



POLICY DOCUMENT

ENSURING ACCESS TO SAFE ABORTIONS

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Policy Statement

Introduction

In 2015, abortions accounted for one-third of all pregnancies with an estimated 15.6 million abortions occurring in India. The abortion rate was 47.0 abortions per 1000 women aged 15–49 years. Approximately 0.8 million abortions were done through other methods that were probably unsafe. [1] These numbers clearly reflect the fact that the restriction of abortion services do not restrict abortion itself but add to the list of unsafe abortions. Access to safe abortion is essential to public health as well as necessary to the fulfilment of human rights. Any person with an unwanted pregnancy who cannot access safe abortion services is at risk of unsafe abortion. Unsafe abortions are the third leading cause of maternal mortality in India [3]. The rate of unsafe abortions is especially higher where access to effective contraception and safe abortion services is limited or unavailable which highlights the urgent need to increase knowledge, accessibility and availability of affordable safe abortion services throughout India.

MSAI Stance

Medical Students Association of India (MSAI) recognizes that safe abortion services are an essential part of healthcare and the right to safe abortions is a human right. MSAI affirms that all individuals must be able to exercise this right at all times and to achieve this, all efforts must be taken to make safe abortions accessible, affordable and available to all individuals who seek them. Further, MSAI believes that the decision regarding an abortion should be solely the decision of the pregnant individual and they should be supported in the process of making this decision with accurate and evidence-based information in a non-directive way, with all options, fully explained by trained, non-judgmental and non-coercive healthcare providers. This right to safe abortions must be upheld at all times and access to safe abortions must be maintained in such a manner to prevent any violations of this right.

Call to Action:

Therefore MSAI calls on:

Governments to:

- Inculcate accessibility to safe abortion services in the current National Programs related to Sexual & Reproductive Health and Rights.
- Ensure availability of safe abortion services as well as safe abortion providers at every level in the public health care delivery system
- Provide adequate funding and material required for the provision of these services
- Promote comprehensive sexuality education, including information on safe abortions, to the masses by means of public health campaigns, advertisements and helplines





- Work to increase awareness among people about their right to safe abortion services, including their right to confidentiality
- Conduct and support research on the accessibility of safe abortion services, including barriers to access, and provide evidence-based information about the need for safe abortion services to the masses
- Monitor and evaluate the implementation of safe abortion programs

The Healthcare Community to:

- Conduct obstetrical trainings for health care providers to equip them to provide safe abortion services
- Provide trainings to health care providers to have non-judgemental attitudes towards abortions and train them to provide comprehensive abortion care
- Ensure the presence of adequate supplies in terms of skilled professional, equipment, workspace, for providing quality-assured abortion services including comprehensive abortion care
- Promote various contraceptive methods to people seeking abortions as well as other people in the reproductive age group to prevent unwanted pregnancies

NGOs to:

- Conduct community-level advocacy programmes for raising awareness about safe abortion services while breaking the stigma around the same
- Work with governmental organizations and provide them with the support that they need to increase the outreach of awareness programmes
- Support other stakeholders by means of fund-raising events, awareness campaigns, health camps etc
- Act as a link between multiple stakeholders to have a fruitful impact

Student Organizations to:

- Increase the number of awareness campaigns especially amongst the health care community providing correct and clear knowledge about abortion services
- Hold advocacy training for medical students to train them to advocate for safe abortion services
- Collaborate with other student organizations and NGOs to have a multidisciplinary approach for making policy documents and guidelines

International Organizations to:

- Provide financial aid for conducting conferences to highlight the dire need of safe abortion services
- Conduct global research on safe and unsafe abortions to use the data collected as a tool to advocate for safe abortions worldwide
- Encourage and support the governments, healthcare communities, NGOs etc to spread awareness about safe abortion services and endeavours for provision of safe abortion services through financial aid or task force/materials
- Monitor restrictions on legal abortions in various nations across the world and intervene in the passing of restrictive laws in an appropriate manner





POSITION PAPER

Background

Safe and Unsafe Abortions

Abortion, in this context, refers to the induced medical termination of pregnancy. Abortions can be safe or unsafe. They are referred to as safe abortions if they are done by a trained service provider under aseptic conditions and by a technique that is appropriate with respect to the weeks of gestation of the pregnancy. Safe abortions include both medical and surgical management of pregnancies. [2]

An abortion is unsafe when it does not fulfil the above-mentioned criteria i.e. it is performed by an individual who is not trained in safe abortion delivery, or in conditions that are not of optimum medical standards. This can involve the ingestion of or the introduction of harmful traditional substances into the uterus or performing outdated surgical methods of abortion or performing surgical methods that are not appropriate for the gestational age or use of external force to terminate the pregnancy. [2]

Abortion in India

In 2015, abortions accounted for one-third of all pregnancies with an estimated 15.6 million abortions occurring in India. The abortion rate was 47.0 abortions per 1000 women aged 15–49 years. Overall, 81% of abortions were medical abortions, 14% were surgical and the remaining 5% (i.e. 0.8 million abortions) were done through other methods that were probably unsafe. [1]

In spite of the existence of legislation in India allowing for the provision of safe abortions, unsafe abortions are the third leading cause of maternal mortality in India. Approximately 8 women die from causes related to unsafe abortion per day in India. [3]

A study titled “The Incidence of Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policy and Programs” by the Guttmacher Institute reveals the following: Abortions in these six states predominantly occur in non-healthcare facilities and thus, are inherently less safe, especially the non-medical abortions. Assam is the only state where the majority of facility-provided abortions were in the public sector whereas, in the other 5 states, facility-based abortions were in the private sector. [3]

Abortion and Reproductive Health

According to a study conducted by the Guttmacher Institute on the incidence of abortion and unintended pregnancy, of a total of 48.1 million pregnancies in 2015, about half were unintended. The unintended pregnancy rate in India was 70 per 1,000 women aged 15–49 years in 2015, which is comparable to that of Bangladesh (67) and Nepal (68). [4]





According to a study conducted in rural Haryana, women's reproductive health was examined according to the number of pregnancies, gestational stage of abortion and the number of abortions by analysing data from an in-depth interview of 329 married women in five villages in 2003. Both late gestational stage and more number of abortions significantly affects and worsens the existing reproductive health problems among women. [5]

Unsafe abortions are already one of the leading causes of morbidity and mortality of women and if in case the woman survives the procedure of unsafe abortion, it affects her reproductive health in a grave manner which acts like a silent killer all her life. Even when safe abortions are performed, due to the health system barriers our country faces, often situations such as no birth attendant, medical environment not being fully sanitary, emergency facilities and supplies being absent or inadequate, doctors not trained or equipped to handle trauma, and basic medical and surgical supplies being unavailable pose a great threat to a woman's reproductive health and one of the measures which need to be taken in order to work on this situation is to improve and uplift our Comprehensive Abortion Care. The provision of safe abortion services is therefore of utmost importance to save women's lives. [6]

Abortion and the SDGs

Access to safe abortions is relevant to various targets in the Sustainable Development Goals and thus, the achievement of these goals depends on ensuring access to safe and legal abortion universally. These targets include:

Target 3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 births (unsafe abortion is a leading cause of maternal death worldwide).

Target 3.7: Ensure universal access to sexual and reproductive health-care services, including family planning, in order to ensure good health and well-being for women of all ages.

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights in order to achieve gender equality and empower women and girls.

This much is clear that universal access to safe and legal abortion is the foundation to strengthening sexual and reproductive health and rights, which in turn is the cornerstone of sustainable development. [7]

Abortions and UHC

Universal Health Coverage is the endeavour that seeks to ensure that all individuals, irrespective of where they come from, can access good quality health care without any impact on their finances. This includes sexual and reproductive health care as well, and thus, includes abortion. It is well acknowledged that abortions are health care and this right to access abortions must be covered in the provision of universal health care. [8]

In countries that are working towards universal health coverage, work on universal access to safe abortions has strengthened sexual and reproductive rights. One such country is Nepal that has a Basic Health Services package under which public health services are accessible to





everyone. This package includes access to free and safe abortions in the 1st trimester of pregnancy. Further, in 2019 the Nepalese government declared public support for the 'Public Health Act' and 'Safe Motherhood Reproductive Health Right Act' which reaffirm that the right to access safe abortions is, in fact, a human right. [8]

Access to universal health care, including access to free/low-cost, safe, and legal abortions, can lead to socio-economic development if supported with actions to improve the status of women in their communities. [9]

To ensure universal coverage of safe abortions, governments must commit to working on universal health coverage and design programs that are comprehensive and include attainment of the highest standards of sexual and reproductive health care. Further, it is important to address the healthcare workforce crisis and increase the cohort of abortion providers. It is also necessary to work on addressing social determinants of health such as gender inequities, the status of women, transgender individuals, and other non-binary identities in Indian society, lack of education, and other potentially harmful social norms that can pose as barriers to accessing safe abortions. [9]

Legislation surrounding Abortion In India

Over the last 25 years, there has been a gradual liberalization of abortion laws throughout the world. Until 1971, abortions in India were governed exclusively by the Indian Penal Code, 1860 and the Code of Criminal Procedure, 1898, and were criminalised except in cases of risk to the life of the pregnant individual. The Medical Termination of Pregnancy Act (The MTP Act) was passed by the Indian Parliament in 1971 and came into force from 1st April 1972 (except in Jammu and Kashmir, where it came into effect from 1st November 1976). Implementing Rules and regulations initially written in 1971 were revised again in 1992. The Medical Termination of Pregnancy Act is a healthcare measure which helps to reduce maternal morbidity and mortality resulting from unsafe and/or illegal abortions. [10]

MTP ACT 1971:

The MTP Act, 1971 lays down:

1. Conditions under which a pregnancy can be terminated
 - a. Continuation of pregnancy can put the pregnant woman's life in danger or cause grave injury to her physical or mental health
 - b. When there is a substantial risk to the foetus including physical or mental disabilities
 - c. When pregnancy is the result of sexual assault
 - d. Socio-economic: where actual or reasonably foreseeable environments (whether social or economic) could lead to a risk of injury to the health of the mother, and
 - e. Failure of contraceptive method in a married woman. This condition is a unique feature of the Indian law and virtually allows abortion on request in view of the difficulty of proving that a pregnancy was not caused by the failure of contraception. This must be extended to include unmarried individuals as well as
 - f.





it is not only contradictory to the fact that abortion is a human right, but it also ignores article 14 of the Indian constitution which calls for equality before the law. It also allows for healthcare providers to discriminate against unmarried individuals and either refuse to provide them abortions or exploit them by hiking prices for abortion provision.

2. Person or persons who can provide abortions

Only a Registered Medical Practitioner (RMP) having experience in gynaecology and obstetrics can perform abortions. A single RMP is sufficient when the length of the pregnancy does not exceed 12 weeks. When the pregnancy exceeds 12 weeks and is not more than 20 weeks, the opinion of two RMPs is necessary to terminate the pregnancy.

According to the new rules of MTP in 1975, RMPs qualify to perform abortions if:

- a. If they have assisted another RMP in the performance of 25 cases of MTP in an approved institution
- b. 6 months housemanship in obstetrics and gynaecology
- c. A postgraduate qualification in obstetrics and gynaecology'
- d. 3 years of practice for doctors in obstetrics and gynaecology for those doctors registered before the 1971 MTP Act was passed
- e. 1 year of practice in obstetrics and gynaecology for those doctors registered on or after the date of the commencement of the Act

3. Place where such terminations can be performed

The Act stipulates that no termination of pregnancy shall be made at any place other than a hospital established or maintained by Government or a place approved for the purpose of this Act by Government. Abortion services are to be provided in hospitals in strict confidence. The name of the abortion seeker is to be kept confidential since abortion has been treated statutorily as a personal matter.

According to the new rules of MTP in 1975, non-governmental institutions may also take up abortions provided they obtain a licence from the Chief medical officer of the district, thus eliminating the requirement of private clinics obtaining a board licence. [10]

Decisions regarding abortions that have crossed 20 weeks gestational limit are currently handled by the legal system. Individuals can appeal to the court asking for abortion provision after crossing the 20 week limit. However, it is preferable to shift this decision making from courts of law to a committee including healthcare professionals to enable them to weigh the medical and social needs of the situation at hand. It is also recommended to increase the gestational limit for abortion provisions as most second-trimester and late-trimester abortions are sought after due to foetal malformations that cannot be detected prior to the 20 week limit.

The MTP Act still has multiple loopholes and gaps and is not rights-based even though it is a relatively more liberal law. Ultimately, we require an abortion law that allows individuals to have abortions simply because they choose to rather than limit their access based on specific clauses. This decision is ultimately the abortion seeker's decision. It could possibly be





influenced by various barriers to access to safe abortion. However, eventually, the abortion seeker should be aware that it is their decision to make.

Impact of liberalization of abortion

The fact that India has legalized abortion does not necessarily mean that it is always available to every pregnant person when they wish to terminate their pregnancy. One of the major reasons for this is that the majority of the population, being in rural areas and far away from government hospitals and clinics, have no access to the facilities provided by the government. Also equally important is the fact that there is not sufficient awareness about the existence of safe and legal abortions in India. In one rural community-based study in Vellore district of Tamil Nadu, it was found that 84 per cent out of 195 women knew where to get an abortion but only 13.8% knew they were conducted by doctors. Women in India lack vital information about what they can safely do if they want an abortion. [6]

Also worth noting is that legal abortions do increase the number of safe abortions. However, sometimes legal abortions can be unsafe too. Often there is no birth attendant, the medical environment might not be sanitary, emergency facilities and supplies are absent or inadequate, doctors are not trained or equipped to handle trauma, and basic medical and surgical supplies such as antibiotics and sterile gloves are scarce or unavailable. However, these dangers to pregnant individuals are present whether a pregnancy is terminated or continued to term. [6]

Hence even though abortion has been legalized in our country, there is a need to raise awareness about this to all the abortion seekers and to fix the gaps and fallacies that exist in the MTP that result in the decision to provide abortions resting in the hands of abortion providers rather than abortion seekers. [6]

Discussion

Access to Safe Abortion as a Human Right

Human rights are about the empowerment and entitlement of people with respect to certain aspects of their lives, including their Sexual and Reproductive Health. These rights are inherent to all human beings and everyone is entitled to these rights. The right to access safe abortions is grounded in human rights. By recognising access to safe abortion as a human right, it creates an avenue for the voices of people seeking abortions to be heard and enables them to challenge political and other forms of exclusion which prevents them from exercising power over decisions and processes that affect their lives. By identifying access to safe abortions as a right rather than a need, safe abortions are made more accessible because if a right is denied, there must be justice.

Human rights instruments provide a basis for the rights of individuals to make decisions regarding their own bodies. In particular, they build upon the right to freedom in decision-making about private matters. Such provisions include protections of the right to physical integrity, the right to decide freely and responsibly the number and spacing of one's children and the right to privacy. [11] They continuously evolve to respond to the needs of groups of people previously not recognized. Principles that apply to human rights include:





1. **Universality:** All human beings worldwide are born with and possess the same human rights
2. **Inalienability:** Human rights are unconditional and cannot be taken away from any human being by any state, institution or another person
3. **Non-discrimination:** Everyone is entitled to all human rights regardless of their social status.
4. **Indivisibility:** All human rights are essential to the integrity of every human being. They have equal status and one right is not more important than another right.
5. **Interdependency:** A person cannot fully exercise one human right without access to the other rights. When one right is advanced or violated, other rights are affected as well. [12]

When looking at access to safe abortions, it is very important to look closely at all these principles and understand that access to safe abortions is a human right and denying safe abortions is a violation of the integrity of that individual.

Governments should respect an individual's human right to make decisions regarding their reproductive health. A person who seeks an abortion- as 15.6 million women in India annually do—must have access to the facilities and care that will enable them to terminate their pregnancy safely. These rights are compromised when a person who seeks abortions can only access them by resorting to unsafe methods or means. [11]

Adolescents, Young People and Abortion

A significant proportion of people seeking abortions include adolescents and young people. Further variability in this proportion exists when considering that other social identities can increase or decrease the chances of having unintended pregnancies when one is an adolescent or a young person (like race, sex, ethnicity, religion etc). These vulnerabilities overlap with existing social stigmas surrounding abortions and interfere with access to safe abortions. Adolescents are often unaware of what to do when faced with an unintended and unwanted pregnancy and often delay seeking care for the same. Further, they are more likely to turn to non-facility-based provision of abortions which can be illegal and/or unsafe. Thus, the incidence of morbidity and mortality due to unsafe abortions is also higher among adolescents. [13]

In India, abortion provision to adolescents is further complicated by the existing legislation governing abortion in India (The MTP Act) as well as that governing adolescent sexuality (The POSCO Act). As per the MTP Act, consent of the parent/guardian is required in case of abortions for minors which can pose as a barrier for adolescents seeking abortion in safe facilities. The Protection of Children from Sexual Offences Act, 2012 which aims at protecting individuals under the age of 18 from sexual assault at violence also serves as an unintentional barrier in access to safe abortions for adolescents. It mandates all individuals who are aware of sexual activity among minors to report it, including healthcare providers. It does not make provision for consensual sexual acts between adolescents. It also contradicts directly with the MTP Act's regulations for confidentiality. Thus, out of fear this information becoming public, adolescents may not seek abortions in safe facilities. [14]





It is important to address the increased mortality and morbidity rates associated with abortions in these age groups and ensure the provision of safe, legal and confidential healthcare for all adolescents and young people. Efforts must also be taken to provide comprehensive sexuality education as a preventive measure. Since various social determinants also contribute to the occurrence of unintended pregnancies among adolescents and young people, they must be addressed. These include working on empowering women and girls, providing universal education up to higher levels, and working to address the shame and stigma associated with women's sexuality in Indian society. [13]

Transgender men, non-binary people and other individuals with the possibility to gestate and Abortion

It is important to consider that it is not necessary that not all individuals who were assigned female at birth might not identify with this gender. This broad category includes transgender men, gender non-binary people, gender non-conforming individuals and other people with the ability to gestate. These individuals may decide to affirm their gender by taking hormone replacement therapy or undergoing gender affirmation surgeries. However, some of these individuals might choose not to affirm their gender, either temporarily or permanently. This might be due to lack of accessibility or affordability of these gender affirmation options or due to not feeling the need to affirm their gender identity by altering their anatomy and physiology. Some may even voluntarily choose to not affirm their gender in order to be able to conceive later in life. Therefore, these individuals who choose not to affirm their gender are capable of becoming pregnant. These pregnancies can be intended or unintended. [15]

Due to the additional vulnerability faced by these individuals in society they might face additional barriers to accessing abortions beyond what a cisgender woman might face. First, healthcare workers are largely uninformed and unaware of the capability of these individuals to gestate and of their needs whether it is to continue the pregnancy or to terminate it. There is a belief among health care professionals and the general population that only 'women' are capable of gestation. In a study carried out in 1988, study participants were mislabeled as women and mothers rather than acknowledging their identity as men and fathers and not affirming to their identified gender. [16]

Secondly, legal barriers for these individuals across the world include criminalisation of their identities as well as lack of civil rights. Further, they are not explicitly mentioned in a lot of legislation surrounding abortion including India's Medical Termination of Pregnancy Act hence leaving the Act open to interpretation by abortion providers and not ensuring that abortion is a right for these individuals. Also, some countries apply forced sterilization laws for transgender individuals upon accessing reproductive health services. There is also an unwillingness among some healthcare providers to provide inclusive health care services. The intersections of these barriers result in a negative experience that is exclusive to these individuals when attempting to access safe abortion services. It must be recognized that access to safe abortions is a human right and is universal. Thus, all efforts must be taken to ensure the inclusion of these individuals in safe abortion provision. [17, 18]

Barriers to Safe Abortions:





People with unwanted pregnancies often resort to unsafe means when faced with barriers to access to safe abortion. These barriers include restrictive abortion laws, unaffordability of abortions, low availability or accessibility of services, the social stigma surrounding abortions, the conscientious objection of health-care providers to abortions and unnecessary requirements by governments for abortion provisions, such as obligatory waiting periods, compulsory counselling for people seeking abortions, coerced delivery of incorrect or misleading information by abortion providers, and medically unnecessary tests that delay care. [19]

- a. **Legal Barriers:** The legal process is overdrawn and slow– There have been instances in the past, where the judiciary has been found to be slow in its response to abortion petitions. For example, in a certain case, a lady suffering from HIV had to deliver a baby as the judiciary was not expedited enough in dealing with her petition. As a result, the 20 week period was lost and induced miscarriage posed risk to both mother and child. The legal system thus needs to put its act together. In cases of abortion petitions, the whole process of hearing should be fast-tracked keeping in mind the 20 week period to have a safe and legally permissible abortion in India. A special bench may also be constituted to fast-track such trials.
- b. **Social Barriers:** Gender inequities, gender-based discrimination, gender-based violence and lack of social support are the major barriers posed to access to safe abortion. Women are often treated unfairly on the basis of being female and may not have the freedom or means to access safe abortion care because of it. Lack of social support is a result of stigma and domestic violence which women face in their households.
- c. **Abortion Stigma:** Abortion stigma leads to silence, fear and barriers to accurate information-related care and experiences. Due to abortion stigma, many people not only have limited information about abortions but often, what they do know is inaccurate, incomplete or tainted by negative judgements, myths and misconceptions. A lot of times, abortion is unintentionally stigmatised by healthcare providers as well due to the societal stigma which surrounds it. Hence this can affect the manner in which abortion providers counsel and treat seekers of abortions. [20]

The following are the kinds of stigma witnessed while accessing safe abortion services:

1. Anticipated (or perceived) stigma: This is the most common stigma which almost everyone has inbuilt in their minds fearing about how others will react to their situation
2. Experienced Stigma: This stigma refers to the actual experience of being discriminated against, and this is something which an individual might have faced from a family member, spouse, peers or friends at either their home or at any community setting
3. Internalized (or self) stigma: Self-stigma is one of the major causes of mental illness and it results due to low self-esteem and confidence when a person starts to absorb all the negative criticism given by the society and starts to have thoughts of self-doubt





4. **Discrimination:** This is another form of stigma in the enacted form. It seriously affects a person's pursuit of happiness because of the distinction made in the society which destroys personal dignity.
5. **Intersecting stigma:** It comes into play due to the already attached stigma due to their social identities and then abortion stigma adding and in totality amplifying the entire situation. [20]
 - d. **Financial barriers:** In many cases, due to financial concerns, individuals opt for medical abortions over surgical abortions. However, healthcare providers can exploit the stigma surrounding abortions and hike prices for these medicines taking undue advantage of an abortion seeker's ignorance and helplessness. Therefore, the need of the hour is to ensure that medical abortion pills should be compulsorily included in the national list of essential medicines, which are to be obligatorily sold at government-approved affordable prices for the abortion seekers' convenience. Even surgical abortions can cost a lot of money and be a drain on the person's finances if they are seeking it from the private sector. This often costs much more than medical abortions do. It is recommended that governments work to place caps on the cost of abortion provision, especially in the private sector, to prevent health care providers from exploiting people seeking abortions and to increase accessibility.
 - e. **Health system barriers:** Medical technologies for safe abortion are no longer a problem, but the availability of and access to these technologies remains a formidable challenge. Countries that are in transition from more to less restrictive abortion laws have to build the infrastructure and skills. Other countries that liberalized the law in the last 10-15 years are still struggling to provide much-needed services, including a change in the attitude of service providers. Therefore, in many countries, there is a need to ensure universal access with adequately trained providers both in the provision of safe abortion procedures and also in counselling, together with necessary equipment and infrastructure. India lacks a sufficient number of registered and trained medical practitioners to take care of its citizens' abortion requirements. This has resulted in pregnant individuals opting for unsafe abortion procedures, which causes about 4000 deaths annually. AYUSH practitioners, auxiliary nurses and midwives can be trained to advice medical abortion pills to pregnant individuals wishing to have abortions. This will help bring down the number of deaths due to unsafe abortion procedures as well as help a lot more people seeking abortions to avail proper medical services. As suggested in the 2014 MTP amendment bill, this provision would have been no less than revolutionary. However, due to political and administrative reasons, this bill was not passed. [21]

Unsafe Abortions: Impact and Prevention

Unsafe abortions are often associated with increased morbidity and mortality. On the contrary, safe abortions are one of the safest medical procedures. The complication rate is extremely low (only 0.23% overall, 0.31% for medical abortion, 0.16% for first trimester surgical abortion, and 0.41% for second-trimester or later abortions). In fact, this is comparable to the complication





rate for a colonoscopy and even lesser than the complication rate associated with wisdom tooth removal and tonsillectomy. [22]

As per a study conducted in India, 67% of abortions in India were classified as unsafe, varying widely across the states, with a disproportionately higher incidence among vulnerable populations. According to another study in India conducted in 6 states only, a vast majority of abortions occur in non-healthcare facilities and are less safe. These out-of-facility unsafe abortions which are medical abortions tend to be associated with lesser complications than when they are surgical abortions. This is not to say that medical abortions which are conducted outside of facilities are inherently safe. A study from Madhya Pradesh showed that 2/3rd of vendors who sell non-facility medical abortion pills do not enquire with seekers about their last menstrual period date and are also unaware of the appropriate methods and dosage according to the gestational age. When addressing unsafe non-facility surgical abortions, the only data available is that of individuals seeking post-abortion care for complications arising from the procedure. [23, 3]

It is important to note that the morbidity and mortality due to unsafe abortions is largely preventable. Matters of limited access to abortions due to lack of resources must be improved by governments by ensuring an increase in providing facilities and providers. Efforts must be taken to ensure increased awareness among the masses about the existence of safe and legal abortion options in India. Gaps and fallacies in the legal framework surrounding abortion must be addressed to ensure that the access to safe abortions becomes a right in India. Legal reform must be set up to evaluate the accessibility of abortions in India. Healthcare providers should be trained in recognising and treating unsafe abortion-related complications and providing the highest standard of comprehensive abortion care to people seeking abortions. Wherever possible, financial barriers in accessing abortions must be addressed including ensuring the option of free to low-cost safe abortion provision in public health facilities. Work must be done in data collection, analysis and research into unsafe abortions in India and this evidence-based data must be used as a framework to design health policies and programs to ensure access to safe abortions. Finally, it is important to also address other determinants in society contributing to unsafe abortions by understanding the impact of lack of autonomy and agency on access to safe abortions and the role of patriarchy in propagating stigma in society regarding abortions. Gender inequity and patriarchal societal norms must be addressed parallel to work being done to empower women, girls, transgender individuals, non-gender conforming individuals, other vulnerable populations and every other person seeking abortions in India. [3, 24]





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