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# UNSAFE ABORTION IN INDIA: ACCESS, SERVICES, AND POLICY

**Jhalak Aggarwal**[1]

*Abstract*

*13 women die due to unsafe abortions in India every day. Almost 6.4 million abortions occur in India annually, making it a leading cause of maternal mortality2. This paper discusses the plight of unsafe abortion services in India, shedding light on the regenerative health issues that are preventable but have been dismissed and neglected by emotional debates and discussions. Socio-economic vulnerability, early pregnancy, and insufficient and inadequate access to healthcare services put many women at the risk of unsafe abortions. The paper draws evidence from various sources to present the author's perspectives on how improper access to safe abortion care acts a major barrier. Studies shows that more than 80 percent of Indian women are not aware of the fact that abortion is legal in India, contributing to women looking for termination via unsafe and perilous practices. Thus, the cost in terms of women's health and lives centres around the need to pursue attempts and efforts to make information on safe abortion practices available and accessible to women in India.*

## INTRODUCTION

Unsafe abortions are one of the leading contributors to the high maternal mortality rate in India, much of which is avoidable. It contributes to 8 percent of maternal deaths in India, becoming the third leading cause of all such deaths in India[3]. The WHO defines unsafe abortions as *"the termination of an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimum medical standards or both"*[4]. It is strongly linked with other complications for the child-bearer such as trauma, haemorrhage

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[1] Public Policy professional with expertise in Health and Climate Change and Environment and presently associated with the Council on Energy, Environment and Water. The author can be reached at aggarwaljhalak17@gmail.com.

[2] Snigdha, Aarzoo. (2018). "13 Women Die in India Every Day Due to Unsafe Abortions - India News." *India Today*, India Today.

[3] Snigdha, Aarzoo. (2018). "13 Women Die in India Every Day Due to Unsafe Abortions - India News." *India Today*, India Today.

[4] UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). (2012). "*Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*". WHO.

and is a major cause of maternal deaths[5]. In spite of being legalised via the Medical Termination of Pregnancy Act in the 1970s, India was home to approximately 15.6 million unsafe abortions in 2015. According to WHO, every eight minutes a woman dies due to complications arising from unsafe abortions in developing countries, making it a leading cause of maternal mortality.[6] According to the research by Adler et al in 2012, there are multiple interrelated factors relevant to under the practice of abortion in India[7] such as

- Women's educational status and labour force participation
- Social class and economic conditions
- Preference for male child

However, the objectives of this paper are: to analyse the socio-economic factors associated with unsafe abortion, to dissect the global discourse on abortion, and lastly, to examine the policies for abortion in India.

## SOCIO-ECONOMIC FACTORS ASSOCIATED WITH ABORTIONS IN INDIA

India is a land with massive social baggage and societal demons such as poverty and illiteracy. About 70% of the population of India inhabit rural areas where safe abortion procedures are not readily accessible.[8] Women men living in such environments have greater chances of unsafe abortions as compared with women living in urban dwellings. Further, inequalities in access to information, opportunities, and decision-making also affect an individual's well-being. Health is considered a special good directly related to a person's well-being, enabling the individual to act as an agent. In the discussion of abortion practices, various factors such as socio-economic aspects, attitudes, and stigma towards young and unmarried women play a crucial role in contributing towards increased unsafe abortion practices.

### Socio-economic Factors

The health outcomes are affected not only by biological factors but also by socio-economic factors and people's positions in social hierarchies. Growing evidence suggests that through appropriate intervention for the social determinants of health, health outcomes can be improved. In addition to this, the implications of abortion are different for unmarried

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[5] Khan KS, Wojdyla D, Say L, et al. Who analysis of causes of maternal death: a systematic review. The Lancet 2006;367:1066–74.

[6] Haddad, Lisa. Nour, Nawal. (2009). "Unsafe Abortion: Unnecessay Maternal Mortality". PubMed.

[7] Adler AJ, Filippi V, Thomas SL, et al. (2012). "*Quantifying the global burden of morbidity due to unsafe abortion: magnitude in hospital-based studies and methodological issues*". International Journal of Gynecology& Obstetrics.

[8] (2019). *Two-Thirds of Abortions Unsafe in over Half of Indian States Studied.* Nuffield Department of Population Health.

girls as opposed to married women due to their different social contexts. Abortions in unmarried women are considered to be a social stigma thus creating obstacles in safe abortions and defeating the purpose i.e. the health of the woman undergoing abortion. In the rural areas despite there being access to a medical centre, unmarried girls are taken to far-off places for the procedure for the sake of preserving her future by keeping the family image intact. In addition to this, providers sometimes refuse to perform the procedure on young women or ask them to bring their parents to the health centre, thus forcing them to resort to unsafe abortions. While the law demands the consent of only the woman if she is above 18 years, various providers nonetheless ask for consent from the spouse or from the woman's relatives. Furthermore, women who are poor, young, uneducated, and/or unmarried delay their abortions due to lack of information on different aspects such as understanding the signs of pregnancy, accessing the location of the required services, and lack of awareness of the legality of choosing the service. Although women from all socio-economic backgrounds access abortion services, there is an explicit class divide in the places in which women obtain the service. We see that private medical facilities are expensive and financially out of reach of most women. Women who access safe facilities are generally from a financially sound background who can afford to pay the various costs associated with the procedure such as the transportation cost, doctor's fees, and other miscellaneous expenses, something which is unlikely for a woman from a weak economic standing. This poverty-trap also makes the option of legal abortion unavailable to women from economically and socially weaker groups, thus forcing them to access services from unskilled and uninformed providers.

**Stigma**

The stigma against premarital sex, the fear of disclosure, shame and silence for women, and/or myths about abortions are causes of unsafe abortions[9]. Various social, cultural, political, and economic factors influence and contribute to this stigma. Our society perceives abortion not through the lens of health and decision-making, but through norms and morals. Women who undergo an abortion are looked down upon. Power also plays a critical role where power over women by societal pressures influences her independent decisions regarding the abortion. This shows domination and social control over the woman, which devalues her and her ability to act as an individual.

[9] Cárdenas, R., Labandera, A., Baum, S.E. *et al.*(2018*). "It's something that marks you": Abortion stigma after decriminalization in Uruguay*. Reprod Health.

**TABLE 1. SOCIAL DETERMINANTS OF HEALTH INQUITIES IN ABORTION CARE**

| **Family and Peer Influences** | **Community Context** | **Availability of Relevant Services** | **Cultural and Social Values** |
|---|---|---|---|
| - Power and decision-making<br>- Income<br>- Marital relationship<br>- Access to resources<br>- Support network<br>- Age<br>- Number of children | - Place of residence i.e. rural or urban<br>- Social position<br>- Awareness<br>- Distance to the facility<br>- Social capital<br>- Laws and rights | - Fees and related costs<br>- Staff skills and -competency<br>- Acceptance by the community | - Women's status<br>- Gender norms<br>- Social cohesion<br>- Image and respect in the society<br>- Health beliefs<br>- Religious factors |

Source: Solar O, Irwin A. (2010). "*A conceptual framework for action on the social determinants of health"*. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

**Family and Peer Influences**: There is a link between the health outcomes and the individual attributes of pregnant women where the family members influence the choice of pregnant women. Women have little to no power and decision-making abilities regarding their own fertility and health care solutions and options. Relationships with partners, access to resources, income of the family, and age affect women's health and the decisions they make.

**Community Context**: Individual women and their families reside in communities, which differ in important social ways. For instance; the place of residence is a crucial factor where urban households use maternal health services and facilities more than rural households due to better physical accessibility and awareness of laws and rights. In addition to the woes of the urban-rural divide, service providers also sometimes discriminate against the marginalized communities due to their low social positions. Communities with high levels of social capital are more likely to challenge this as material and psychosocial resources are shared by members who work together to address their problems collectively.

**Availability of relevant services**: The availability of requisite services plays a key role in defining maternal health outcomes. Services are inaccessible sometimes due to physical, financial, or social barriers. Further, the quality of health personnel and services are also of significance. The technical quality of health outcomes depends on appropriate staffing equipment, and on the correct use of clinical protocols.

**Cultural and Social Norms**: A woman's status, health beliefs and religious norms influence her decisions regarding pregnancy and delivery care. The gender dynamics that play out in households where men or elderly family members have more power result in the norm that women should accept their choices.

## ACCESS: A MAJOR BARRIER TO SAFE ABORTION

Access can be defined as "*the ability of patients to use the services they want to use and are recommended to use by experts*"[10]. Given the lack of skilled and accessible professionals, millions of women in India risk injury and death by choosing unsafe abortions. This limited access to services has become a major cause of increasing maternal mortality in India, contributing to almost 8 per cent of all maternal deaths from unsafe abortions. Women in the backward and rural regions are largely affected as they have limited access to medically-safe abortions. The access to safe abortion practices is hindered by:

**Availability:** The availability of appropriate healthcare services at the right place and at the right time to meet the needs of pregnant women is extremely important. But we see that physical access is a major contributor to increasing unsafe abortions. For example, a study revealed that in order to reach an abortion provider in Madhya Pradesh, a woman has to travel an average distance of 20km (Hussain et. al., 2018). Furthermore, only a few primary health-care facilities in rural area offer abortion care services. (Iyengar, 2016). The primary health-care centres are usually the first point of contact for underprivileged women and such a low number highlights the problem of availability for safe abortion practices.

**Affordability:** Financial hindrance acts a significant barrier of access for women seeking safe abortions. The disparity between the number of individuals using the services and their ability to pay is marked. The informal fees charged by public providers and the high prices in private setting exploits women's vulnerability and poor knowledge of law, irrespective

[10] Wright J., Williams R., Wilkinson J.R. (1998). *Health needs assessment: Development and importance of health needs assessment.* Br. Med. J.

of their class and ability to pay. This is especially prevalent when the pregnancy is unwanted and socially unacceptable. In addition, the state unfortunately is not the leading abortion service provider. Abortion care services are mainly concentrated in the private sector, leading to higher out-of-pocket expenses. The cost of abortion also varies depending on various factors such as the stage of pregnancy the women is in when she seeks an abortion, her marital status, whether it is a sex-selective abortion, and whether the provider is registered.

**Acceptability:** Many times, neither the law nor the policy create barriers to access but instead, it is the providers themselves who do so. There is sometimes a clear misfit between provider and patient attitudes towards each other as well as their expectations of each other. Although the law does not mandate the consent of the spouse or of the third-party for an abortion except in case of a person under the age of full legal responsibility, such consent is insisted on by abortion providers. The reason for this is the need to protect themselves from social and legal issues resulting from complications or even death as a result of the abortion; this is a position brought about by the low social status of women and their dependency on their husbands.

**Table 2: Ratios of MTPs, Government Approved MTP facilities and Population by State**

| *State* | *No. of MTPs (1993-1994)* | *No. of Facilities* | *State Population (1996)* | *MTP: Facility ratio* | *MTP: Population ratio`* | *1000 Population Facility ratio* |
|---|---|---|---|---|---|---|
| Andra Pradesh | 13179 | 373 | 7,21,55,000 | 37 | 0.19 | 1,93,445 |
| Assam | 21372 | 100 | 2,47,26,000 | 214 | 0.86 | 2,47,260 |
| Bihar | 11060 | 209 | 9,30,05,000 | 53 | 0.12 | 4,45,000 |
| Gujarat | 10263 | 700 | 4,55,48,000 | 15 | 0.23 | 65,069 |
| Haryana | 22438 | 228 | 1,85,53,000 | 98 | 1.21 | 81,373 |
| Karnataka | 9077 | 471 | 4,93,44,000 | 19 | 0.18 | 1,04,764 |
| Kerela | 34433 | 559 | 3,09,65,000 | 62 | 1.11 | 55,394 |
| Madhya Pradesh | 33086 | 295 | 7,41,85,000 | 112 | 0.45 | 2,51,475 |
| Maharashtra | 97079 | 1775 | 8,65,87,000 | 55 | 1.12 | 48,781 |
| Orissa | 19510 | 169 | 3,44,40,000 | 115 | 0.57 | 2,03,787 |
| Punjab | 19436 | 242 | 2,23,67,000 | 80 | 0.87 | 92,426 |
| Rajasthan | 29023 | 316 | 4,97,24,000 | 92 | 0.58 | 1,57,354 |
| Tamil Nadu | 42364 | 623 | 5,94,52,000 | 68 | 0.71 | 95,429 |
| Uttar Pradesh | 12103 | 425 | 15,66,92,000 | 29 | 0.08 | 3,68,687 |
| West Bengal | 64273 | 452 | 7,46,01,000 | 142 | 0.86 | 1,65,047 |
| **India** | **609915** | **9271** | **93,42,18,000** | **63** | **0.65** | **1,00,768** |

Johnson, Heidi. (2002), *"Abortion Practice in India: A review of Literature"*. Centre for Enquiry into Health and Allied Themes.

In Table 2 above, we can see that according to population per MTP facility ratio, Bihar has only one centre for 445,000 people. The MTP facilities

are more prevalent in states such as Uttar Pradesh, Madhya Pradesh, and Orissa, but still serve an average of 200,000 people. The lowest number of centres is present in the six states with the highest number of abortions. This clearly suggests that the current number of facilities insufficient and inadequate to meet the population demands and needs. Efforts to rectify these inadequacies must be made since the current efforts have just touched the surface and failed to bring down the number of unsafe abortions.

> **Case Study 1:** This is the story of a woman from Assam who was a victim of an unsafe abortion practice. In early 2016, she became pregnant for the fourth time. When she realised this, she kept it a secret from her family because raising three children had already taken a toll on her physically, emotionally, and financially. She decided to terminate the pregnancy but since abortions were considered a taboo, she decided to do it secretly. She approached a private clinic in Guwahati where the process was carried out by an untrained practitioner. She noted that after her abortion, the secretion was not cleaned properly. After a month, she felt pain in her abdomen which increased with every passing day. Her brother took her to the district hospital where she was diagnosed with uterine cancer. The doctors suspected that since her abortion was not completed fully, the remains of the dead foetus inside the woman made her vulnerable to the disease. [11]

## GLOBAL PERSPECTIVE ON UNSAFE ABORTIONS

The world has made impressive progress on the main causes of maternal mortality – severe bleeding, infection, blood pressure, and obstructed labour. However, unsafe abortion – the only almost completely preventable cause – has been paid less attention to in this quest. The rate of unsafe abortion is still at least one in 12 maternal deaths globally[12]. If we look at abortions across the globe, 60 countries have laws prescribing the gestational limits[13]. However, laws in 23 countries including Canada, Germany, Denmark, and Vietnam are extremely liberal allowing abortion on the request of the woman at any time during the pregnancy both for foetus abnormalities and social reasons.

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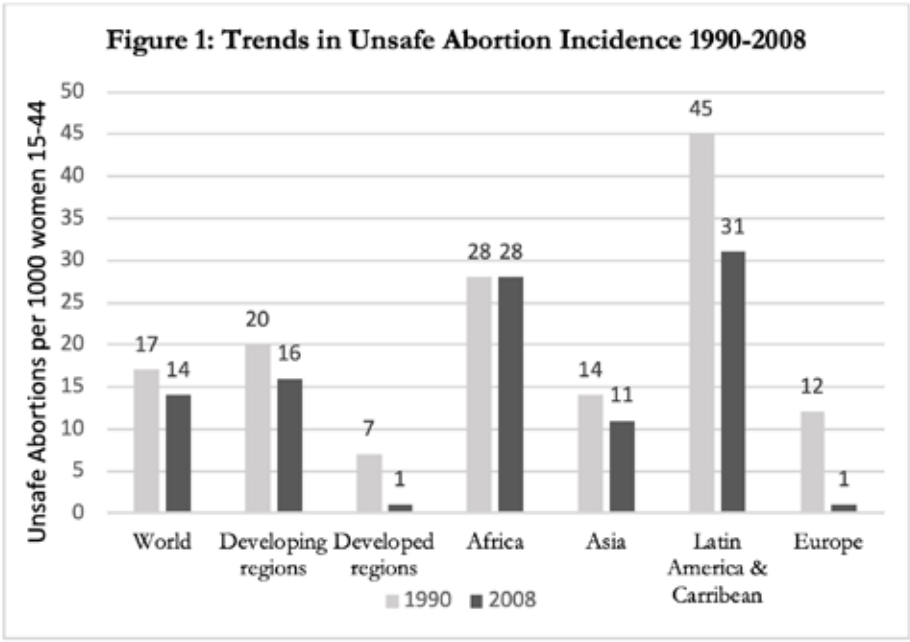
[11] (2018)"Why Is Unsafe Abortion Still A Reality For Millions Of Women In India?". Feminism India.

[12] Murshid, Munzur; Haque, Mainul. (2019). "*Unsafe Abortion: A Forgotten Emergency: Women's health*". Médecins Sans Frontières (MSF) International.

[13] Manning, Vinoj. (2020). "*Discourse: Returning Women Their Body.*" Deccan Chronicle.

During the 1994 International Conference on Population and Development (ICPD), access to safe abortions was observed as critical for public health. Trends suggest that abortion law reforms in developing countries have reduced abortion-related deaths and risks[14]. For instance, in Nepal, abortion-related risks, complications, and deaths as a proportion of maternal illnesses decreased by 48 percent. Similarly, in Ethiopia, abortion related complications decreased by 70 percent. However, if we compare the results with India, only 40 percent of abortions are considered safe, even though abortion has been broadly legal for over 40 years.




Source: UNDP/UNFPA/WHO/World Bank Special Programme of Research, (HRP). (2012). "*Unsafe Abortion Incidence and Mortality - Global and Regional Levels in 2008 and Trends*". WHO.

In Figure 1 above, we can see the trend in the number of unsafe abortions incidences from the years 1990-2008. The graph also suggests that the rise in the total number of unsafe abortions is largely attributed to the increasing population size of women of reproductive age between15-44 years. Further, the unsafe abortion rate has decreased in all major regions of the world since 1990 but exhibits only a minor decrease in Africa. In the regions of Latin America and the Caribbean, the rate has decreased by almost one third from the base level. The incidence rate in Asia also

[14] Barot, Sneha. (2018). "*The Roadmap to Safe Abortion Worldwide: Lessons from new global trends on incidence, legality, and safety*". Guttmacher Institute.

decreased by 17 per cent from 14 in 1990 to 11 in 2008. Lastly, we can say that since unsafe abortions are negligible in the sub-region of Eastern Asia i.e. Vietnam, China, and Singapore, the rate is relatively low in Asia as compared to other regions[15].

Going ahead, various international agreements recognise, support, and reinforce safe and legal abortion as a woman's right, anchored in the rights to life, liberty, equality, non-discrimination, and more. In *K.L v Peru*, the UN Human Rights Committee acknowledged and admitted that the government's inability to ensure legal abortion services for a 17-year old girl carrying an anencephalic foetus violated her rights to privacy and freedom[16]. In addition to this, the ICPD links government responsibilities under international deals and pacts to their commitments to promote safe abortions and prevent unsafe ones. Numerous national and international laws, policies, and legislations recognise the right to abortion. To illustrate this, Colombia's Constitutional Court in 2006 found that "*women's sexual and reproductive rights have finally been recognized as human rights, and have become part of constitutional rights, which are the fundamental basis of all democratic states*"[17]. Though India was amongst the first to pass a liberal law for abortion, the time has come to revise the law and bring it in tandem with international standards, conventions, and guidelines.

## ABORTIONS IN INDIA: LAW AND POLICY

India was one of the earliest countries to pass the Medical Termination of Pregnancy Act (MTP Act), 1971 which governs and regulates abortion services to save women's lives, safeguard their physical and mental health, and protect their socio-economic rights. It allows termination of pregnancy up to twenty weeks for situations when continuation is a risk to health or the pregnancy is a result of rape, incest, or the failure of a contraceptive method. Yet around 56 percent of abortions in India are performed illegally (Guttmacher Study 2017). While the changing debate on rights has emphasised abortion services as a woman's right to decide and exercise power over her body, the MTP Act still predominantly focuses on married women's maternal mortality problems. Despite this liberal law, non-availability of trained professionals and detailed documentation, information asymmetry about the legality of abortions, and social constraints contribute to abortion-related deaths. Based on this paper, the author's proposed recommendations for the MTP Act are as follows:

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[15] UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). (2012). "*Unsafe Abortion Incidence and Mortality - Global and Regional Levels in 2008 and Trends*". WHO.

[16] (2014) "*A Global View of Abortion Rights*". Centre for Reproductive Rights.

[17] (2016). "*10 Years of Legal Abortion in Colombia*". Centre for Reproductive Rights.

- Increasing the provider base to AYUSH providers, nurses, and ANMs
- Increase gestation limit from twenty to twenty-four weeks for vulnerable categories.
- No upper gestation limit for cases with foetal abnormalities

Furthermore, the abortion law in India authorizes the state governments to manage and control the abortion services. The states have accepted the law, but they differ greatly in interpretation and implementation. Many states have added protocols and created more entry barriers, administrative delays, and irrelevant controls to ensure safety and prevent unsafe abortions. For instance, Haryana and Delhi require the architectural plan of the service centres and details of car parking provisions as mandatory requirements to be submitted for being registered. Similarly, Maharashtra needs a blood bank to be present within 5km of the facility, a requirement which is completely unnecessary[18]. As Hirve (2004) concludes, these regulations highlight that the state focus is to have control rather than facilitate abortion care.

Furthermore, the POCSO Act 2012 mandates the revelation of all the abortion cases for girls under the age of 18 years. In many cases, to protect identities or to safeguard either the boy or the girl, the girl's family members themselves are not inclined to report the case, which is a mandatory step to avail abortion services. The problem of breaking the system or seeker's will creates a constant conflict for service providers, making them liable for offence. These provisions often increase the provider's vulnerability and force women, particularly minors i.e. below the age of 18 years, to avail services under unregistered unsafe practitioners.

An amendment in the act was made in 2002, now commonly known as the Medical Termination of Pregnancy Amendment Act. It recognised a safe place for abortion that is "*a hospital run or maintained by the government, or any place approved by the Government or District Level Committee constituted by that Government with* the *Chief Medical Officer or District Health Officer"*(MTP Act Amendment, 2002).

In addition to this, it stated that for a pregnancy less than twelve weeks old, the opinion of single doctor alone suffices; if the pregnancy is between twelve and twenty weeks, the opinion of two doctors is necessary; and in other urgent medical situations, the opinion of a single registered medical practitioner will be sufficient. However, no changes were made to increase the acceptable gestation period during which an abortion can

18 Siddhivinayak S Hirve. (2004). "*Abortion Law, Policy and Services in India: A Critical Review*", Reproductive Health Matters.

be undergone. So the question still remains: what about rape survivors or vulnerable women? What about women with complications and risks in the upper limit of the defined gestation period?

India's abortion policy and regulations are progressive, but better access to safe abortions is hindered by unnecessary societal and misguided practices. It is time that the MTP is reworked for better implementation and increased access for women by allowing second trimester abortions, empowering decision-making, and addressing the gaps in the current law which prevents women from taking decisions for themselves and their bodies. There should be priority actions and investments to address the social determinants that compel women to seek out unsafe abortions. The policy action on social determinants of health inequities for unsafe abortions can be reduced by targeting programmes for the disadvantaged and underprivileged population, abolishing gaps in the health outcomes for the haves and have-nots, and addressing the social health gradients.

> **Case Study 2:** In March 2017, the Supreme Court rejected a plea made by a 37-year old woman from Maharashtra to terminate her 26-week-old foetus on the grounds that the child suffered from Down's Syndrome. The Supreme Court denied the petition since it was not was not a life-threatening disease and there was no risk to the woman's health. She challenged the validity of the law saying that it does not allow a woman to exert her right. However, the law permits termination in extreme cases if continuation of the pregnancy is likely to cause grave injury to the woman's health and/or increases or induces the risk of abnormalities in the child, but in this case, the panel of doctors held that the baby had chances of survival and there was no physical risk to the mother. Hence, her plea was rejected.[19]

## CONCLUSION

This review exhibits that morbidity and mortality from unsafe abortions remain a serious issue for Indian women. Abortion care is neglected, as is much of India's health care. The combination of poor quality of care and a poor work ethos with ineffective laws has resulted in the unregulated growth of exploitative and unsafe abortion services. To bring down the mortality rate due to unsafe abortions, it is imperative that access is made available. Based on the study, here are a few recommendations:

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[19] Sinha, Bhadri. (2017). "SC denies permission to abort 26-week-old foetus suffering from Down's Syndrome". Hindustan Times.

**Strengthen access to safe abortion services**: It is important to execute training and service delivery guidelines. The providers must be trained, with appropriate medicines and equipment at all levels of facilities.

**Better knowledge of the MTP Act**: In many parts of India, the providers insist that the consent of a family member is necessary for abortions. However, Section 4 of the MTP Act clearly states that while consent is a prerequisite, adult women of sound mind do not require consent from anyone to terminate the pregnancy under the existing MTP Act. Only minors and mentally ill women require the consent of their guardians. Sometimes due to the asymmetry of information, women undergo unsafe abortion practices. Thus, measures should be taken to improve the awareness levels of women to ensure that it is known that only their consent is required to carry out the MTP procedure if they are above 18 and mentally sound.

**Increase the number of service providers**: In India, the abortion law of 'physician only' is followed. However, the number of doctors could easily be increased by amending the law such that it authorises medical practitioners with a bachelor's degree and relevant experience to provide abortion care.

**Increase the upper limit for abortion**: In cases where serious foetal abnormalities are diagnosed, the MTP Act must be modified to allow for later abortions i.e. after 20 weeks of pregnancy.

**Improve and simplify access to abortion care**: According to the law, women are required to seek the medical opinion of one doctor for the first-trimester abortion and two doctors post this. Though expert opinion is important, the MTP Act can be simplified to reduce the requirement to the provider's opinion, thus increasing women's access.

Many women groups strongly advocate for and support limiting regulations of pregnancy outcomes and enabling women to make decisions regarding their pregnancies as they are the owners of their bodies. The decision about the number of children and when to have children is personal and hence, should be in the hands of the child-bearer. Based on the analysis, it is also important to target programme implementation and intervention at the community levels to narrow the rural-urban divide. In India, the social factors around abortion overpower the law and become major decision-making factors contributing to the decision of choosing unsafe abortion procedures. Thus, the need of the hour is to address the social determinants of health, and to improve women's access to safe abortion services, particularly in disadvantaged and rural areas.

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