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TYPES, INCIDENCE, AND MANAGEMENT OF ABORTION IN THE INDIAN POPULATION: A CLINICAL AND PUBLIC-HEALTH REVIEW

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1. ABSTRACT

Background: Abortion is a major reproductive-health event in India, where a large proportion of pregnancies are unintended. Recent national estimates indicate that millions of abortions occur annually, most of which are medication-based and often performed outside health-facility settings[12,3]. **Objectives:** To summarize the **types of abortion**, available **national and subnational incidence, data**, and **evidence-based management strategies** for both spontaneous and induced abortion in the Indian context. **Methods:** Narrative review of national-level abortion-incidence studies, nationally representative surveys, and Government of India and WHO-based guidelines on safe abortion and post-abortion care (PAC) published between 2015 and 2025[1,3,4]. **Results:** In 2015, an estimated **15.6 million abortions** occurred in India, corresponding to **47 abortions per 1000 women aged 15–49 years**. About **81%** were medication abortions, **14%** surgical, and **5%** unsafe methods; nearly **80%** were performed outside health-facility settings. Spontaneous abortion adds further "pregnancy wastage," with 10–20% of clinically recognized pregnancies terminating before 20 weeks. Recommended management includes **expectant, medical (misoprostol-based), or surgical (manual/electric vacuum aspiration) approaches**, with strong emphasis on timely PAC and post-abortion contraception to reduce unintended pregnancies and maternal mortality. **Conclusions:** Safely delivered, accessible abortion and PAC are critical to reducing maternal morbidity and mortality in India; scaling up regulated, equitable, medical-abortion services within the public-health system is essential[1,3,6].

KEYWORDS: Abortion; spontaneous abortion; induced abortion; unsafe abortion; medical abortion; post-abortion care; India; maternal morbidity.

2. INTRODUCTION

"Abortion" refers to termination of a pregnancy before 20 weeks of gestation and is broadly classified as **spontaneous** (miscarriage) or **induced** (therapeutic, social, or sex-selective)[5,6]. In India, induced abortion is governed by the **Medical Termination of Pregnancy (MTP) Act, 1971**, and its subsequent amendments, which permit termination under specified medical and social indications within defined gestational limits[7,8]. Despite progressive legislation, a substantial proportion of abortions occur outside formal health-facilities, often from self-managed or unsafe sources, contributing to significant morbidity and mortality[1,3].

National estimates from 2015 show that **15.6 million abortions** occurred in India, yielding an **abortion rate of 47 per 1000 women aged 15–49 years[1,2]**. Nearly **70 unintended pregnancies per 1000 women** and approximately half of all pregnancies being unintended underline the need for improved contraception, better pre-conception counselling, and strengthened early-pregnancy-care infrastructure. India's maternal mortality ratio (MMR) remains sensitive to unsafe abortion, which is estimated to contribute to about **8% of pregnancy-related deaths[4,7].**

Existing literature on abortion in India focuses on incidence, care-seeking patterns, and post-abortion complications, but proper, guideline-oriented reviews that integrate **abortion typology, incidence, and standardized management in Indian settings are limited[1,3,9].**

3. METHODS

This article is based on a **narrative review** of national-level abortion-incidence studies, nationally representative surveys (including NFHS-5 data), and Indian and WHO-based guidelines on safe abortion and post-abortion care (PAC) published between 2015 and 2025[1,3,9,5]. We searched **PubMed, WHO-IRIS, and Ministry of Health and Family Welfare (MoHFW) repositories** using the key terms *abortion incidence, abortion management, medical abortion, post-abortion care, spontaneous abortion, and India[1,3,4]*.

We included:

- National-level studies estimating abortion and unintended-pregnancy incidence in India in 2015[1,2,10].
- Subnational studies on facility-based treatment of abortion-related complications (six-state dataset)[3,9].

- Recent national documents: Comprehensive Abortion Care (CAC) training and service-delivery guidelines and the CAC Provider's Manual issued by the Ministry of Health and Family Welfare, India[4,7].
- WHO Abortion Care Guideline and analyses on self-managed abortion using NFHS-5 data[5,11].

Articles were synthesized by **abortion type** (spontaneous vs induced), **setting** (facility vs non-facility), **method** (medical vs surgical vs unsafe), and **management approach** (expectant, medical, surgical, PAC, and contraception)[1,3,4].

4. RESULTS

4.1. Types of abortion

Abortion is broadly divided into spontaneous and induced categories, each with subtypes relevant to Indian practicece [6,5].

Type	Description	Clinical relevance in India
Spontaneous abortion (miscarriage)	Pregnancy loss before 20 weeks without intentional termination; includes threatened, inevitable, incomplete, complete, missed, and recurrent miscarriage.	Accounts for 10–20% of clinically recognized pregnancies; recurrent miscarriage affects 1–5% of couples[6].
Therapeutic abortion	Induced termination for medical indications (e.g., fetal anomaly, maternal medical condition).	Permitted under MTP-Act; often performed in tertiary centres[7,8].
Social/humanitarian abortion	Induced termination for social, economic, or humanitarian reasons (e.g., rape, adolescent pregnancy, extreme poverty).	Common in urban and peri-urban settings; often delayed due to stigma, cost, or poor access[1,12]
Sex-selective abortion	Induced termination motivated by fetal sex, usually associated with male-favouring selective continuation.	Associated with higher odds of unsafe-abortion practices, especially in some regions[12,11].

In clinical practice, abortions are further described by status and products of conception (POC) present:

- **Threatened abortion: vaginal bleeding with closed cervix and viable pregnancy[6].**
- **Inevitable abortion: bleeding with open cervoid, non-viable pregnancy[6].**
- **Incomplete abortion: retained POC with ongoing bleeding[6].**
- **Complete abortion: expulsion of all POC, minimal bleeding[6].**
- **Missed abortion: fetal demise without cervical dilatation or expulsion[6].**

4.2. Incidence of abortion in India

Reliable national-level estimates from 2015 indicate that **15.6 million abortions (14.1–17.3 million)** occurred in India, corresponding to an **abortion rate of 47.0 per 1000 women aged 15–49 years[1,2]**. There were **48.1 million pregnancies**, with a rate of **144.7 pregnancies per 1000 women** and **70.1 unintended pregnancies per 1000 women**, showing that nearly half of all pregnancies are unintended[1].

About **3.4 million abortions (22%)** were obtained in health facilities, **11.5 million (73%)** medications abortions outside facilities, and **0.8 million (5%)** through other methods likely to be unsafe. Overall, **12.7 million (81%)** abortions were medication-based, **2.2 million (14%)** surgical, and **0.8 million (5%)** involved unsafe methods[1,2].

Subnational studies on six Indian states (Assam, Bihar, Gujarat, Madhya Pradesh, Tamil Nadu, and Uttar Pradesh) show that **self-managed or non-facility medical abortion** accounts for **63–83% of all abortions,** with particularly high proportions in Bihar, Gujarat, and Uttar Pradesh[9,11].

Unsafe-abortion-related complications are a major contributor to maternal morbidity: a 2015 national-level study estimated **5.2 million women treated for abortion-related complications annually**, with a **rate of 15.7 per 1000 women of reproductive age per year.** In India, unsafe abortion is estimated to contribute to about **8% of maternal mortality**, highlighting the public-health burden of poor access to safe-abortion services[4,7].

4.3. Management of spontaneous abortion

Management of early-trimester pregnancy loss includes expectant, medical, and surgical options, selected by gestational age, hemodynamic status, and patient preference[6,13].

Management modality	Indications	Indian-practice notes
Expectant management	Hemodynamically stable women with early-first-trimester incomplete or missed abortion; counselling about waiting for spontaneous expulsion over days to weeks. Failure rate ~25%.	Suitable in low-risk, stable patients with good follow-up; lower-cost option in resource-constrained settings[6].
Medical management	Incomplete or missed abortion (≤12–14 weeks) using misoprostol ± mifepristone regimens. Misoprostol-only failure rates range ~5–30% in different settings.	Widely used in India; national guidelines specify dosing and timing for first-trimester medical abortion[4,7].
Surgical management	Incomplete abortion with heavy bleeding, hemodynamic instability, retained POC, or failed medical/expectant management.	MVA is emphasized in national CAC/PAC guidelines as a safe, low-risk option for

Management modality	Indications	Indian-practice notes
	Manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA) is preferred.	early-trimester evacuations[4,7].

For recurrent miscarriage, evaluation includes **parental karyotyping, antiphospholipid-syndrome testing, and ultrasound assessment of uterine anatomy** when indicated, with management tailored to identified causes. Counselling on future-pregnancy risk and lifestyle modification forms an important part of care[6].

4.4. Management of induced abortion and post-abortion care

Induced abortion in India includes legal MTP-Act-based terminations and unsafe attempts outside the legal framework. National and WHO-based policies promote comprehensive abortion care (CAC), integrating contraception, psychosocial support, and PAC to reduce repeat unintended pregnancies and complications[4,5,8].

Methods of induced abortion in India:

- Medical abortion (MA):
- First-trimester: mifepristone (200–400 mg) oral + misoprostol (400–800 µg, oral or vaginal) according to WHO-endorsed and national-guideline schedules[5,4].
- Effectiveness exceeds 95% in compliant regimens; self-managed abortions are rising, especially in eastern and central India, using both formal prescriptions and informal sources[9,11].
- Surgical abortion:
- Vacuum aspiration (MVA or EVA) for early-trimester pregnancies; dilatation and evacuation (D&E) for selected second-trimester cases[4,14].
- Second-trimester abortions account for about 13% of all terminations, with higher rates in regions with poor access to early-service provision[14].

Post-abortion care (PAC):

India's CAC Training and Service-Delivery Guidelines (2023) and CAC Provider's Manual (2023) recommend:

- Timely assessment and management of retained products, hemorrhage, infection, and uterine perforation[4,7].
- Provision of emergency contraception and long-acting reversible contraception (LARC) or other modern methods before discharge to reduce repeat unintended pregnancies[4,6,8].

• Counselling on danger signs (excessive bleeding, fever, persistent pain) and structurally-planned follow-up[4,5].

National guidelines emphasize woman-centred, non-judgmental counselling, respect for autonomy, and confidentiality in both facility-based and self-managed-abortion contexts[4,5,8].

5. DISCUSSION

This review highlights that **abortion is a common reproductive-health event** in India, with high rates of both spontaneous loss and induced termination. The 2015 estimate of **15.6 million abortions (47 per 1000 women)** and **70 unintended pregnancies per 1000 women** underscores the need for **improved contraceptive services, better pre-conception counselling, and early-pregnancy-care access[1,2].**

Most abortions in India are **medication-based and obtained outside formal health facilities**, increasing the risk of incomplete abortion, infection, and delayed care. Subnational data show that states such as **Bihar, Madhya Pradesh, and Uttar Pradesh** bear the highest burden of abortion-related complications, reflecting inequalities in safe-service availability. The fact that unsafe abortion contributes to about **8% of maternal deaths** further emphasizes the importance of strengthening public-sector abortion and PAC serviceces[4,6].

On the clinical side, national and WHO-based guidelines support **expectant, medical, and surgical strategies** for early-trimester loss, with **misoprostol-based regimens and MVA** being safe and feasible in Indian settings. The rising trend of **self-managed medical abortion**, particularly in eastern and central India, presents both opportunities (expanded access) and risks (inadequate counselling, delayed help-seeking), necessitating provider-training and community-based education[9,11].

Programmatically, integrating **post-abortion contraception and counselling** into routine CAC/PAC can reduce repeated unintended pregnancies and subsequent abortion demand. Training of **doctors, nurses, and pharmacists** in medical-abortion provision and complication recognition, along with expansion of **MTP-Act-approved facilities**, would enhance quality and equity of care[4,8].

Limitations of this review include its **narrative, non-systematic design** and reliance on **older national incidence data (2015)**; newer NFHS- and survey-based analyses from 2019–2021 provide updated insights on self-managed abortion but remain in evolution[9,11]. Future research should focus on **effectiveness and safety of different PAC models**,

cost-effectiveness of expanding medical-abortion access, and **regional variations in unsafe-abortion burden** across Indian states[3,6].

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