

The Transformative Terrain: An In-Depth Analysis of Abortion Trends in India through NFHS-5 National Data¹

Sushanta K. Banerjee and Sumit Gulati

INTRODUCTION

In 1971, India marked a significant milestone by enacting the Medical Termination of Pregnancy Act (MTP Act). This landmark legislation sanctioned abortions for various reasons, including safeguarding a woman's life, preserving her physical and mental well-being, addressing economic or social considerations, cases of rape or incest, fetal impairment, and instances where pregnancy ensued from contraceptive failure among married women.¹ Under the original MPT Act, the termination of pregnancies rested solely in the capable hands of registered medical practitioners operating within approved and licensed facilities. However, the trajectory of abortion care in India embarked on a transformative journey driven by pivotal decisions made by the Drugs Controller of India. In 2002, a milestone was achieved when they approved the use of mifepristone, revolutionizing pregnancy termination within 49 days of gestation. Subsequently, in 2008, the approval extended to encompass the combination of mifepristone and misoprostol for medical pregnancy termination, effectively extending the permissible gestational age to 63 days.^{2,3} These changes put India at the forefront of access to medical abortion in the developing world.⁴ Despite the availability of medical abortion (MA) options in India for over two decades, the formal health system—comprising both public and private sectors—has demonstrated a slow pace in adopting medical abortion as a standard modality for pregnancy termination. Simultaneously, the landscape of abortion access has undergone a seismic shift, with widespread access to MA drugs through pharmacies, ushering in the potential for more self-managed abortions (SMAs) nationwide.⁵ The last abortion incidence study in India indicated that a substantial 73% (equivalent to 11.2 million cases) of induced abortions transpired outside the purview of the formal health system using self-managed medical abortion.⁶ While facility-based studies have scrutinized the uptake of MA since its regulatory approval, they offer an incomplete portrait of abortion services availed outside the formal healthcare system.⁶ Furthermore, scant attention has been dedicated to recent investigations into the prevalence, trends, and determinants of self-managed abortion within this context.⁷

This comprehensive study harnesses the rich dataset of the National Family Health Survey Round 5 (NFHS-5) to meticulously elucidate the prevalence and evolving patterns of self-managed abortion (SMA) in India.

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Additionally, it delves into the multifaceted factors influencing women and couples in their decision to opt for SMA over provider-assisted abortion care. The study also investigates post-abortion complications among women who self-managed their abortion compared to those who sought care from healthcare providers.

DATA AND METHODS

For the first time, the NFHS-5 (2019–2020)- a nationally representative large-scale cross-sectional survey, collected information on abortion methods along with the place of abortion, service providers, and outcome of abortion, including postabortion complications. This survey covered 724,115 women in the reproductive age group of 15-49 years and captured individual-level information, including age, marital status, reproductive and maternal care history, and outcomes of pregnancies. This paper defined self-managed abortion (SMA) as an attempt to terminate a pregnancy using medical abortion performed outside of health facilities without any clinical supervision. Women who reported any episodes of induced abortion were asked about the a) place of abortion, b) service providers, and c) method of abortion. Utilizing these three variables, this paper estimated the prevalence of SMA when women reported conducting abortions at home by themselves or with some assistance of relatives without any external/clinical support using medical abortion. Conversely, women who sought abortion services outside their homes and received clinical assistance from healthcare providers were classified as having undergone provider-assisted abortions. To analyze temporal trends in the prevalence of SMA and provider-assisted abortion, we considered the time of the last abortion considering the reported year of the abortion event.

We used descriptive statistics for both categorical and continuous variables, reporting frequencies, percentages, and confidence intervals for the former and means and standard deviations for the latter.

In exploring the determinants of SMAs, we conducted bivariate and multivariate analyses, incorporating socio-demographic and selected pregnancy-related variables such as gestational age, reasons for pregnancy termination, and the year of abortion. Before finalizing the multivariate models for assessing the factors influencing SMA, we conducted a comprehensive literature review to identify potential predictors based on existing research. Our primary outcome of interest, self-managed abortion, was treated as a binary variable. It assumes a value of 1 if the woman reported terminating her pregnancy at home without any assistance from healthcare providers (HCPs) and 0 if the abortion occurred outside the home with clinical support from any category of HCPs, including medical doctors, nursing staff, and other

healthcare workers. Additionally, this study explored the associations between self-managed abortion and self-reported postabortion complications while controlling for relevant social and demographic parameters, shedding light on the nuanced relationship between abortion practices and subsequent health outcomes.

RESULTS

Trends in self-use across India and its states

In the 2019-20 National Family Health Survey, a notable subset of 7,696 women, drawn from a substantial survey cohort of 724,115 respondents, disclosed their experiences with terminating pregnancies. Of these, almost one-third (29%) of women in India reported using self-managed abortion (Figure 1), as opposed to abortion provided by a physician (55%), a nurse/auxiliary nurse midwife/lady health volunteer (13%), or a traditional birth attendant (also known as “Dai”)/other (1.1%). A majority of the provider-assisted abortions took place in private clinics or hospitals, followed by public sector facilities (data not shown here). However, the prevalence of self-managed abortion exhibited substantial regional variations, ranging from a noteworthy 55% in the state of Odisha to negligible instances (0%) in the states and union territories (UTs) of Mizoram, Lakshadweep, and Ladakh.

[Figure 1a].

A compelling geographical pattern emerged when examining the prevalence of SMAs across India's diverse regions (See Fig 1b). Notably, the incidence of SMA exhibited relatively higher rates in the eastern (45%), central (39%), and north-eastern (31%) parts of the country. In stark contrast, the southern (9%) and western (11%) regions of India reported significantly lower proportions of women who had opted for self-managed abortions. These regional disparities provide valuable insights into the complex interplay of factors influencing reproductive healthcare choices across the nation.

[Figure 1b]

An intriguing and consistent trend unfolded over the course of an 8-year period, spanning from 2014 to 2021, as evidenced in Figure 2. The data pointed to a noteworthy shift in the abortion landscape among women who reported undergoing the procedure. During this period, there was a discernible movement away from relying on healthcare providers to administer abortions in favor of a pronounced preference for self-management. In 2014, self-management of abortions accounted for 19% of reported cases, a

proportion that substantially escalated to 44% by 2021. Conversely, the prevalence of provider-assisted abortions demonstrated a corresponding decline from 81% in 2014 to 56% in 2021.

[Figure 2]

Profile of women and factors associated with self-management of abortion

Table 1 describes the demographic and pregnancy-related attributes that influenced the choice of women for SMAs and provider-assisted abortions. In many demographic categories, there were factors significantly correlated with SMAs. Although the mean age of women obtaining an abortion for both self-managed and provider-assisted abortions was just over 28 years, young women were more likely to opt for SMAs than their older counterparts. Women in the oldest age groups (35+ years) were more likely to seek abortion from a provider when compared to 15-19-year-olds (OR: 0.49, CI: 0.31-0.78, $p < 0.05$). Rural women were also more likely to opt for SMAs than urban women; however, the variations were insignificant. Education of women played an important role; women with higher education (21%) were significantly less likely (OR: 0.76, $p < 0.05$) to opt for SMAs compared to their counterparts with no education (33%). Further, self-managed abortions were more pronounced among the poorest wealth quintiles (36%; OR: 1.2, $p < 0.05$) when compared to the middle (26%) and wealthiest (24%) quintiles. Although the caste of women marked no significant variations in their choices, Hindu women who reported seeking abortion had an increased likelihood of choosing self-managed abortion over provider-assisted abortion compared to Muslim women (OR: 0.79, $p < 0.05$). Further, working women were 1.2 times as likely to self-manage an abortion when compared to non-working women (OR: 1.17, $p < 0.03$). Regional locations of women accounted for the most striking variations of SMAs: abortion seekers from the eastern region (45%, OR:5.6, $p < 0.01$) and central regions (39%, OR:4.5, $p < 0.01$) were 5.6 and 4.5 times more likely to choose SMAs than women from the western region. SMAs were concentrated among women with lower gestational ages at the time of abortion. Women up to 2 months gestational age were 5.0 times more likely to opt for SMAs (45%, OR:5.0, $p < 0.0$) than women who sought abortions post 3 months gestation. Further, women with 3+ children were more likely than women with up to one child to opt for self-management over provider-assisted abortion (OR:1.2, $p < 0.05$). Self-reported reasons for pregnancy termination also played interesting associations with SMAs; women who reported pregnancy complications, contraceptive failure, and male/female foetuses as the reasons for pregnancy terminations were significantly less likely to opt for SMAs than women who reported unplanned pregnancies.

[Table 1]

Abortion-related complications of self-managed abortion

We compared rates of abortion-related complications by place of abortion and person performing the abortion (Table 2). The overall rate of complication for all types of abortion was 14.6%. The highest proportion of complications was among women who sought abortion services after three months gestation (19%) and who used nurses/ANM/LHV (17.5%). Surprisingly, women who self-managed their abortion had reported a lower rate of complications (12.6%) compared to all other categories, including doctors (14.9%).

[Table 2]

Table 3 examines the correlates of abortion complications using bivariate and multivariate analyses. Once again, even after controlling all potential socio-demographic attributes, self-managed abortion was not significantly associated with a higher likelihood of complications when compared to an abortion performed by a provider (OR: 0.88, CI: 0.75- 1.06, p-val=0.179). Complications of abortion were significantly lower among women who had a lower gestational age at the time of abortion, particularly those with 2 months (OR: 0.66, CI: 0.56- 0.77, p<0.01) and under 2 months (OR: 0.64, CI: 0.53- 0.76, p<0.00) gestation.

[Table 3]

We further examined the interaction effects of abortion type (self-managed vs. provider-assisted) and gestational age (Table 4). Among women who self-manage abortion, the risk of complications is higher at older gestational ages when compared to women who seek abortions from providers. At more than 3 months gestational age, women who self-manage an abortion have an 81% higher likelihood of complications when compared to women with <2 months gestation and SMAs (OR: 1.6, CI: 1.09- 2.28, p<0.005). Using that same referent, women who used a provider at more than 3 months gestation have only a 47% higher risk of complications (OR:1.5, CI: 1.19-1.94, p< 0.00) compared to provider-assisted abortion at below 2 months gestation. At gestational ages greater than 3 months, both women who self-manage and those who use providers have a similar risk of complications compared to women (in their respective categories) with a gestational age of less than 2 months.

[Table 4]

DISCUSSION

Our findings suggest that approximately one in three abortions in India are self-managed. The findings also reveal that self-management of abortion has been on a steady rise in the past 8 years, as rates of provider-assisted abortions have been on the decline. In some states, such as Odisha, the proportion of self-managed abortions is almost equal to that of provider abortions. This trend highlights an increasing preference by women in India to self-manage abortion care, primarily through the use of medical abortion. This is especially true of women with lower levels of education, in the lowest quintiles of wealth, and who live in rural areas. If this current trajectory persists, it foretells a significant transformation in the landscape of abortion care in India. In the near future, self-management may supersede the utilization of healthcare providers, emerging as the predominant choice for women seeking abortion services across the nation. These findings echo those of other studies of self-managed abortion care (primarily using medical abortion), which show an increasing preference for self-administered abortion care in the home.^{7,6}

Self-managed abortion is a safe and effective method of pregnancy termination when compared to traditional provider-based care. Up to two months of gestational age, there is no increased risk of complications for women who self-manage their abortion. In this study, the risk of complications due to self-managed abortion increased only at higher gestational ages (3 months or greater); however, the risks were comparable to those of provider-assisted abortion beyond 3 months gestation. A number of studies from various global contexts concur that self-managed abortion, particularly self-use of medical abortion, is a safe and effective means of pregnancy termination and that women who self-manage abortions at home have similar or higher rates of success to that of clinic-based care (ranging from 80% to 97%).⁸⁻¹⁴ Furthermore, studies show that women can estimate their gestational age with a small margin of error that does not affect abortion outcome and can determine when to seek post-abortion care for complications.¹⁵⁻¹⁷ However, similar to the current study, two other studies in India demonstrated an increased risk of incomplete abortion or complications at higher gestational ages.^{18,19}

Although this was the first time after almost three decades that the fifth round of NFHS captured national-level data on abortion methods and abortion providers, the NHFS-5 did not supply questions to discern why self-managed abortion care is on the rise in India, but there are a number of potential reasons why women may be using this method more and more. Medical abortion has been legal in some form in India since 2002, laying the groundwork for the widespread availability of self-management methods through

pharmacies around the country. Furthermore, efforts by the Government of India to increase the use of MA through facility-based training and distribution may have resulted in broader knowledge of self-management methods, even among those who do not use clinic-based care.²⁰ A 2015 abortion incidence study estimated that the majority of abortions taking place in India were done at home, using medical abortion.⁶ The lower cost, and ready access to medical abortion, as compared to clinic-based care, may also be contributing to the increased use of self-managed abortion in India.^{21,7} Even in other contexts, women report high satisfaction with SMAs with MA due to its accessibility, affordability, comfort, confidentiality, and privacy.^{8,9,22,7}

Though self-management of abortion with MA increases the availability of abortion options for women, there are some caveats to consider as this method increases in popularity. As the self-use of MA rivals the dominance of provider-based care, providers may begin to lose skills in manual vacuum aspiration and technologies for later gestational age and postabortion complications due to a lack of practice and a decreased emphasis on training in these skills. Future interventions may begin to shift abortion provision efforts to new segments of the health system (such as community or pharmacy level), which may further endanger providers' ability to offer safe and effective abortion care on demand. Such a loss would threaten a woman's choice to have the method of care that she prefers and to ensure that the method is applied correctly. Furthermore, self-management of abortion may still result in complications, particularly at higher gestational ages, so women must be educated on the signs and symptoms that require post-abortion care. This is especially true for women in poor, rural communities, who may be at higher risk of complications of abortion, whether self-managed or provider-based.

To broaden women's options for safe and timely abortion in India, it is imperative that future initiatives prioritize several key programmatic areas. First, self-management of abortion can be supported by guaranteeing the MA supplies to communities through pharmacies. This should be complemented by sufficient orientation of pharmacists to ensure that they provide women with the proper information, indications, procedures, protocols, and risks of MA. In India in particular, studies have shown that pharmacists may lack the capacity to provide accurate MA information to clients and may require training on basic elements such as calculating gestational age, dosage and timing of MA drugs and legal gestational limits for MA use.^{23,24} Pharmacists can also serve as an essential referral link to facilities for women who experience post-abortion complications. At the facility level, providers should be trained to offer effective and non-judgmental post-abortion care for all women but should be especially sensitive to the needs of

those who self-managed their abortion and may be timid about clinic-based care. Finally, women themselves need more education on a range of information that can improve their ability to make choices, the legal indications of abortion, the appropriate timing and administration of MA drugs, the normal symptoms of MA, and when and where to seek additional care and support in case of complications. Intervening at each of these points can significantly impact women's access to abortion.

It is essential to consider certain limitations when interpreting the findings of this study. As previously mentioned, all data in this study are self-reported, which introduces a notable susceptibility to significant underreporting of abortion-related information. This underreporting is primarily attributed to the profound cultural sensitivity and enduring social taboos surrounding the topic of abortion. Furthermore, the study faces challenges in verifying the skills and training levels of healthcare providers reported to have performed abortions and the true nature of self-reported postabortion complications. The study's data may not provide adequate substantiation of the qualifications and competency of these healthcare professionals in abortion procedures. These limitations underscore the need for a cautious interpretation of the findings and emphasize the complex nature of researching sensitive topics like abortion in cultural contexts where disclosure may be inhibited. Researchers and policymakers should be aware of these constraints when utilizing the study's results for decision-making and policy formulation.

CONCLUSIONS

This research is a critical foundation for comprehending the prevalence and associated risks of self-managed abortion in India. The findings illuminate a compelling narrative: self-managed abortion is steadily gaining popularity as a method of pregnancy termination, and it exhibits the potential to be as safe and effective as provider-based care. Furthermore, there are indications that it may soon emerge as the preferred choice for abortion in India. This evolving landscape underscores the importance of ongoing support for women and healthcare stakeholders through comprehensive education, training, and access to necessary supplies. Such support mechanisms are instrumental in ensuring that women can exercise their reproductive choices with safety and in a timely manner, irrespective of the method they opt for.

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Fig 1a. Prevalence of self-managed abortion in India by states & UTs, 2019-2021 (%)

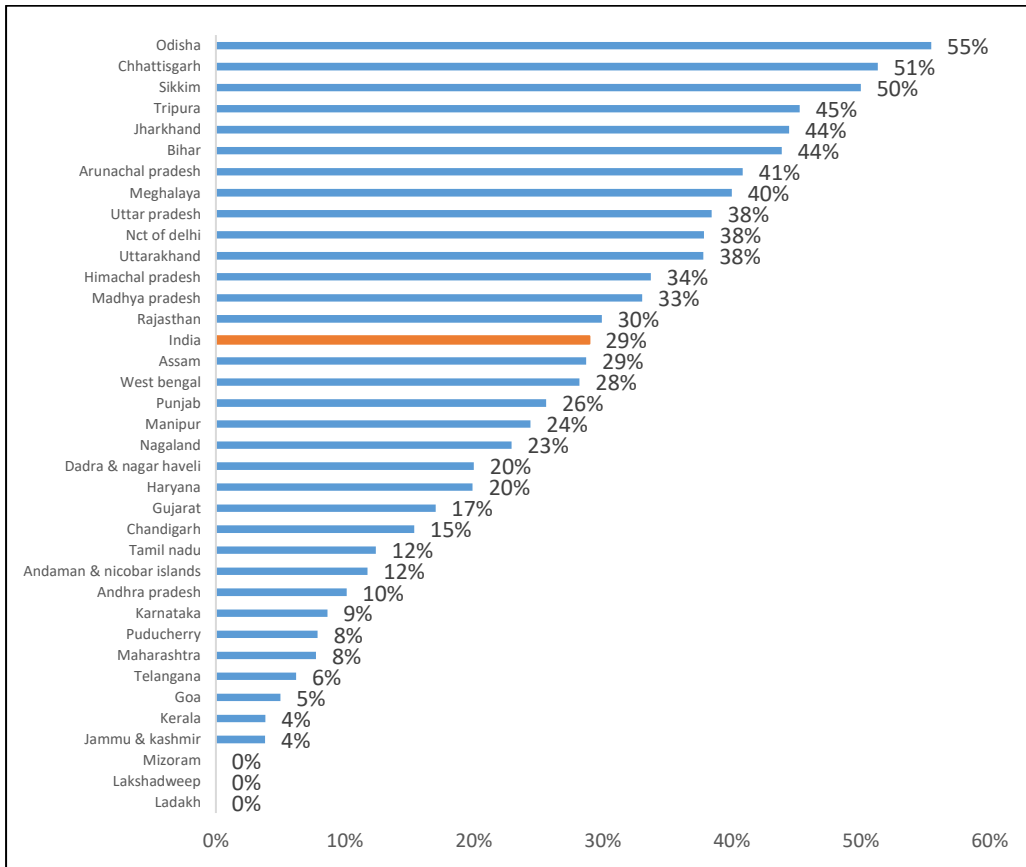


Fig 1b. Regional distribution of self-managed abortion in India by states & UTs, 2019-2021 (%)

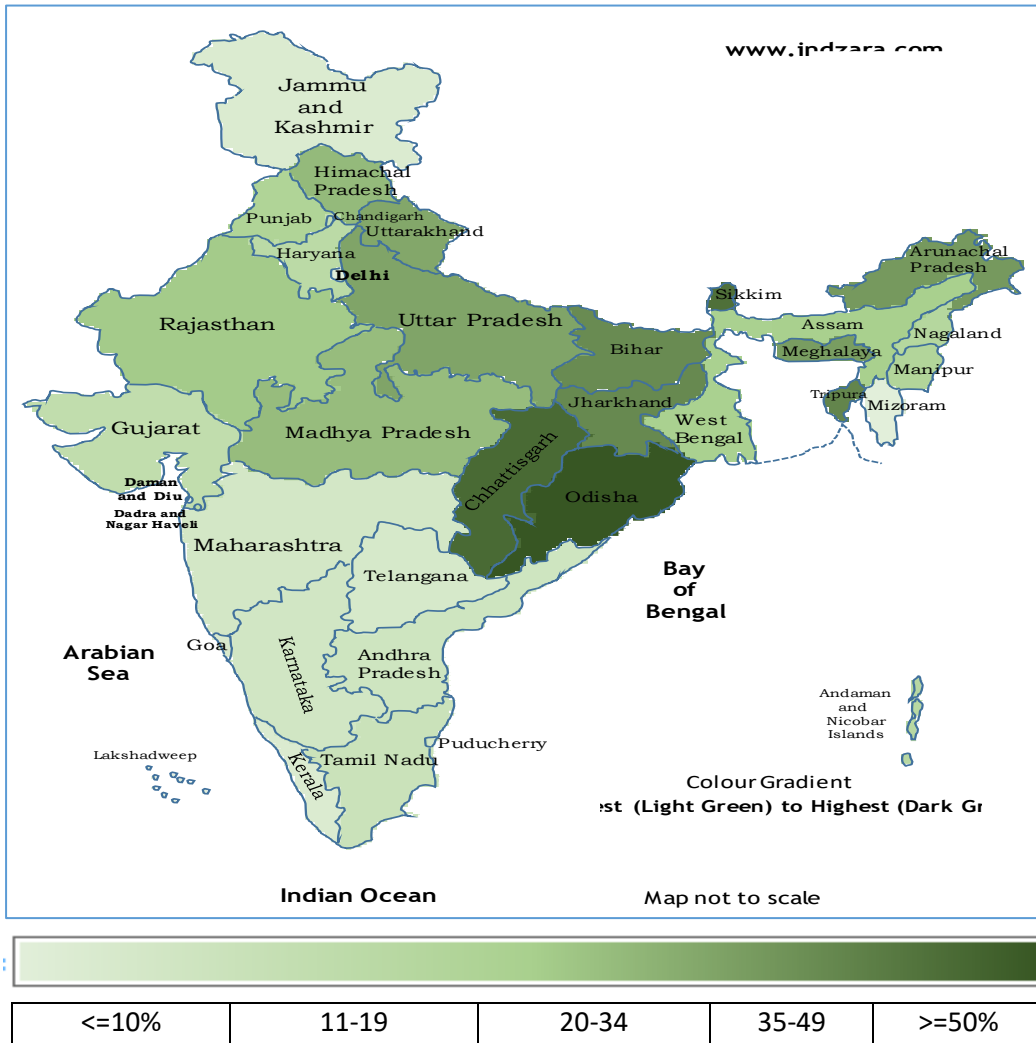


Figure 2: Trends of SMAs and provider-assisted abortions in the last eight years (2014-2016), in India

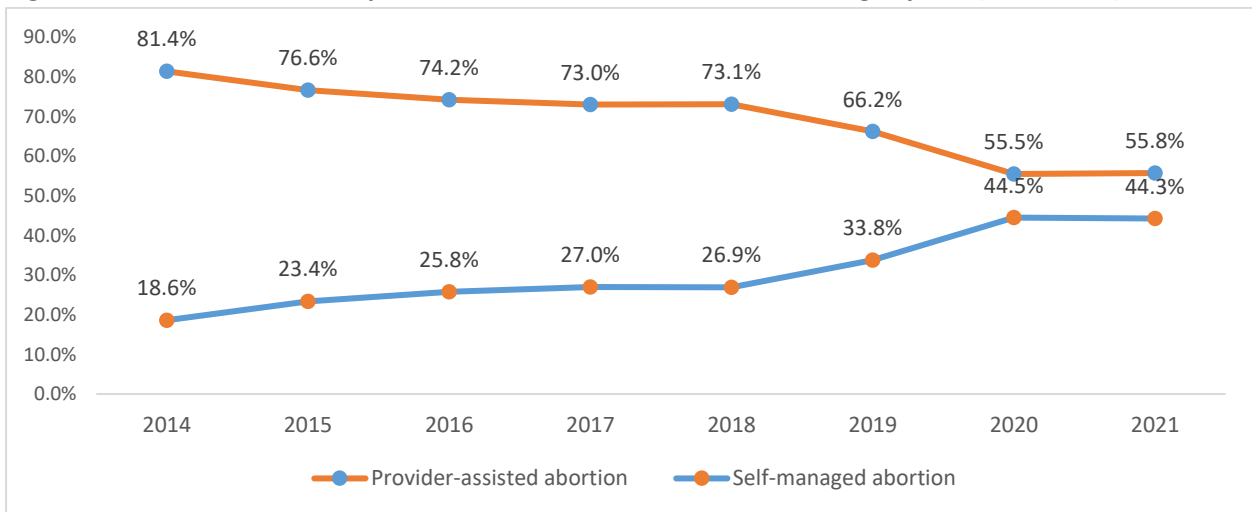


Table 1 Factors associated with self-managed abortion versus provider-assisted abortion, India 2019-21 (SMA=1 and provider-assisted abortion=0)

Characteristics of women	Self-managed abortion (%)	Provider-assisted abortion (%)	Odds ratio (confidence interval)	P-value
	(N=2,229)	(N=5,467)		
Age				
15-19 (<i>r</i>)	32.5 (50)	67.5 (104)		
20-24	32.1 (500)	67.9 (1059)	0.99 (0.65-1.5)	0.936
25-29	30.5 (821)	69.5 (1875)	0.80 (0.52-1.21)	0.278
30-34	27.8 (518)	72.2 (1346)	0.66 (0.43-1.03)	0.062*
35 & above	23.9 (340)	76.1 (1083)	0.49 (0.31-0.78)	0.003***
Mean age (SD)	28.5 (5.55)	29.3 (5.81)		
Place of residence				
Urban (<i>r</i>)	24.6 (546)	75.4 (1670)		
Rural	30.7 (1683)	69.3 (3797)	1.02 (0.89-1.17)	0.805
Region				
West (<i>r</i>)	10.8 (67)	89.2 (554)		
North	25.6 (341)	74.4 (992)	3.27 (2.42-4.4)	0.000***
Central	38.8 (632)	61.2 (995)	4.47 (3.34-5.96)	0.000***
East	44.8 (643)	55.2 (791)	5.6 (4.19-7.5)	0.000***
Northeast	31.4 (430)	68.6 (938)	2.75 (2.03-3.73)	0.000***
South	8.8 (116)	91.2 (1197)	1.12 (0.8-1.56)	0.519
Education				
No education (<i>r</i>)	32.8 (343)	67.2 (703)		
Higher	20.9 (283)	79.1 (1073)	0.76 (0.6-0.96)	0.021**
Secondary	29.9 (1317)	70.1 (3094)	0.94 (0.79-1.13)	0.473
Primary	32.4 (286)	67.6 (597)	0.9 (0.73-1.11)	0.314
Caste				
General (<i>r</i>)	26.4 (554)	73.6 (1541)		
ST	33.5 (309)	66.5 (613)	1.2 (0.97-1.48)	0.098
SC	30.5 (484)	69.5 (1101)	1.08 (0.91-1.28)	0.435
OBC	28.5 (882)	71.5 (-2212)	1.06 (0.92-1.23)	0.475
Religion				
Hindu (<i>r</i>)	29.8 (1848)	70.2 (4346)		
Muslim	24.7 (206)	75.3 (627)	0.79 (0.65-0.96)	0.017**
Christian	28.6 (83)	71.4 (207)	0.99 (0.71-1.38)	0.939
Sikh	22.5 (38)	77.5 (131)	0.88 (0.58-1.33)	0.529
Others	25.7 (54)	74.3 (156)	0.76 (0.53-1.09)	0.128
Working				
Not working (<i>r</i>)	28.4 (1843)	71.6 (4653)		
Working	32.2 (386)	67.8 (814)	1.17 (1.01-1.36)	0.038**
Wealth Index /SLI				
Rich (<i>r</i>)	23.9 (750)	76.1 (2380)		
Middle	26.2 (436)	73.8 (1230)	0.98 (0.84-1.16)	0.804
Poor	35.9 (1043)	64.1 (1857)	1.21 (1.03-1.43)	0.021**
Marital Status				
Currently married (<i>r</i>)	28.8 (2155)	71.2 (5334)		
Currently not married	35.8 (74)	64.2 (133)	1.14 (0.71-1.82)	0.611

Years since marriage				
<i>Never married (r)</i>	47.4 (45)	52.6 (50)		
0-4 years	27.0 (419)	73.0 (1133)	1.91 (0.94-3.86)	0.075*
5-9 years	28.8 (871)	71.2 (2153)	1.06 (0.79-1.42)	0.706
10-14 years	30.1 (529)	69.9 (1227)	0.99 (0.79-1.26)	0.927
15 years and above	28.8 (365)	71.2 (904)	0.94 (0.77-1.16)	0.549
Living Children				
<i>0-1 (r)</i>	24.4 (703)	75.6 (2182)		
2	30.2 (896)	69.8 (2076)	1.11 (0.95-1.29)	0.210
3+	34.3 (630)	65.7 (1209)	1.24 (1.02-1.51)	0.031**
Gestational age at the time of abortion				
<i>3 months & above (r)</i>	11.1 (296)	88.9 (2389)		
2 months	34.3 (1019)	65.7 (1951)	3.26 (2.8-3.79)	0.000***
Less than 2 months	44.8 (914)	55.2 (1127)	5.03 (4.29-5.91)	0.000***
Mean (SD)	1.7 (0.84)	2.6 (1.44)		
Reason for abortion				
<i>Unplanned pregnancy (r)</i>	37.7 (1688)	62.3 (2788)		
Complications during pregnancy	13.6 (293)	86.4 (1859)	0.42 (0.36 – 0.49)	0.000***
Female / Male fetus	17.5 (103)	82.5 (487)	0.45 (0.36 – 0.58)	0.000***
Contraception Failure	28.1 (74)	71.9 (189)	0.74 (0.54 – 0.99)	0.047**
Economic reasons	33.1 (71)	66.9 (144)	1.17 (0.85 – 1.61)	0.329
Overall Prevalence	28.9	71.0		

Table 2: Rates of abortion complications by provider and place, India 2019-21

Performed by	Complication from abortion	
	%	n
Doctor	14.9	634
Nurse/ANM/LHV	17.5	192
Dai / Other	16.4	17
Self	12.6	281
Place of abortion		
Public facility	16.2	322
Private facility	15.0	555
Home	12.3	242
Elsewhere	12.2	5
Method of abortion		
Medical Abortion	13.9	707
Surgical	16.4	379
Other / Don't know	12.8	38
Gestational age at time of abortion		
3 months & above	18.5	495
2 months	12.9	384
Less than 2 months	12.0	245
Total	14.6	1124

Table 3 Factors influencing post-abortion complications: A bivariate and multivariate analysis (Post-abortion Complication: Yes=1 & No=0), India 2019-21

Characteristics of women	Unadjusted %	Odds Ratio Exp (B)	95% confidence interval for Exp (B)		P-value
	(N=1,124)		Lower	Upper	
Age					
15-19 (<i>r</i>)	16.9				
20-24	14.6	0.98	0.62	1.56	0.942
25-29	13.2	0.98	0.61	1.57	0.925
30-34	15.7	1.19	0.73	1.94	0.496
35 & above	15.5	1.07	0.64	1.80	0.791
Mean age (SD)					
Place of residence					
Urban (<i>r</i>)	13.5				
Rural	15.0	1.12	0.96	1.32	0.156
Region					
West (<i>r</i>)	16.4				

North	18.1	1.12	0.86	1.47	0.392
Central	15.1	1.03	0.79	1.35	0.826
East	15.3	0.98	0.75	1.29	0.921
Northeast	12.4	0.66	0.49	0.88	0.005***
South	11.1	0.58	0.44	0.78	0.000***
Education					
<i>No education (r)</i>	16.6				
Higher	13.4	0.85	0.65	1.13	0.275
Secondary	14.6	0.96	0.78	1.19	0.717
Primary	14.2	0.89	0.69	1.16	0.391
Caste					
<i>General (r)</i>	16.5				
ST	13.6	0.87	0.68	1.12	0.292
SC	15.4	1.00	0.83	1.22	0.930
OBC	13.2	0.87	0.73	1.02	0.092*
Religion					
<i>Hindu (r)</i>	14.1				
Muslim	18.9	1.41	1.14	1.73	0.001***
Christian	12.4	1.09	0.73	1.63	0.685
Sikh	15.4	0.79	0.50	1.24	0.312
Others	15.7	1.19	0.79	1.78	0.409
Working					
<i>Not working (r)</i>	14.9				
Working	12.8	0.86	0.72	1.04	0.115
Wealth Index /SLI					
<i>Rich (r)</i>	14.0				
Middle	15.3	1.16	0.96	1.39	0.124
Poor	14.9	1.11	0.92	1.34	0.280
Marital Status					
<i>Currently married (r)</i>	14.4				
Currently not married	21.7	1.19	0.73	1.96	0.488
Years since marriage					
<i>15 years and above (r)</i>	16.6				
0-4 years	14.6	0.73	0.53	1.01	0.059*
5-9 years	13.9	0.78	0.60	1.01	0.060*
10-14 years	13.8	0.79	0.62	1.00	0.056*
Never married	26.3	1.44	0.69	3.04	0.334
Living Children					
<i>0-1 (r)</i>	16.2				
2	13.7	0.77	0.65	0.91	0.003***
3+	13.7	0.60	0.48	0.75	0.000***
Gestational age at time of abortion					
<i>3 months & above (r)</i>	18.4				
2 months	12.9	0.66	0.56	0.77	0.003***
Less than 2 months	12.0	0.64	0.53	0.76	0.000***
Mean (SD)					
Self-managed abortion					
No	15.4				

Yes	12.6	0.88	0.75	1.06	0.179
Method of abortion					
MMA	13.9				
Surgical	16.4	1.06	0.92	1.25	0.402
Other	12.8	0.76	0.53	1.09	0.131

Table 4: Interaction effect of provider type and gestational age on post-abortion complications in India, India 2019-21

Interaction	Complications Unadjusted % (N=1,124)	Odds Ratio Exp (B)	Significance level (p)	95% confidence interval for Exp (B)	
				Lower	Upper
Performed by provider and gestation <2 months ^R	12.2				
Performed by provider and gestation 2 months	12.6	0.98	0.877	0.75	1.27
Performed by provider and gestation 3 months and above	18.0	1.5	0.001***	1.19	1.94
Self-use and gestation <2 months	10.6	0.8	0.169	0.59	1.09
Self-use and gestation 2 months	12.6	0.9	0.761	0.71	1.27
Self-use and gestation 3 months and above	18.9	1.6	0.014**	1.09	2.28