and using inappropriate methods. It may result in massive hemorrhage, uterine perforation, sepsis and septic shock, cervical and vaginal injuries, and damage to adjacent organs (the intestine and bladder) [3, 5]. Late consequences include chronic inflammatory diseases of the pelvic organs, impaired fallopian tube patency and secondary infertility, an increased risk of ectopic pregnancy, intrauterine adhesions (Asherman syndrome), chronic pelvic pain, and menstrual irregularities [3]. Such patients often seek care late, which complicates treatment.

Women's recourse to illegal abortion is often driven by a lack of information about available services, fear of social stigma, missed time limits, and limited access to contraceptives. Therefore, the availability of safe services and the quality of counseling are among the most important conditions for reducing complications. For a health care worker, this means listening to the patient respectfully and without judgment and guiding her toward the right course of action.

Instrumental methods, particularly dilation and curettage, have been associated in several cohort studies with an increased risk of preterm birth and low birth weight in subsequent pregnancies [1]. For this reason, modern guidelines prefer vacuum aspiration or the medical method to curettage [1, 4].

Post-Abortion Rehabilitation and Choice of Contraceptive Method

Rehabilitation Measures

The goals of rehabilitation are to prevent complications, restore the endometrium, normalize the menstrual cycle, and prepare the woman for a future pregnancy. A follow-up examination is performed 7–14 days after the abortion: the completeness of the abortion is assessed clinically and, if necessary, confirmed by ultrasound or by measuring the serum level of β-human chorionic gonadotropin [1]. Normal bleeding lasts from a few days to two weeks; if heavy bleeding, fever, or pain occurs, the woman should seek medical care immediately.

The rehabilitation program includes antibacterial prophylaxis when risk factors are present, analgesics, correction of anemia with iron supplements, and abstinence from sexual intercourse and tampon use until the bleeding stops. Researchers specifically emphasize the need to strengthen medical follow-up, antibiotic prophylaxis, and psychological support in the early post-abortion

period [2]. Psychological counseling helps a woman understand her situation and make her subsequent decisions consciously.

Preparation for a future pregnancy is also an integral part of rehabilitation. The woman is advised to undergo a general medical check-up, to have sexually transmitted infections detected and treated, to take folic acid, and, in the event of a severe complication, to remain under the follow-up of a gynecologist. In women who have undergone instrumental intervention in the uterine cavity or have had an inflammatory disease, fallopian tube patency and the condition of the uterus may need to be assessed separately.

Choosing a Contraceptive Method

After an abortion, ovulation may return very early, sometimes within two weeks, so a woman should protect herself without waiting for her next period [3, 4]. According to WHO recommendations, after a first-trimester abortion almost all modern methods can be started immediately: combined and progestin-only pills, implants, injectable DMPA, intrauterine devices, and condoms [4]. After a medical abortion, hormonal methods can be started on the day misoprostol is taken, whereas an intrauterine device is inserted once it is certain that the abortion is complete. If there are signs of sepsis or infection, an intrauterine device is not inserted, and another method is chosen until the infection has been treated. A brief overview of the methods is presented in Table 1.

Table 1. Timing of Initiation of Contraceptive Methods After Abortion

Method	When it can be started	Notes
Condom	When sexual activity resumes	Also protects against infections
Combined and progestin-only pills	On the day of the abortion; in medical abortion, on the day misoprostol is taken	Risks of thrombosis, migraine with aura, and high blood pressure are taken into account
Implant and injectable DMPA	On the day of the abortion	Provides long-term protection
Intrauterine device	Once it is certain that the abortion is complete	Not inserted if infection is present
Surgical contraception (sterilization)	If there is no infection and the woman firmly wishes it	Irreversible method; prior counseling is required

When choosing a method, the woman's age, number of births, plans for future childbearing, previously used methods, contraindications, cost, and convenience are taken into account. For women who wish to become pregnant in the future, long-acting reversible methods (implant, intrauterine device) are especially useful in reducing the risk of repeat abortion. During counseling, the woman's wishes are respected and no method is imposed on her; if necessary, information on emergency contraception after unprotected sexual intercourse is also provided [4].

Conclusion

Medical abortion performed under qualified medical supervision in the early weeks of pregnancy has high effectiveness and a low risk of complications, and it is therefore regarded as a worthy alternative to surgical methods. Illegal abortion, however, remains a source of severe consequences such as hemorrhage, sepsis, and infertility. To preserve women's reproductive health, comprehensive counseling before the abortion, regular follow-up after the procedure, psychological support, and prompt provision of a modern contraceptive method are necessary. This approach reduces the number of repeat abortions and strengthens the health of women of reproductive age.

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