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Epidemiological Profile and Determinants of Abortion Cases in Ilam Province, Western Iran: A Two-Year Population-Based Registry Study

rostam menati

Psychosocial Injuries Research Center, Ilam University of Medical Sciences, Ilam, Iran, Iran, Islamic Republic Of

walieh Menati

waliehmenati@yahoo.com

Psychosocial Injuries Research Center, Ilam University of Medical Sciences, Ilam, Iran, Iran, Islamic Republic Of

Taha Ashayeri

Department of Sociology, Faculty of social science, University of Mohaghegh Ardabili, Ardabil, Iran, Iran, Islamic Republic Of

Article

Keywords: Abortion, Spontaneous abortion, Induced abortion, Miscarriage, Registry study, Reproductive health, Prenatal care, Iran

Posted Date: September 24th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10557552/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

In Iran, induced abortion is legally restricted to a narrow set of medical indications, and existing evidence on abortion is drawn largely from fragmented facility-based, survey, and forensic-referral sources. We conducted a province-wide registry study to characterize abortion cases in Ilam Province, western Iran, a border region with distinct ethnic composition and limited prior registry-based evidence.

Methods

This retrospective, registry-based cross-sectional study included all spontaneous and induced abortion cases recorded across the 12 counties of Ilam Province over two consecutive Iranian calendar years, 1402 and 1403 (approximately March 2023 to March 2025). Data were extracted from the provincial reproductive health registry maintained by the Provincial Health Deputy of Ilam University of Medical Sciences. Sociodemographic and clinical variables were summarized descriptively, and a multivariable logistic regression model was used to identify factors independently associated with induced/legal versus spontaneous abortion.

Results

A total of 1,962 abortion cases were recorded. Mean maternal age was 33.9 ± 6.6 years, and 42.2% of women were aged ≥ 35 years. Most abortions (70.9%) occurred in the first trimester (mean gestational age 11.3 ± 4.4 weeks). Abortion type was spontaneous in 80.7% of cases, induced/legal in 11.1%, and ectopic pregnancy in 1.1%; 28.3% of women had a prior abortion history. An underlying maternal disease, most commonly thyroid disorder, was reported in 29.6% of women, and 71.1% had received prenatal care. Case volume increased by 30.3% between the two years (852 to 1,110 cases), a rise that plausibly reflects improved case ascertainment rather than a true increase in incidence. In multivariable analysis (n = 922), each additional week of gestational age was associated with higher odds of induced/legal abortion (adjusted odds ratio [aOR] 1.14, 95% confidence interval [CI] 1.09–1.19, $p < 0.001$), while receipt of prenatal care was associated with lower odds (aOR 0.63, 95% CI 0.42–0.94, $p = 0.023$).

Conclusions

This province-wide registry analysis identifies marked geographic disparities in prenatal care coverage and highlights chronic maternal disease, particularly thyroid dysfunction, as an important correlate of abortion history in a western Iranian border province. Strengthening prenatal care outreach in underserved counties, routine screening for chronic conditions among women of reproductive age, and

standardization of abortion registry data may together improve surveillance accuracy and reproductive health outcomes in the region.

Introduction

Abortion, whether spontaneous or induced, is among the most common adverse reproductive health outcomes worldwide and imposes substantial physical, psychological, and economic burdens on women and health systems. Globally, an estimated 73.3 million pregnancies ended in abortion annually between 2015 and 2019, corresponding to a rate of 39 per 1,000 women aged 15–49, with substantial variation across regions driven by differences in contraceptive access, unmet need for family planning, and the legal status of abortion (1). Spontaneous pregnancy loss alone is estimated to affect approximately one in ten women over their lifetime, with roughly 23 million miscarriages occurring each year worldwide, yet it remains comparatively understudied relative to its burden(2). In this study, the term “abortion” refers to both spontaneous (miscarriage) and induced termination of pregnancy unless otherwise specified.

In Iran, induced abortion is legally restricted outside a narrow set of medical indications. Following the enactment of the Single Article Act on therapeutic abortion in 2005, termination of pregnancy before 19 weeks of gestation is permitted only with maternal consent and confirmation by three medical specialists and the Legal Medicine Organization, in cases of severe fetal anomalies or life-threatening maternal conditions (3). Outside these criteria, estimates of abortion are derived from heterogeneous sources, including household surveys, forensic medicine records of applicants for legal abortion, and single-facility studies. Consequently, reported prevalence varies widely. A recent systematic review and meta-analysis estimated an overall abortion prevalence of 18.1% (95% CI: 14.5–21.7%), with substantial heterogeneity by region and study design (4). However, few studies have utilized complete, multi-year, province-wide registry data to examine abortion patterns in Iran.

International evidence has identified several consistent risk factors for pregnancy loss, including advanced maternal age (5), elevated body mass index (BMI) (6), and chronic maternal conditions, particularly thyroid dysfunction. A systematic review and meta-analysis has shown that untreated thyroid disorders nearly double the risk of miscarriage before 20 weeks of gestation (7). Whether these associations hold in the context of western Iran remains unclear, as the underlying genetic and epidemiological profile differs from that of populations in which most existing evidence has been generated. Notably, Kurdish populations in western Iran have a relatively high prevalence of consanguineous marriage and hemoglobinopathies, including β-thalassemia, which may influence reproductive outcomes (8).

Access to reproductive healthcare services, including prenatal care, is also unevenly distributed across Iran. Studies in western provinces have documented disparities in the geographic distribution of healthcare facilities and personnel(9). Spatial accessibility analyses in Kermanshah Province indicate that rural residents, as well as women, children, and older adults, face disproportionate barriers to

accessing health services (10). However, comparable evidence is lacking for neighboring Ilam Province. In particular, it remains unclear whether geographic disparities in prenatal care coverage exist across its counties and whether such disparities are associated with the distribution of recorded abortion cases.

To address these gaps, we conducted a population-based, retrospective, registry-based study of all recorded abortion cases across the 12 counties of Ilam Province, western Iran, over two consecutive Iranian calendar years. The objectives of this study were to: (1) describe the sociodemographic and clinical characteristics of women experiencing abortion; (2) assess geographic variation in abortion case volume and prenatal care coverage across counties; (3) identify factors associated with a history of prior abortion; and (4) evaluate temporal trends in abortion cases and prenatal care coverage over the study period.

Methods

Study design and data source

This study was designed as a population-based retrospective registry study of all recorded abortion events in Ilam Province, Iran, over two consecutive Iranian calendar years (1402–1403; approximately March 2023 to March 2025). Data were obtained from the provincial reproductive health registry maintained by the Health Deputy of Ilam University of Medical Sciences. This registry captures abortion-related events from all 12 counties in the province through standardized reporting forms and integrated electronic health records from public and private hospitals, maternity centers, and diagnostic laboratories. The study protocol was approved by the Ethics Committee of Ilam University of Medical Sciences (ethics code: IR.MEDILAM.REC.1404.087). All data were anonymized prior to analysis to ensure confidentiality. As the study used routinely collected registry data, no direct contact with participants was required. The study was conducted in accordance with the Declaration of Helsinki and national regulations governing the use of health data(11).

Study population and eligibility criteria

The study population included all women with a recorded abortion event in the provincial registry during the study period. All records with an abortion date within the defined time frame were eligible for inclusion. Records were excluded from seasonal analyses only if the abortion date could not be reliably assigned to a calendar month due to inconsistent formatting in free-text fields. These records were retained for all other analyses. Implausible values (maternal age <12 or >55 years, gestational age <0 or >42 weeks, or BMI <10 or >60 kg/m²) were recoded as missing rather than excluded.

Variables and definitions

The following variables were extracted: maternal age, gestational age at abortion, body mass index (BMI), gravidity, prior abortion history, abortion type, missed abortion status, underlying maternal disease, prenatal care utilization, maternal and spouse occupation, county of residence, and date of

abortion. Maternal age was defined at the time of abortion and categorized as <20, 20–34, and ≥35 years. Gestational age (in weeks) was categorized into trimesters: first (≤13 weeks), second (14–27 weeks), and third (≥28 weeks). Gravidity was classified as 1 (primigravida), 2–3, and ≥4 pregnancies. Abortion type was categorized as spontaneous abortion, induced/legal abortion, and ectopic pregnancy. Given its distinct pathophysiology, ectopic pregnancy was treated as a separate clinical category and analyzed descriptively. Induced/legal abortion included terminations performed under approved medical or legal indications. Missed abortion was defined as a nonviable intrauterine pregnancy with absent fetal cardiac activity on ultrasound, representing a subtype of spontaneous abortion(12).

Underlying maternal disease included any documented acute or chronic condition (e.g., diabetes mellitus, hypertension, thyroid disorders, cardiovascular disease, or infectious diseases). Prenatal care utilization was defined as at least one documented prenatal care visit prior to the abortion event. Occupational status for both mother and spouse was categorized as employed or unemployed. The abortion date was extracted from free-text entries using multiple formats (Y/M/D, D/M/Y, D.M.Y, and Persian month names). A custom parsing algorithm successfully assigned calendar months to 95.8% of records (1,879/1,962); the remaining records were excluded from seasonal analyses only.

Missing data and data quality

Missing data were present in several variables: maternal age (16.0%), BMI (33.2%), gravidity (5.2%), abortion type (7.1%), prior abortion history (8.0%), underlying disease (6.0%), and prenatal care utilization (10.2%). BMI had the highest proportion of missingness and is acknowledged as a key limitation. Missing values were not imputed due to the substantial proportion of missingness in key variables and the absence of auxiliary variables to support valid imputation. Instead, missing data were retained as such. For multivariable analyses, listwise deletion was applied.

Statistical analysis

Continuous variables were summarized as mean ± standard deviation (SD), and categorical variables as frequencies and percentages. Group comparisons for continuous variables were conducted using independent-samples t-tests or one-way analysis of variance (ANOVA), as appropriate. Categorical variables were compared using the chi-square test or Fisher’s exact test when expected cell counts were less than 5.

To identify factors independently associated with abortion type, a multivariable binary logistic regression model was fitted with abortion type (induced/legal vs. spontaneous) as the dependent variable. Covariates included maternal age, gestational age, BMI, gravidity, prior abortion history, underlying disease, and prenatal care utilization. Adjusted odds ratios (aORs) with 95% confidence intervals (CIs) were reported. Ectopic pregnancy cases (n=21) were excluded from regression analyses due to small sample size and analyzed descriptively. For missed abortion, only 57 of 1,576 spontaneous abortion cases (3.6%) had this classification. After listwise deletion for a seven-variable model, only 14 events remained (events-per-variable = 2.0), which is below the recommended threshold for stable regression

modeling(13, 14). Therefore, multivariable analysis was not performed for this outcome, and bivariate findings are reported as exploratory.

All analyses were conducted using Python (version 3.12; Python Software Foundation). A two-sided p-value <0.05 was considered statistically significant.

Results

Descriptive characteristics

Table 1 summarizes the characteristics of the 1,962 abortion cases included in the analysis. The mean maternal age was 33.9 ± 6.6 years; 42.2% (827/1,962) of women were aged ≥35 years and 2.0% (39/1,962) were younger than 20 years. The mean gestational age at abortion was 11.3 ± 4.4 weeks, and 70.9% (1,391/1,962) of abortions occurred in the first trimester (≤13 weeks).

BMI category was available for 1,769 women (90.2%), while numeric BMI values were recorded for a subset (n=1,311). Among the overall study population, 24.5% were classified as normal weight, 42.1% as overweight, 22.7% as obese, and 0.9% as underweight. More than half of the women were gravida 2–3 (54.5%, 1,070/1,962), and 28.3% (555/1,962) reported a prior abortion.

Regarding abortion type, 80.7% (1,584/1,962) were spontaneous abortions, 11.1% (217/1,962) were induced/legal abortions, and 1.1% (21/1,962) were ectopic pregnancies. Among spontaneous abortions with recorded missed-abortion status (n=1,576), 3.6% (57/1,576) were classified as missed abortions.

An underlying maternal disease was reported in 29.6% (580/1,962) of women. The most frequently reported condition was thyroid disorder (274 cases), followed by thalassemia minor (68), hypertension (44), and diabetes (34). Prenatal care utilization was documented for 1,762 women, of whom 71.1% (1,253/1,762) had received at least one prenatal care visit. Unless otherwise specified, percentages are calculated based on the total study population (N=1,962), and variable-specific denominators reflect available data due to missingness.

Table 1. Descriptive characteristics of the registry population (N = 1,962).

Characteristic	n	%
Maternal age, years — mean ± SD	33.9 ± 6.6	(n=1,648)
<20	39	2.0
20–34	782	39.9
≥35	827	42.2
Gestational age, weeks — mean ± SD	11.3 ± 4.4	(n=1,855)
1st trimester (≤13w)	1,391	70.9
2nd trimester (14–27w)	457	23.3
3rd trimester (≥28w)	7	0.4
BMI, kg/m² — mean ± SD	27.4 ± 4.2	(n=1,311)
Underweight	17	0.9
Normal	481	24.5
Overweight	826	42.1
Obese	445	22.7
Gravidity		
1 (primigravida)	387	19.7
2–3	1,070	54.5
≥4	402	20.5
Prior abortion history — Yes	555	28.3
Abortion type		
Spontaneous	1,584	80.7
Induced / legal	217	11.1
Ectopic pregnancy	21	1.1
Missed abortion (no FHR) — among spontaneous	57 / 1,576	3.6
Underlying maternal disease — Yes	580	29.6
Thyroid disorder	274	14.0
Thalassemia minor	68	3.5
Hypertension	44	2.2
Diabetes	34	1.7

Characteristic	n	%
Prenatal care received — Yes	1,253	71.1

Footnotes: a Percentages calculated based on total sample (N=1,962) unless otherwise noted; variable-specific denominators reflect missing data. b Numeric BMI recorded for n=1,311; BMI category available for n=1,769 (90.2%). c Missed abortion status recorded among n=1,576 spontaneous abortions. d Prenatal care status documented for n=1,762 women.

Geographic and temporal distribution

As shown in Figure 1, Ilam county accounted for the largest proportion of cases (27.8%, 545/1,962), followed by Dehloran (16.1%), Abdanan (12.1%), Eyvan (8.8%), Chardavol (8.2%), Mehran (8.2%), and Darreh Shahr (8.0%); each of the remaining counties contributed less than 5% of total cases. The number of recorded abortion cases increased from 852 in 1402 to 1,110 in 1403, a 30.3% relative increase. Among women with recorded maternal age, the proportion aged ≥35 years was higher in 1403 than in 1402 (54.3% vs. 45.8%, p<0.001). The proportion of women with a recorded underlying disease was lower in 1403 compared with 1402 (28.3% vs. 35.7%, p<0.001), while prenatal care utilization was higher (75.8% vs. 65.1%, p<0.001). Mean gestational age at abortion was slightly lower in 1403 (10.9 vs. 11.7 weeks, p<0.001). The distribution of abortion types did not differ significantly between the two years (p=0.061).

The seasonal distribution of cases (Table 2) was relatively even across the year in both calendar years, with a modest peak in winter (206 cases in 1402 and 296 in 1403) and a trough in autumn. The monthly distribution of cases is shown in Figure 2.

Table 2. Seasonal distribution of abortion cases by Iranian calendar year.

Year	Spring	Summer	Autumn	Winter	Total
1402	205	201	175	206	852
1403	276	278	242	296	1,110

Correlates of abortion type

In the multivariable logistic regression model including 922 complete cases (restricted to spontaneous and induced/legal abortions), gestational age was independently associated with abortion type (Table 3, Figure 3). Each additional week of gestation was associated with higher odds of induced/legal abortion (adjusted odds ratio [aOR] 1.14, 95% confidence interval [CI] 1.09–1.19, p<0.001). Prenatal care utilization was associated with lower odds of induced/legal abortion compared with spontaneous abortion (aOR 0.63, 95% CI 0.42–0.94, p=0.023). Maternal age, BMI, gravidity, prior abortion history, and underlying maternal disease were not independently associated with abortion type after adjustment for covariates (Table 3). .

Table 3. Adjusted logistic regression: predictors of induced/legal (vs spontaneous) abortion (n=922).

Predictor	aOR	95% CI	p
Maternal age (per year)	1.01	0.98–1.05	0.476
Gestational age (per week)	1.14	1.09–1.19	<0.001
BMI (per kg/m²)	1.01	0.96–1.06	0.813
Gravidity (per pregnancy)	1.03	0.85–1.24	0.779
Prior abortion history (yes vs no)	1.03	0.63–1.67	0.917
Underlying disease (yes vs no)	1.05	0.69–1.60	0.807
Prenatal care (yes vs no)	0.63	0.42–0.94	0.023

Missed abortion (exploratory, bivariate only)

Among spontaneous abortions with known status, 57 cases (3.6%) were classified as missed abortion. Due to the limited number of events and insufficient events-per-variable after listwise deletion (14 events for seven covariates; events-per-variable = 2.0), multivariable modeling was not performed for this outcome. In bivariate analyses, women with missed abortion were older on average than those with other spontaneous abortions (35.8 vs 33.9 years, p=0.034). No statistically significant associations were observed for gestational age (p=0.099), BMI (p=0.57), gravidity (p=0.14), prior abortion history (p=0.99), underlying disease (p=0.57), prenatal care utilization (p=0.61), or trimester (p=0.53).

Discussion

This study examined all abortion cases recorded by healthcare centers in Ilam Province during the 1403–1404 Iranian calendar years, using a census-based approach across all 12 counties of the province. Unlike most previous studies conducted in Iran, which have relied on facility-based samples, indirect estimation methods, or self-report surveys—approaches that may be susceptible to selection bias and underreporting (15–17) the design of the present study is based on complete provincial registry data, thereby enhancing internal validity.

The increase in recorded abortion cases from 852 in 1402 to 1,110 in 1403 should be interpreted with caution and does not necessarily reflect a true rise in the incidence of abortion in the province. This increase occurred concurrently with improved antenatal care registration coverage (from 65.1% to 75.8%) and likely reflects improved case ascertainment and more complete registration rather than a genuine epidemiological shift. This interpretation is consistent with substantial evidence from Iran indicating chronic underreporting in abortion surveillance, a problem attributed to legal restrictions, social stigma, and reliance on indirect estimation methods such as the network scale-up method and the single-sample count technique(16, 17).

The mean maternal age in this cohort (33.9 ± 6.6 years) was higher than values reported in national studies of applicants for legal abortion. This discrepancy is likely attributable to differences in case definitions, eligibility criteria, and study populations rather than a genuine shift in the demographic structure of Ilam Province. In addition, the strong association observed between maternal age and history of abortion is consistent with existing epidemiological evidence indicating that abortion risk increases with advancing maternal age, a phenomenon that may be driven by rising rates of oocyte aneuploidy and chromosomal abnormalities(18, 19).

A high prevalence of overweight and obesity was observed, with nearly three-quarters of participants falling into these categories. Although unadjusted analyses showed a higher frequency of abortion history among obese women, this association did not persist after adjustment for maternal age and chronic diseases. This attenuation suggests that the crude relationship between body mass index (BMI) and abortion history in this population may be substantially confounded by factors such as age and comorbidities, rather than reflecting an independent biological effect. This pattern is consistent with recent meta-analytic evidence indicating that much of the excess risk of pregnancy loss attributed to elevated BMI operates through, or is intertwined with, metabolic and age-related pathways(20, 21). It should be noted, however, that not all available evidence supports such complete attenuation. For instance, a retrospective cohort study found that, even after adjustment for age and race, obese women had a 56% higher likelihood of euploid miscarriage compared with non-obese women, suggesting an independent effect of obesity not fully explained by maternal age alone(22). This discrepancy with the present findings may stem from differences in outcome definition (overall abortion versus karyotype-confirmed miscarriage), a smaller effective sample size, or reduced statistical power in the current analysis due to listwise deletion of nearly half of the eligible BMI records, and warrants further investigation in future studies with more complete BMI data.

Chronic disease emerged as an independent predictor of prior abortion history, with thyroid dysfunction — predominantly subclinical — constituting the largest share of these conditions. This finding aligns with a growing body of evidence, including recent systematic reviews and clinical guidelines, indicating that untreated subclinical hypothyroidism is associated with an elevated risk of miscarriage, even though debate continues regarding diagnostic thresholds and the benefit of universal screening in pregnancy(7, 23). This debate extends beyond diagnostic thresholds alone: high-quality randomized controlled trials have consistently shown that levothyroxine treatment in pregnant women with subclinical hypothyroidism or positive thyroid antibodies confers no benefit to either mother or child, and concerns have even been raised about potential harm from overtreatment(24). Accordingly, the association observed in the present study between thyroid disorders and abortion history should be interpreted primarily as a basis for targeted clinical screening in high-risk populations, rather than as justification for universal screening or definitive treatment of all subclinical cases. The presence of minor thalassemia as the second most common chronic condition also reflects the regional genetic epidemiology of western Iran, where founder mutations, population structure, and a high prevalence of consanguineous marriage have sustained elevated carrier rates of hemoglobinopathies(25, 26). Collectively, these

findings indicate that both endocrine factors and inherited hematological disorders play a meaningful role in adverse reproductive outcomes in this setting.

Substantial geographic disparities in antenatal care coverage were observed across counties, with Malekshahi and Ilam City showing the lowest coverage. These inequities are consistent with existing evidence on the uneven distribution of health workforce and facilities across western Iranian provinces, where geographic remoteness, inequitable resource allocation, and limitations in the referral system continue to restrict access for rural and underserved populations(27, 28). Given the geographic and infrastructural similarities between Ilam Province and other western provinces such as Lorestan, these disparities likely reflect structural inequities within the health system rather than individual differences in care-seeking behavior. Counties with persistently low coverage would therefore likely benefit more from targeted programs to expand access and strengthen referral systems than from demand-side interventions alone.

In the multivariable model, only maternal age and chronic diseases remained independently associated with abortion history. However, the absence of an independent association between antenatal care and abortion should not be interpreted as evidence that antenatal care is ineffective. This finding may reflect the fact that abortion often occurs early in pregnancy, before sufficient opportunity exists to receive or complete antenatal care. Residual confounding by unmeasured socioeconomic factors, such as household income, educational attainment, and distance to healthcare facilities, may also contribute to this finding.

Strengths and limitations

The principal strengths of this study include its population-based, near-census design, covering all counties of Ilam Province over two years using registry data from healthcare centers, which enhances the generalizability of the findings at the provincial level. Nevertheless, this study has several limitations. First, its conduct in a single province limits the generalizability of the findings to other provinces. Second, approximately one-third of BMI data were missing; therefore, results related to BMI should be interpreted with caution. Third, in the multivariable analysis of abortion type, listwise deletion left only 922 of 1,801 eligible cases (51.2%), and this substantial reduction may have introduced selection bias. Additionally, the low prevalence of "missed abortion" precluded multivariable analysis for this outcome, and the corresponding results should be considered exploratory and unadjusted. Finally, as with other studies based on routine registry data, the possibility of misclassification—particularly in distinguishing spontaneous abortion from missed abortion—cannot be excluded.

Conclusion

This province-wide registry analysis indicates that maternal age and chronic disease — particularly subclinical thyroid dysfunction and thalassemia minor — are the principal independent correlates of prior abortion history in Ilam Province, while the crude association with BMI appears to be substantially

confounded. The rising number of registered cases most likely reflects improved surveillance rather than a true increase in abortion incidence, underscoring the value of continued investment in registry completeness. Persistent geographic disparities in prenatal care coverage, especially in Malekshahi and Ilam city, point to structural rather than purely individual-level barriers to access. These findings support three concrete priorities for maternal health policy in the province: (1) strengthening prenatal care outreach and referral pathways in underserved counties; (2) implementing routine screening and management of chronic conditions — particularly thyroid disorders — among women of reproductive age; and (3) improving the structure and standardization of abortion registry data, including clearer criteria for classifying abortion type. Future multi-province and longitudinal studies, ideally incorporating external denominator data, are needed to confirm the generalizability of these findings and to evaluate the impact of targeted interventions on reproductive health outcomes in western Iran.

Abbreviations

BMI: Body Mass Index

CI : Confidence Interval

aOR: Adjusted Odds Ratio

SD: Standard Deviation

ANOVA : Analysis of Variance

EPV: Events Per Variable

Declarations

Ethics approval and consent to participate

The study protocol was approved by the Ethics Committee of Ilam University of Medical Sciences (ethics code: IR.MEDILAM.REC.1404.087). As the study used routinely collected, de-identified registry data from healthcare centers, the requirement for individual informed consent was waived by the Ethics Committee. All methods were carried out in accordance with the relevant guidelines and regulations, including the Declaration of Helsinki.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are not publicly available due to confidentiality restrictions on provincial health registry data but are available from the corresponding

authors on reasonable request.

Competing interests

The authors declare that they have no competing interests.

Funding

This study received no specific funding from any funding agency in the public, commercial, or not-for-profit sectors.

Authors' contributions

RM conceived and designed the study, performed data management, conducted the statistical analysis, and drafted the manuscript. WM contributed to study design, supervised data collection, and critically revised the manuscript for important intellectual content. TA contributed to the interpretation of findings from a sociological perspective and critically revised the manuscript for important intellectual content. WM and TA jointly supervised the study as co-corresponding authors. All authors read and approved the final manuscript.

Acknowledgements

The authors would like to thank the staff of the healthcare centers of Ilam Province for their assistance with data registration and collection.

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Figures

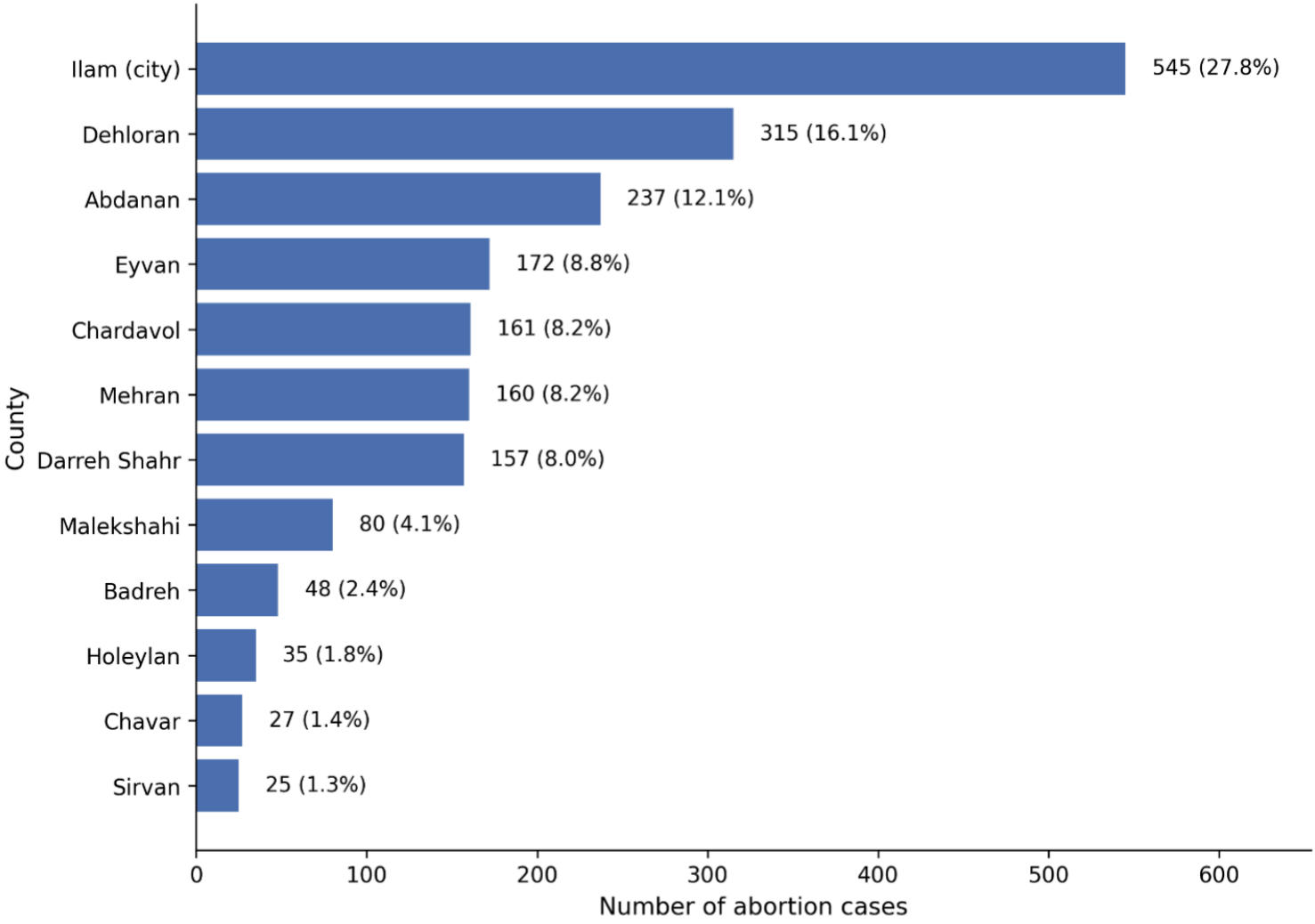


Figure 1

County-level distribution of abortion cases in Ilam Province, 1402–1403

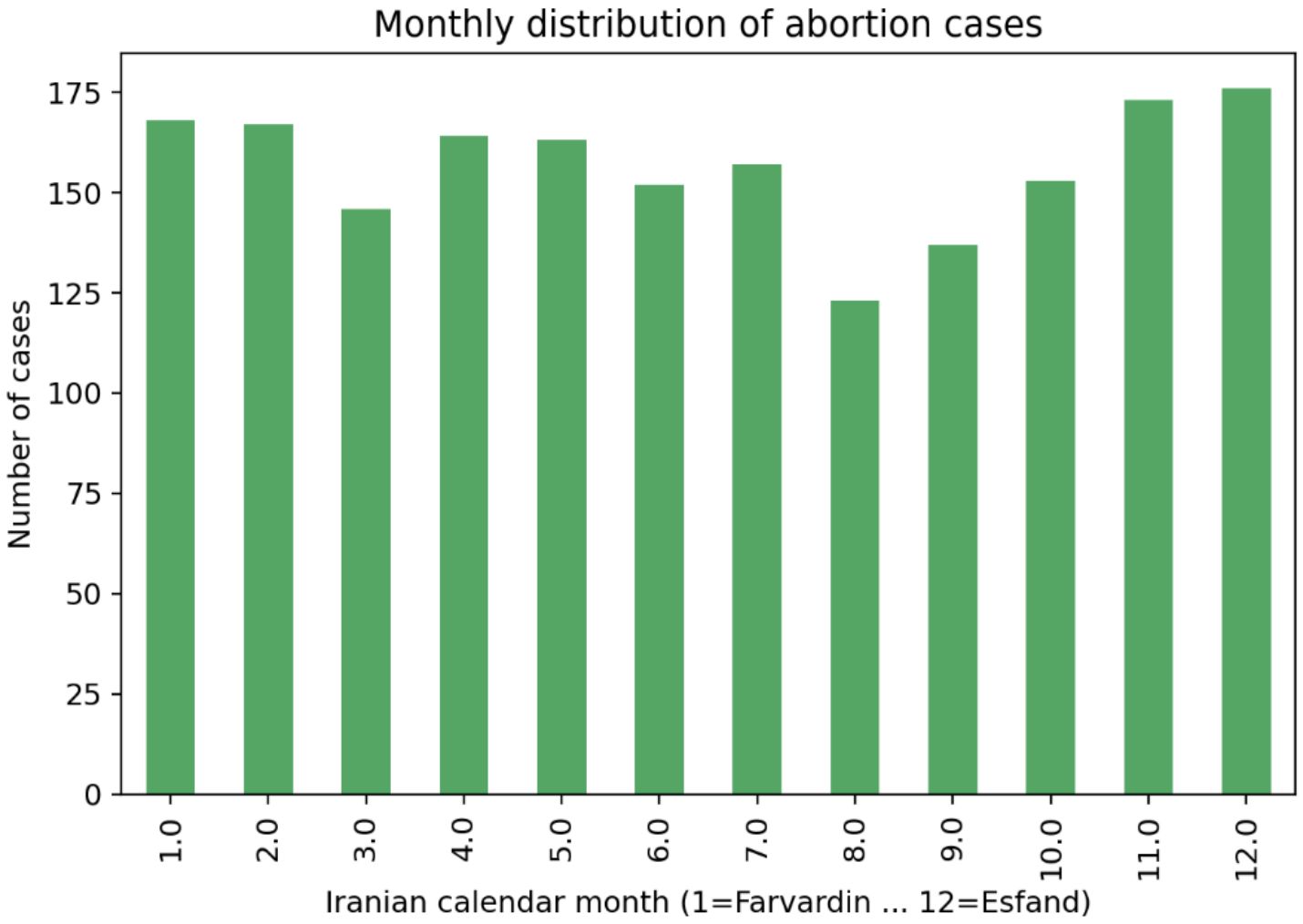


Figure 2

Distribution of cases by Iranian calendar month (month recovered for 95.8% of records).

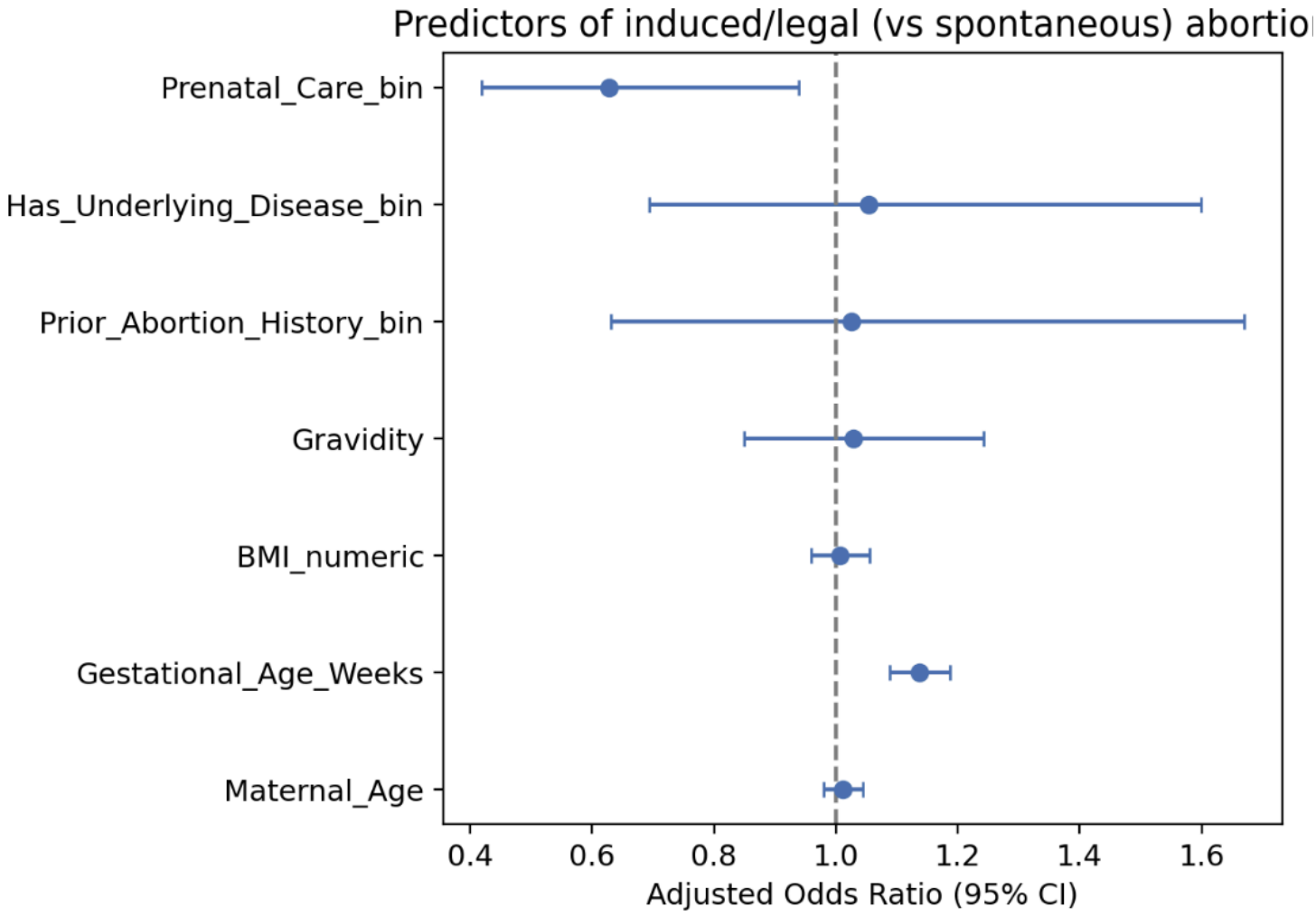


Figure 3

Adjusted odds ratios (95% CI) for induced/legal abortion versus spontaneous abortion.