The incidence of abortion and unintended pregnancy in India, 2015

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Summary

Background Reliable information on the incidence of induced abortion in India is lacking. Official statistics and national surveys provide incomplete coverage. Since the early 2000s, medication abortion has become increasingly available, improving the way women obtain abortions. The aim of this study was to estimate the national incidence of abortion and unintended pregnancy for 2015.

Methods National abortion incidence was estimated through three separate components: abortions (medication and surgical) in facilities (including private sector, public sector, and non-governmental organisations [NGOs]); medication abortions outside facilities; and abortions outside of facilities and with methods other than medication abortion. Facility-based abortions were estimated from the 2015 Health Facilities Survey of 4001 public and private health facilities in six Indian states (Assam, Bihar, Gujarat, Madhya Pradesh, Tamil Nadu, and Uttar Pradesh) and from NGO clinic data. National medication abortion drug sales and distribution data were obtained from IMS Health and six principal NGOs (DKT International, Marie Stopes International, Population Services International, World Health Partners, Parivar Seva Santha, and Janani). We estimated the total number of abortions that are not medication abortions and are not obtained in a health facility setting through an indirect technique based on findings from community-based study findings in two states in 2009, with adjustments to account for the rapid increase in use of medication abortion since 2009. The total number of women of reproductive age and livebirth data were obtained from UN population data, and the proportion of births from unplanned pregnancies and data on contraceptive use and need were obtained from the 2015–16 National Family Health Survey-4.

Findings We estimate that 15·6 million abortions (14·1 million–17·3 million) occurred in India in 2015. The abortion rate was 47·0 abortions (42·2–52·1) per 1000 women aged 15–49 years. 3·4 million abortions (22%) were obtained in health facilities, 11·5 million (73%) were medication abortions done outside of health facilities, and 0·8 million (5%) abortions were done outside of health facilities using methods other than medication abortion. Overall, 12·7 million (81%) abortions were medication abortions, 2·2 million (14%) abortions were surgical, and 0·8 million (5%) abortions were done outside of other methods that were probably unsafe. We estimated 48·1 million pregnancies, a rate of 144·7 pregnancies per 1000 women aged 15–49 years, and a rate of 70·1 unintended pregnancies per 1000 women aged 15–49 years. Abortions accounted for one third of all pregnancies, and nearly half of pregnancies were unintended.

Interpretation Health facilities can have a greater role in abortion service provision and provide quality care, including post-abortion contraception. Interventions are needed to expand access to abortion services through better equipping existing facilities, ensuring adequate and continuous supplies of medication abortion drugs, and by increasing the number of trained providers. In view of how many women rely on self-administration of medication abortion drugs, interventions are needed to provide women with accurate information on these drugs and follow-up care when needed. Research is needed to test interventions that improve knowledge and practice in providing medication abortion, and the Indian Government at the national and state level needs to prioritise improving policies and practice to increase access to comprehensive abortion care and quality contraceptive services that prevent unintended pregnancy.


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Researchers were known to greatly underestimate abortion incidence because they exclude abortions by private-sector doctors who are trained in abortion provision but do not work in registered facilities and abortions provided by other formally trained health professionals who do not have specific training in abortion but nonetheless provide the services. The latter include providers trained in systems other than the allopathic or Western system of medicine, principally Ayurveda, Unani, Siddha, and Homeopathy, some of whom provide abortion services. These data also exclude abortions using medication abortion drugs sold without a prescription and abortions by untrained providers.

Government-sponsored, large-scale, representative, community-based surveys such as the National Family Health Survey (NFHS) collect information about abortion through face-to-face interviews with women. In the 1998–99 NFHS-2 and the 2007–08 District Level Household and Facility Survey 3, women reported that 1·7–1·8% of pregnancies ended in abortions. This approach is known to result in high levels of under-reporting. Women’s experience with accessing abortion services has been assessed in a few state-specific studies in the past decade. Although abortion incidence was not reported, a measure of prevalence was included in some studies (e.g., lifetime experience of abortion) but with some limitations (limited in coverage and with potentially high under-reporting).

### Added value of this study

To the best of our knowledge, this is the first study designed to measure the national incidence of abortion in India. To estimate the total number of abortions in the country as a whole, we combined data on the number of facility-based abortions (surgical and medication), the number of medication abortions outside facilities, and the number of abortions outside facilities using methods other than medication abortion.

### Implications of the findings

The new national estimate of abortion incidence in India and the distribution of abortions by component (facility-based, using medication abortion outside of facilities, and outside of facilities with methods other than medication abortion) have important implications in terms of access and safety in the provision of abortion services. Most abortions are medication abortions, and most medication abortions are obtained outside health facilities. Although the combined medication abortion protocol of mifepristone plus misoprostol is highly effective and safe when administered correctly, little is known about what kind of information women are getting when they obtain this method from chemists and informal vendors, and whether they are taking it correctly. This is an important evidence gap that should be further explored.

The public sector has a relatively small role in abortion service provision. An implication of these findings is that the broader role of the public sector in providing high-quality health care to poor and vulnerable women needs to be reviewed and assessed in terms of possible need for an expanded role in providing abortion care. Pending amendments to the Medical Termination of Pregnancy Act (including the proposal to permit trained mid-level health professionals to provide abortion services) would be a feasible option for expanding access to safe, legal abortion services.

The incidence of unintended pregnancies and incidence of abortion are consistent with the level of unmet need for contraception among women in India and underscore the need for further investment to meet women’s and couples’ contraceptive needs and ensure access to safe abortion services. The updated estimate of abortion incidence will be incorporated into future estimates of abortion incidence at the subregional, regional, and global levels and will improve the accuracy of these estimates.
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