Unsafe abortion is defined as an abortion performed either by persons lacking necessary skills or in an environment lacking minimal medical standards or both. Although unsafe abortion is entirely preventable, it remains a significant cause of maternal morbidity and mortality in much of the developing world. Globally, an estimated 19 million unsafe abortions take place each year. Worldwide an estimated 68,000 women die as a consequence of unsafe abortion. Approximately 1 in 10 pregnancies end in unsafe abortion, giving a ratio of 1 unsafe abortion to about 7 live births.

Where contraception is inaccessible or of poor quality, many women will seek to terminate unintended pregnancies, despite restrictive laws and lack of adequate abortion services. In spite of several decades of work in this area, less than half of all women in the reproductive age group in India use contraception. Four out of every 10 women in rural India who underwent abortion reportedly did so because they did not want any more children. Prevention of unplanned pregnancies by improving access to quality family planning services even in rural areas must therefore be the highest priority.

The other priority in India would be to improve access to quality abortion services including post-abortion care. Although the Medical Termination of Pregnancy Act, 1971 has been under implementation since 1972, unsafe abortions still account for 9 percent of maternal deaths in India. The Government of India under the Reproductive & Child Health (RCH) programme has trained health providers in surgical abortion techniques, including manual vacuum aspiration. At the same time, activities have been undertaken for improving the awareness and knowledge about safe abortion in the community. Although the number of centres where pregnancy can be terminated has increased, there are still only 11,025 recognized medical termination of pregnancy (MTP) clinics in the country. These are unequally distributed among and within states. Even among approved centres, only a small proportion was functional.

Medical methods provide a safe and effective option for abortion. The most widely used regimens rely on the antiprogestogen, mifepristone, which binds to progesterone receptors, inhibiting the action of progesterone and hence interfering with the continuation of pregnancy. An initial dose of mifepristone is followed by administration of a synthetic prostaglandin analogue (usually misoprostol), which enhances uterine contractions and helps expel the products of conception. Bleeding occurs for nine days on an average but can last for up to 45 days in rare cases. According to the Cochrane review on medical methods for first trimester abortion, 200 mg of mifepristone is as effective as 600 mg (RR 1.07; 95% CI 0.87-1.32). Oral misoprostol is less successful than vaginal misoprostol and is associated with more failures (RR 3.0; 95% CI 1.44-6.24). Mifepristone alone is less effective than a combination of mifepristone and prostaglandins (RR 3.76; 95% CI 2.3-6.15).

In this issue of the Journal, Mittal and colleagues reported data from 150 women with early pregnancies (< 63 days) recruited at their centre as part of a large WHO multinational study of three misoprostol regimens for early medical abortions. Mifepristone administration followed by oral or vaginal misoprostol administration two days later was associated with complete abortion in 96-100 per cent. Nausea was the main side effect in this group. Additional misoprostol for 1 wk after abortion had no effect on the perceived blood loss. More importantly, women in this group appeared to be satisfied with the regimens: 96 per cent stated that they would prefer medical to surgical abortion. It is equally important to...
note that 86 per cent felt that medical abortions should be conducted only at the health facility under strict medical supervision.

Mifepristone has been approved in India since 2002 for termination of early pregnancy up to 7 wk (49 days of amenorrhoea) in a facility with provision for safe abortion services and blood transfusion. But will this eliminate the mortality and morbidity associated with unsafe abortion?

Medical abortion is currently available mostly in the private sector. If medical abortion can be provided only in a government approved facility and only by those trained in surgical abortion techniques, the problem of limited access for safe abortion will continue. Forty per cent of unsafe abortions admitted to the Postgraduate Institute of Medical Education and Research, Chandigarh had been performed by medical doctors. Medical abortion, in contrast, requires less investment in resources as compliance and success rates are high. Most surgical interventions after medical abortion are unnecessary and follow up visits can be scheduled within a week of receiving mifepristone. It should be possible to train and licence more providers in safe medical abortion practices even if they have not had formal training in surgical abortion techniques and their facilities are not government approved for abortion. This may require a reconsideration of present policies and regulations in order to maximize the benefits of this option for women in India.

For the medical abortion option to be used successfully in India, the woman and her family should recognize an unplanned pregnancy as early as possible and seek early consultation from a qualified health provider - a major change from the present state of health seeking behaviour. Key messages on health education and information regarding safe abortion options should go beyond the urban elite and reach even remote and marginalised communities of India.

Matthews Mathai
Department of Making Pregnancy Safer
World Health Organization
CH 1211 Geneva 27
Switzerland
e-mail: mathaim@who.int

The views expressed in this commentary are solely the author’s and do not necessarily represent the views of the World Health Organization or its Member states.

References