PMA2020 ABORTION SURVEY RESULTS: RAJASTHAN, INDIA

April–June 2018

KEY FINDINGS

- In 2017, the estimated annual incidence of likely abortions in Rajasthan, India was 23.6 per 1,000 women aged 15 to 49 when including information related to the experience of respondents' closest confidantes - this is equivalent to nearly 440,000 likely abortions. However, this may still be an underestimate.
- Nearly 4 out of 10 abortions were considered dangerous, and 25% of women experienced complications for which they sought postabortion care at a health facility.
- Women living in urban areas and poor women were the most likely to have had a dangerous abortion.
- In Rajasthan, most hospitals provided postabortion care (95%) and induced abortion services (92%). However, lower level facilities were much less likely to do so.

More than **2%** of women of reproductive age in Rajasthan had a likely abortion in the 12 months prior to this study, which is equivalent to **441,011** annual abortions.

Abortion in India

In India, abortion has been legal for a broad set of conditions since the passage of the Medical Termination of Pregnancy Act in 1971.[1] Recent estimates indicate that approximately 15.6 million abortions occurred throughout the country in 2015.[2] This is equivalent to a national rate of 47 abortions per 1,000 women aged 15 to 49 years.[1] The majority (73%) of these abortions were medication abortions that occurred outside of health facilities. These findings indicate that nearly half of all pregnancies in India were unintended and a third of all pregnancies were resolved by induced abortion.[2] These data, however, lack details from a woman's perspective and do not provide estimates for the state of Rajasthan.

In 2018, Performance Monitoring and Accountability 2020 (PMA2020) conducted a survey to produce updated and expanded estimates of abortion-related indicators. The survey results provide new insights into the characteristics of women who have an abortion and the pathways leading to abortion within or outside the health care system.

PMA2020 Measurement of Abortion Incidence

Direct and indirect incidence measures

Prior research demonstrates that asking women directly about their experience with abortion results in substantial underestimation of this stigmatized behavior. To generate more valid data, interviewers asked respondents about their closest confidante's experience with abortion prior to asking the respondent about her own experience. The responses were used to produce direct (self-report) and indirect (confidante) estimates of abortion incidence. This latter approach draws on the Guttmacher Institute's proposed adaptations of existing social network-based methodologies for abortion measurement.[3,4,5]

In this survey, interviewers asked 5,832 women aged 15 to 49 years two sets of questions on abortion for themselves and their closest confidante: one asked about "pregnancy removal" and the other about "regulating a period when you were worried you were pregnant."

CONFIDANTE:

A confidante is a respondent's closest female friend or relative. A respondent and confidante share very personal information with each other, and, similar to the respondent, the confidante lives in Rajasthan and is between the ages of 15 and 49.

[1] *Government of India. (1971). The medical termination of pregnancy act [Act No. 34, 1971]. New Delhi: Government of India,.*
[2] *Singh, S., Shekhar, C., Acharya, R., Moore, A. M., Stillman, M., Pradhan, M. R., … Browne, A. (2018). The incidence of abortion and unintended pregnancy in India, 2015. The Lancet Global Health, 6(1), e111-120.*
[3] *Rossier, C., et al. (2006). "Estimating clandestine abortion with the confidants method--results from Ouagadougou, Burkina Faso." Social science & medicine 62(1): 254-266.*
[4] *Yeatman, S. and J. Trinitapoli (2011). "Best-friend reports: A tool for measuring the prevalence of sensitive behaviors." Am J Public Health 101(9): 1666-1667.*
[5] *Sedgh, G. and S. Keogh (forthcoming). "Novel approaches to estimating abortion incidence."*

One-year likely abortion incidence (per 1,000 women) for female respondents and their closest female confidantes

	Respondent	Confidante
Pregnancy removal	7.0	15.6
Period regulation	3.3	12.1
Combined*	9.5	23.6
Annual number of abortions	177,525	441,011

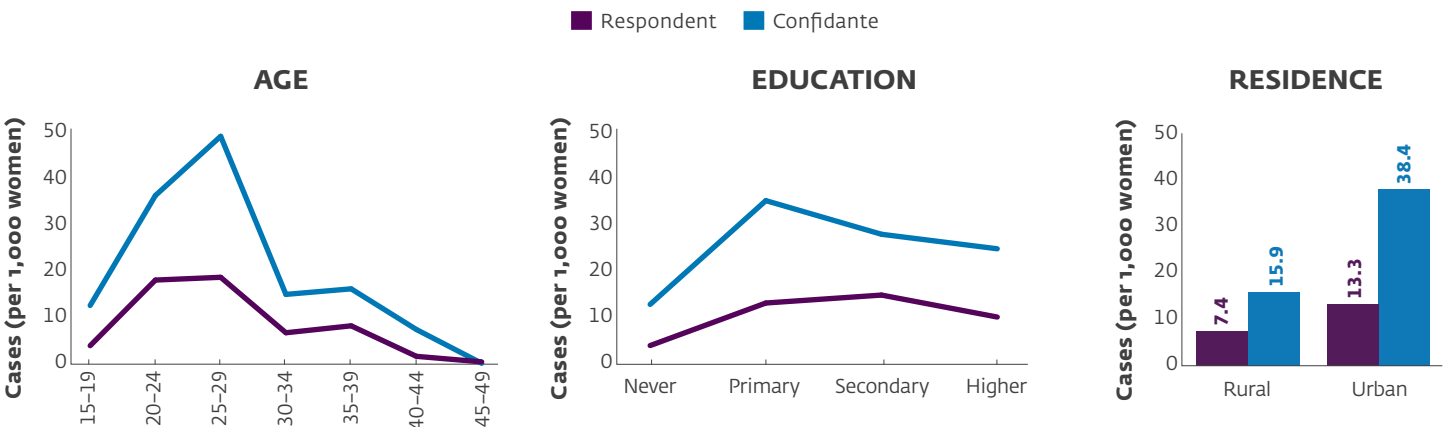
**The combined rate is not equal to the sum of the pregnancy removal and period regulation rates as some women reported both a pregnancy removal and a period regulation in the prior year.*

"[My husband] said we already have two kids [and] our economic condition is also not good. He left the decision to me. But it was better that we take good care of both kids than to have a third one. All of my family members supported me [having an abortion]."

— 28-YEAR-OLD MARRIED WOMAN

Abortion incidence was highest among women in their 20s, women with primary or secondary education, and women living in urban areas.

One-year likely abortion incidence (pregnancy removal and period regulation combined) among female respondents and their closest female confidantes in Rajasthan, by background characteristics

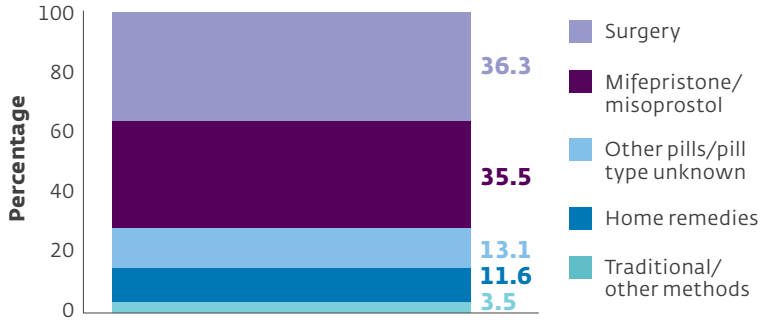


Pathways to Abortion and Abortion Safety

Based on self-reported abortion data (pregnancy removal and period regulation combined), 16% of women indicated they used multiple methods to terminate their pregnancy. Altogether, 36% underwent surgery to ultimately terminate their pregnancy, 36% used mifepristone/misoprostol, and 28% used other or unspecified medications or traditional methods for their abortion.

Respondents' likely abortion final method

whether one or more methods was used



"I was frightened, since I had never taken [an abortion pill] I didn't know what would happen or [if] nothing would happen. I was even afraid that I might die; a lot of people have died. [The abortion pill] suits some people and doesn't suit other people. Had I taken it earlier it would have been better but I did not, so I was afraid."

— 30-YEAR-OLD WOMAN

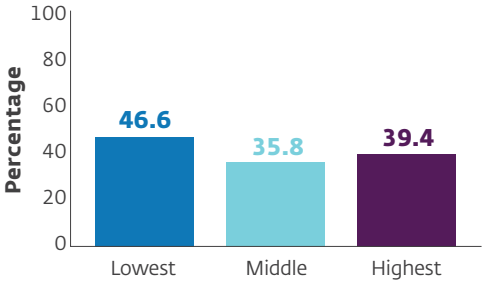
Nearly **4 out of 10** abortions were considered dangerous, and **25%** of women experienced complications for which they sought postabortion care at a health facility.

Safety of respondents' likely abortions

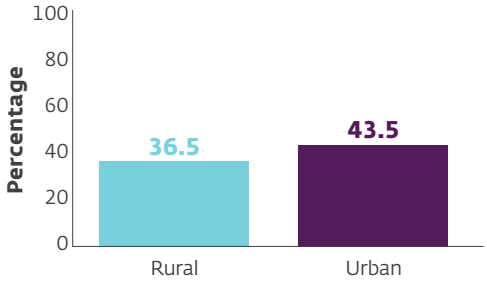
pregnancy removals and period regulations combined

Overall, 40% of abortions were categorized as dangerous. Women in the lowest wealth tertile (47%) and women in urban areas (44%) were the most likely to have had a dangerous abortion.

DANGEROUS BY WEALTH TERTILE



DANGEROUS BY RESIDENCE



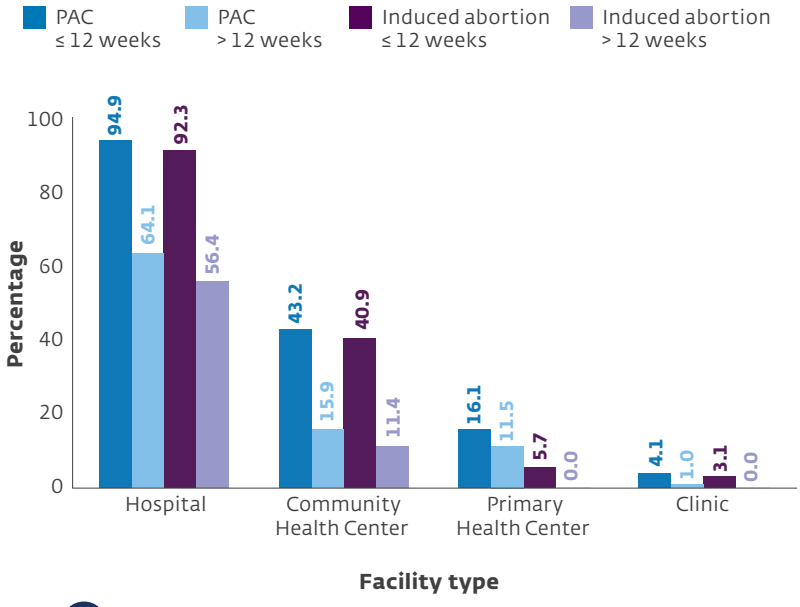
PMA2020 DEFINITION OF DANGEROUS ABORTION

Women who terminate a pregnancy using methods other than facility-based surgery or medication abortion drugs experience abortions that are more likely to result in maternal morbidity and mortality. We categorize these abortions as dangerous abortions.

Service Delivery: Postabortion Care (PAC) and Induced Abortion Service Availability

Most hospitals provided induced abortion services (95%), but only 87% had the necessary equipment, medicines, and other services (i.e. signal functions) to provide basic induced abortion care. Less than half of community health centers provided any postabortion or induced abortion care services, and only 16% of primary health centers provided any abortion care.

Percentage of facilities offering postabortion and induced abortion care at 12 weeks or less and more than 12 weeks gestation, by facility type (n=268)



Percentage of facilities that have all basic and comprehensive induced abortion care signal functions, by facility type (n=268)*

Facility type	Basic	Comprehensive
Hospital	87.2	41.0
Community Health Center	34.1	2.3
Primary Health Center	3.4	0.0
Clinic	1.0	0.0

**Basic induced abortion care signal functions include ≤12 weeks gestation removal of retained products, ≤12 weeks gestation medical termination of pregnancy, antibiotics, oxytocic drugs, intravenous replacement fluids, and provision of any contraception; comprehensive induced abortion care signal functions include basic induced abortion care signal functions plus >12 weeks removal of retained products, >12 weeks medical termination of pregnancy, blood transfusion, laparotomy, 24/7 postabortion care service availability, and provision of long-acting reversible contraception.*

"Whatever happens will happen with me only. [My husband] just said if it is a girl again, things will become difficult for me. I do not earn much."

— 26-YEAR-OLD MARRIED WOMEN

METHODOLOGICAL CONTRIBUTIONS OF THE PMA2020 ABORTION SURVEY

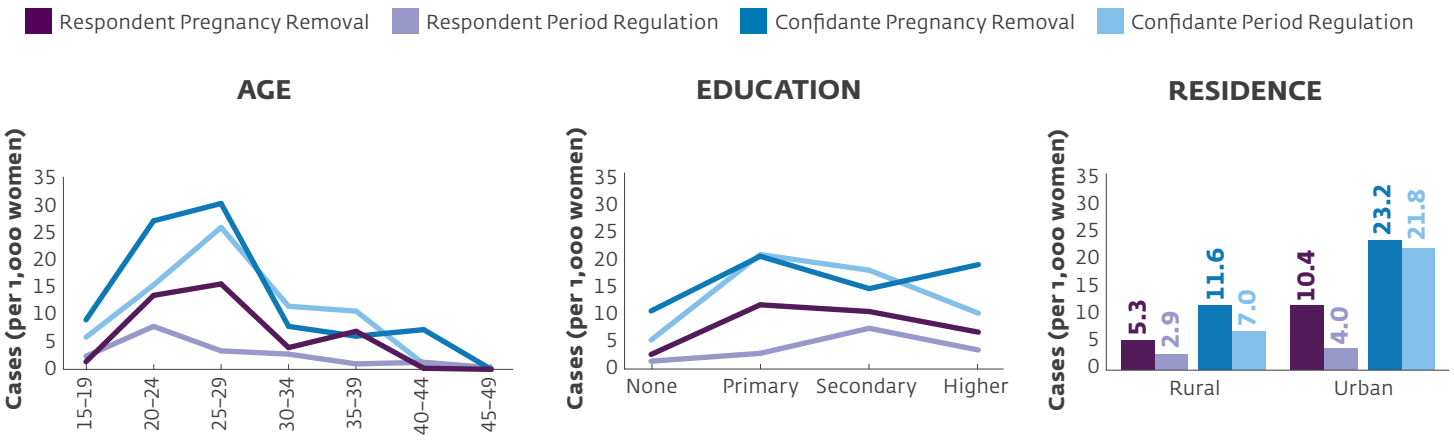
Direct Versus Indirect Estimation of Abortion

Prior to this PMA2020 survey, researchers generated recent India abortion estimates from facility-based data on abortion complications, then multiplied those data by an inflation factor to account for the abortions that likely occurred outside of health facilities (known as the Abortion Incidence Complications Methodology, or AICM).[2] While this indirect approach has proven more useful than an underreported direct measurement of abortion, it is nevertheless important to draw from innovations in the field to further improve direct reporting and other community-based indirect methodologies. These methods can yield rich data on the characteristics of women undergoing abortions and the specifics of their abortion experiences, including for abortions occurring outside of the health care system. PMA2020's community-based data on respondents' and confidantes' abortions seeks to address these limitations.

Pregnancy Removal Versus Period Regulation

Pregnancy removal and period regulation incidences largely follow similar trends by age, education, and residence. However, asking separately about period regulation captures additional likely abortions that would otherwise be missed if asking only about pregnancy termination.

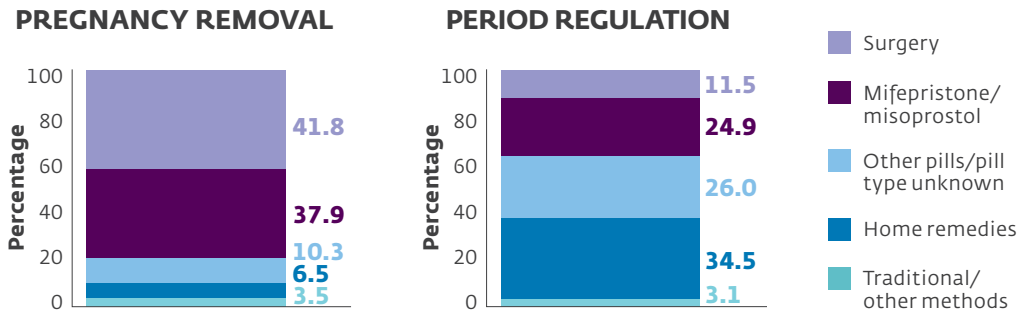
One-year incidence of pregnancy removal and period regulation for respondents and their closest female confidantes, by characteristics



Respondents' likely abortion final method

whether one or more methods was used

Respondents most often ultimately used surgery to remove a pregnancy, whereas they primarily relied on pills and traditional methods for period regulations at a time when they were worried they were pregnant.



SAMPLE DESIGN

The PMA2018/Rajasthan survey used a two-stage cluster design. A sample of 147 enumeration areas (EAs) was drawn by the International Institute for Population Sciences from a master sampling frame. In each EA, data collectors listed and mapped households and private health facilities; supervisors randomly selected 35 households from each EA sampling list. Interviewers surveying the households invited all eligible females aged 15 to 49 years to consent for the female survey. The final completed sample included 4,933 households (98.3% response rate), 5,832 de facto females (98.4% response rate), and 268 advanced facilities (98.0% response rate). Among the female respondents who reported a recent abortion, data collectors followed up with and conducted in-depth qualitative interviews with 30. The advanced health facilities interviewed included: 39 hospitals, 44 community health centers, 87 primary health centers, and 98 clinics. Data collection occurred from April to June 2018. The female estimates in this brief reflect weighted values; facility estimates are unweighted.

The PMA2020 project is implemented by local universities and research organizations in 11 countries, deploying a cadre of female resident interviewers trained in mobile-assisted data collection. The Indian Institute of Health Management Research implemented the PMA2020/Rajasthan project with overall direction and support provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health. An Anonymous Donor provided funding for the abortion module development, implementation, and analysis.

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