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Original Research Article

The hidden crisis: unsafe abortion and the fight for women's health

Afsana[1]*, Tehzeeb Alam[1], Yetoo Mateena[2]

[1]Department of Social Work, Mahatma Jyotiba Phule Rohilkhand University, Bareilly, Uttar Pradesh, India
[2]Department of Sociology, Delhi Public School, Sangam, Anantnag, Jammu and Kashmir, India

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***Correspondence:**
Dr. Afsana,
E-mail: afsanasiddiquioct2015@gmail.com

ABSTRACT

Background: In addition to having theological, moral, cultural, and political implications, abortion is a sensitive and divisive topic that also raises public health issues. Between 4.7 percent and 13.2 percent of maternal deaths each year are caused by unsafe abortion. Every year, unsafe abortions result in the hospitalization of more than 7 million women in impoverished countries.
Methods: The structural violence repertoire was used as a theoretical lens, the women were assisted in in-depth interviews to reflect and narrate the perceptions around abortion, and the qualitative approach was adopted for developing the narratives through oral history.
Results: According to studies, women frequently engage in risky abortion procedures and employ the same inexperienced personnel and traditional techniques that pose health risks. The findings also showed that the rate of induced abortion is rising, and it remains a mystery as to why women choose to have their abortions outside of hospitals and expose themselves to a variety of hazards.
Conclusions: Therefore, it is important to understand the extent of structural violence related to unsafe abortions and to implement a program to raise knowledge of health services.

Keywords: Illegal abortion, Morbidity and structural violence, Mortality, Unsafe abortion practices, Women health

INTRODUCTION

"*Nearly every death and injury that results from unsafe abortion is entirely preventable. That's why we recommend women and girls can access abortion and family planning services when they need them*".[1]

Unsafe abortion is a prominent example of health inequality, serving as a primary, preventable cause of maternal mortality and disability worldwide.[2] Although surrounded by religious, moral, cultural, and political dimensions, abortion also poses significant public health challenges.[3] According to the World Health Organization (1993), unsafe abortion is defined as the termination of an unintended pregnancy by individuals lacking the requisite skills or in conditions that do not meet minimal medical standards- or both.[4] This issue is particularly pressing in developing countries, where almost all maternal deaths occur. For example, in low-resource settings, the risk of maternal mortality is notably higher, with 1 in 4,900 women at risk of death compared to 1 in 180 in developed nations.[5] The primary contributors to maternal mortality include postpartum hemorrhage, infections, unsafe abortion, eclampsia, obstructed labor, ectopic pregnancies, embolism, and anesthesia complications. Tragically, over 60% of these deaths occur in Africa and 30% in Asia, underscoring the profound healthcare disparities in these regions.[6]

This study aimed to address these disparities by exploring abortion and abortion practices within the Indian context, a setting where social, legal, and medical issues

surrounding abortion practices are particularly complex. Additionally, the research will demystify the structural violence that often exacerbates unsafe abortion practices, which contribute to adverse health outcomes and reinforces systemic inequalities. Finally, the study will develop a behavior change communication intervention plan, aiming to promote safer practices and improve awareness and healthcare access among vulnerable populations.

A glance at global trend

Liberalization of abortion laws is the current global trend. Except for Nicaragua, all of the 38 nations that have altered their abortion laws since 2000 have increased the number of legal bases on which women may obtain abortion services. Since 2020, South Korea, Argentina, Mexico, and Thailand have all decriminalized abortion with some restrictions on gestational age, while New Zealand has loosened its abortion laws.[7]

Tragically, however, only around half of all abortions take place under such conditions, with unsafe abortions causing around 39 000 deaths every year with the number and rate of US abortions increased from 2017 to 2020. The US abortion rate increased as 1 in 5 pregnancies terminated in 2020.[8]

The US Supreme Court has also struck down the constitutional right to abortion with its recent decision by overturning a landmark 50-year-old decision, after which the legal status of the right to abortion was abolished.

According to UNICEF (2018), India is responsible for at least 25% of maternal and child deaths worldwide. India is home to one in seven unplanned pregnancies worldwide[9,10] In India, unsafe abortions are the third greatest cause of maternal mortality, and each day, over 8 women pass away due to complications associated to unsafe abortions.[11] It is believed that unsafe abortion accounts for 9 to 20% of all maternal fatalities in India.[12]

Evidence shows that restricting access to abortions does not reduce the number of abortions that take place. In countries where abortion is most restricted, only 1 in 4 abortions are safe, compared to nearly 9 in 10 in countries where the procedure is broadly legal.[13]

'Secrecy' around abortion and unsafe abortion practices in India

Abortion is the least popular and most covert birth control option in India (Patel, 1994). Importantly, unsafe abortion is not a "free choice" issue; rather, it is a result of socioeconomic determinants and differences in health chances between people and groups.[14] Women who are unable to pay for or access medical care may try to end the pregnancy on their own or may turn to unskilled practitioners (such as shamans, homeopaths, and herbalists) who use a range of techniques.[15]

Abortion timing in India

According to Sebastian et al, in India, induced abortions are carried out in the first trimester in around 85% of cases, 10% in the second, and less than 2% in the third.[16] While India has the greatest rate of second-trimester abortions, which are rising steadily, the main causes of these abortions are poor MTP accessibility and incompetent practitioners.[17] Abortions during the second trimester are 12 percent more likely to experience problems than those during the first.[18]

Methods for unsafe abortion

There are many ways to induce an abortion, including vaginal and oral methods. Dai (traditional birth attendants) induce abortions using sticks, herbs, roots, and foreign objects placed into the uterus. Fetex paste, light tents, and pins are some other vaginal procedures. Rural healthcare practitioners sell oral contraceptives such prostaglandins, chloroquine tablets, and high doses of other contraceptive medications. Traditional methods include consuming caustic liquids like bleach or flooding the vaginal area with them; physically torturing someone by having them leap or fall from large heights; dancing intensely; or having them engage in long durations of vigorous and continuous sex. Turmeric and papaya, a blend of carrot seeds and jaggery, tea leaves and jaggery, etc.[19-21]

Effects of unsafe abortion methods on women's health

Morbidity and mortality are still major issues for Indian women as a result of improper abortion procedures. Between 10 and 50 percent of women experience a variety of co-morbidities, including secondary infertility, STIs, abdominal pain, fits, digestive problems, heavy bleeding, etc. Urgent action must be taken to stop these tactics.[22-24]

METHODS

This qualitative study was conducted to understand the impact of structural violence on unsafe abortion practices among women at Soban Singh Jeena Base Hospital in Haldwani, where patient information was collected between February 2024 and April 2024. Participants were selected based on specific criteria: women aged 15 to 49, as defined by the National Family Health Survey (NFHS) guidelines, who were married and had engaged in unsafe abortion practices. All participants had experienced health complications resulting from these practices and subsequently sought medical treatment.

In-depth interviews were conducted with 25 women, allowing for a comprehensive understanding of their experiences and perspectives on unsafe abortion and the structural barriers they faced within the healthcare system. This method was chosen to capture the rich narratives and personal histories that reveal the socio-cultural dimensions of abortion and structural violence.

The data gathered were analyzed thematically, highlighting common themes and patterns to reveal the broader social factors influencing unsafe abortion practices and the related health-seeking behaviors among women.

Ethical concerns and considerations

Ethics regulating research in sensitive subjects such as reproductive health requires that respondent's consent be obtained and that the researcher always express a promise of confidentiality at the beginning of the interview. As a part of the ethical considerations involved in the present research, the researcher introduced herself and her research topic to the research participants and developed a rapport with them during data collection. For the purpose of the research, she requested one hour of their time to perform the interview and took permission for the revisit for more information, clarification and update, if so needed. Each individual research participant was also told at the beginning, that her participation is completely voluntary and that there is no compulsion to answer the queries. She was advised that if she was made uncomfortable by any of the topics under discussion for some reason, she can ask to stop the interview. Before starting the field interviews, written inform consent has been taken from all the participants. However, in the case where the participant is not literate, oral consent from the research participant was taken and the researcher read translated Hindi version of the consent form for all the participants. The confidentiality of data collected and respondent anonymity was maintained during the analysis, and data was collected only with the informed consent of the respondents. The interviews were performed in a private environment until the consent was obtained. The data computerized did not use or record the name of the respondent.

Structural violence and unsafe abortion practices in Uttarakhand

The traditional methods reflect the lack of awareness, effective usage of modern temporary contraception, and even poor access to abortion because of which they take recourse to traditional risky concoctions.[25] In understanding the reproductive health of married Muslim women of Uttarakhand (India). Initially, the unsafe abortion practices and the silent culture are refereeing the structural violence. So, it is very important to revisit the condition of structural violence around abortion and abortion practices. In consequence, the structural violence repertoire was used as a theoretical lens and the women were facilitated in in-depth interviews to reflect and narrate their perceptions of abortion.

Traditional abortion practices

High numbers of abortions are performed in unsafe circumstances, two out of five unsafe abortions occur among women younger in age.[26,27] There are many traditional and indigenous hot concoctions for abortion including vaginal and oral methods.

High numbers of abortions are performed in unsafe circumstances, two out of five unsafe abortions occur among women younger in age.[21] There are many traditional and indigenous hot concoctions for abortion including vaginal and oral methods. The narratives below reflect this.

"If you don't want a child, do abortion, or else eat a powder of celery mixed with dried ginger at home, or consume the solution of old jaggery (black in colour) which is well cooked, then drink its water 3-4 times a day, or reddish pills of Mala-D and drink celery and dried ginger water above it. Baby gets aborted by drinking boiled Pepsi, lifting weight or jumping". [IDI-2]

"A young 18 years old lady with a three months old child told that "we are informed that if you don't want a child, and it's been only one or a half month, then bring a bottle of Pepsi (cold drink), boil it like tea, drink it at night and sleep, everything will be cleansed till morning". [IDI-6])

"Mix dry ginger, clove, jaggery, and tea then cook it well and drink it for two or three days, abortion will happen. It is told that even a three-month-old conception can also be aborted by using this method". [IDI-7]

A lady in her 30s having three children, three miscarriages, one induced abortion and now with tubectomy had the following prescription. "*Eat raw papaya at home, ripened papaya doesn't work, you will have to eat raw papaya only, lift some weight or else eat warm things like egg, meat and fish, but all of these will work in the beginning, if it is delayed then you will have to go to the doctor".* [IDI-8]

The narrative from the field reflect that women are using different kind of unsafe abortion practices like eating powder of celery mixed with dried ginger, solution of old jaggery, drinking boiled Pepsi, lifting weight or jumping from the high point, reddish pills of Mala-D, a concoction made of ginger, clove, jaggery, and tea; eating raw papaya, eating food that is considered hot like egg, fish, meat, etc. During the fieldwork, the researcher found that most women feel shy while talking about abortion while some women talk very frankly about this topic. They shared their own and some societal experience with the researcher. When women agree to induce abortion, they still do not agree to visit a doctor. They believe that self-medication is common for induced abortion. Women believe that through indigenous methods (concoctions) abortion can be done easily. In the study, a large number of women are using indigenous methods for abortion. They use garam taseer (hot effect concoction) things like- haldi (turmeric), papeeta (papaya), purana gudh (old jaggery), annannaas (pineapple), til (white sesame seeds), anda (egg), machli (fish), shehad (honey) and the mixture of azwain (celery), purana gudh and sonth (dry ginger), sonth azwain, til and

gudh ke laddu sont, long (clove), adrak (ginger) and chai patti (tea)" and "boiled black pepsi". and some women do hard work like- wazan uthalo (weight lifting), rassi kud khelo (skipping) etc.

Self-medication for abortion

During the second trimester, induced abortion will still be dangerous but women still are hesitant to visit the doctor. Self-medication is common for induced abortion and it is only after complications that they land in hospitals.[28] A lady aged 35 years with five children (four girls and one boy) told that she underwent 5-6 abortions. "*I mean I have had 6 abortions since the birth of my last child. I use to take medicine from the medical store, which costs Rs 350 and it worked. If I miss the menstrual cycle for a month, I check my pregnancy by using a pregnancy kit, then I take medicines from the medical store or I go to a local doctor, but it is very painful, I feel so much pain in my waist and it bleeds all night. Earlier I used to have dry ginger and celery water to abort the baby. In the beginning, I took some home remedies like celery water and dry ginger to abort the baby. I also used to lift weight or jump rope to terminate pregnancy, but who will go through so much of tension, the best thing to do is bring the medicine which costs Rs 350 and have it, but if more time has passed then, one has to see a doctor. Home remedies like solution of celery, dry ginger and black jaggery can be taken 2-3 times a day, it will induce bleeding"*. (IDI-24)

"Once I got pregnant before my third child. Due to the delay in the period, I checked pregnancy myself by a pregnancy kit at home and I got confirmed that I have conceived. Since I did not want to have that baby, I took a medicine given by a local doctor. As I was pregnant for just 15-20 days, so I didn't face any problem". (IDI-3)

"A few months ago I was pregnant; the doctor told me that it is not okay for me to be pregnant, since my body is weak. But now as I am pregnant already, what can I do? The doctor asked me to get abortion but I did not which caused me great trouble. I started bleeding and my whole body was swollen but due to the fear of the doctor, I did not go to the hospital. I took a medicine from the medical store at home, which caused the still baby to decay in the womb itself, and poison spread in my whole body. I had a very bad condition, so when I went to the doctor, she was very angry, scolded me and didn't see me. However, after pleading her, she checked me. That was a very bad condition. I do not know how Allah has saved me". (IDI-5)

Women believe that through self-medication, abortion can be done easily. It was found that women get medicines from a local shop just by spending a few pennies which also helps them to hide their identity as abortion remains a taboo in the Indian socio-cultural milieu. The women who can't afford medicines from the local shops go far the 'unsafe practices' which are quite popular in the area like celery water and dry ginger. Women also lift weights or jump rope to terminate their pregnancy. Sometimes solution of celery, dry ginger, and black jaggery is also used to induce bleeding. The researcher found that women know that self-medication is very harmful, still, they use self-medication for abortion. They go to the medical store or untrained health attender and take medicine and face many health problems. Thus, these unsafe abortion practices can sometimes prove to be lethal for women.

Life at risk due to unsafe abortions

Every year, tens of thousands of women die as a result of unsafe abortions around the world.[29]

According to the respondent- "*there is no such harm from home remedies, but there are many life-threatening abortion practices. In my neighbourhood, there is a woman who left her four children and died. She had been expecting just a few days ago, not more than two and a half months. She pushed some sharp objects into her uterus, and then she was agonized with pain like a fish without water. There was a lot of bleeding. She was taken to the hospital but she died two days later"*. [IDI-3]

The study found that unsafe abortion practices are common and women are using the same with untrained hands, and indigenous methods which are leading to fits, excessive bleeding, abdominal pain, menstruation problems, and even death. It is still a secret why women are avoiding hospitals and putting themselves at life-threatening risks by using these indigenous or traditional methods of unsafe abortion practices.

RESULTS

Demographic profile of the respondents

Further among 25 ever-married women respondents, 24 were married and only one was a widow. In the case of the family type, 18 respondents were living in an extended family and the remaining 7 were had a nuclear family (Table 1).

Table 1: Age of respondents.

	Age at the time of interview	Age at marriage
Mean	26 years	18 years
Minimum	16 years	14 years
Maximum	35 years	25 years
Total	25	25

In the present study, the self-reported caste category shared by the respondent was that 6 respondents belonged to general category and 19 were from other backward classes (OBC). Table 2 further provides that in terms of the possession of ration cards, 9 respondents were APL (above poverty line) and 16 were BPL (below poverty line).

Table 2: Marital status and family type.

Marital status	Frequency	%	Type of family	Frequency	%
Married	24	96	Extended	18	72
Widow	1	4	Nuclear	7	28
Total	25	100	Total	25	100

Table 3: Caste category.

Caste	Frequency	%	Ration card	Frequency	%
General	6	24	APL	9	36
OBC	19	76	BPL	16	64
Total	25	100	Total	25	100

In this research, 8 respondents were illiterate, 3 respondents had studied till primary and 6 respondents were educated till middle (Table 3). Also 3 respondents had done high school, 2 intermediates, and 2 were undergraduate. Only one respondent had post-graduation.

Table 4: Educational status.

Education	Frequency	%
PG and above	1	4
UG	2	8
Intermediate	2	8
High school	3	12
Middle	6	24
Up to primary	3	12
Illiterate	8	32
Total	25	100

The respondents were engaged in four categories of work viz. Anganwadi helper, dai, house maker and unskilled workers (Table 4). Among the 25 respondents, 22 were house makers.

Table 5: Nature of occupational engagements.

Working Status	Frequency	%
Anganwadi helper	1	4
Dai (traditional birth attendant)	1	4
House maker	22	88
Unskilled worker	1	4
Total	25	100

Income usually depends on the occupation of the people. In the present study the average income of the respondent was INR 6500 per month. Among the 25 respondents, the minimum income was 2500 and the maximum was 20000 (Table 5).

The number of living children is closely linked with the reproductive health of the women and is also indicative of family planning among the couple. Among the 25 women respondents, most of the respondents (10) were having two children and 7 were having one child (Table 6). Four respondents were having three children and three respondents were having five children.

Table 6: Family income.

Total No.	25
Mean	6500.0000
Mode	5000.00
Minimum	2500.00
Maximum	20000.00

Table 7: Number of currently living children.

Number of children	Frequency	%
Having one child	7	28
Having two children	10	40
Having three children	4	16
Having four children	1	4
Having five children	3	12
Total	25	100

Among 25 respondents, 9 women suffered from miscarriage two times and seven respondents got miscarriage once (Table 7). Only one respondent got miscarriage three times and eight respondents never got a miscarriage.

Table 8: Miscarriage.

Miscarriage	Frequency	%
Never	8	32
1.00	7	28
2.00	9	36
3.00	1	4
Total	25	100

Table 8 provides details on the abortion experiences of the respondents. Among 25 respondents, 11 respondents never had any abortion, while 6 respondents had it once, 5 respondents had it twice and 3 respondents had it three times. And surprisingly one respondent experienced abortion 7 times in her life.

Antenatal care (ANC) is the care which one gets from health professionals during the pregnancy. In this study, 10 respondents used at least 3 ANC checkups and 11 respondents had IFA and 18 had tetanus injections (TT) during pregnancy (Table 10). 15 respondents did not report any ANC checkups, 14 respondents skipped IFA tablets while 7 respondents did not have tetanus injection.

Table 9: Abortion experiences.

Abortion	Frequency	%
Never	11	44
1.00	6	24
2.00	5	20
3.00	2	8
7.00	1	4
Total	25	100

Table 9 shows the child mortality and stillbirth experiences of respondents. Among 25 respondents, 5 respondents lost their 1 child and 2 lost 2 children after birth. While 2 respondents had 1 stillbirth and 1 respondent experienced 1 stillbirth.

Table 10: Contraceptive methods.

Contraceptive method	Frequency	%
Condoms	12	48
Pills	1	4
IUD	1	4
Female sterilization	3	12
Withdrawal	3	12
Any other	1	4
Not anyone	4	16
Total	25	100

Findings

Unsafe abortions are prevalent, with a significant portion occurring among younger women.

Various traditional and indigenous methods are used, including both vaginal and oral concoctions, such as: celery powder with dried ginger; old jaggery solution; boiled pepsi; eating raw papaya, and hot foods like egg, fish, and meat; home mixtures like ginger, clove, jaggery, and tea, or turmeric, papaya, and pineapple.

Physical actions such as lifting weights or jumping from heights are also attempted for inducing abortion.

Women feel varying levels of discomfort in discussing abortion; many rely on self-medication or indigenous practices rather than seeking professional help.

Self-medication is widespread, especially during the second trimester, despite knowing the risks involved.

Many women avoid hospitals and obtain cheap medications from local shops to maintain privacy, given the stigma around abortion.

Those unable to afford medicines turn to popular unsafe methods in the area, like celery water with dry ginger or black jaggery concoctions.

Physical activities, such as lifting weights or skipping, are also used to induce abortion.

Women are aware of the harmful effects of self-medication, yet resort to it, often leading to health complications from using unprescribed medications or consulting untrained health attendants.

Unsafe abortion practices pose severe risks, with cases of death reported from dangerous methods.

Respondents noted that while they believe home remedies are safe, certain unsafe practices can be life-threatening.

For example, one case involved a woman inserting sharp objects, resulting in severe bleeding and death shortly after hospitalization.

The study highlights the adverse outcomes of using untrained and indigenous methods, including fits, excessive bleeding, abdominal pain, menstrual issues, and fatalities.

Despite the known risks, women often avoid hospitals and instead use unsafe traditional methods, putting their lives at significant risk.

DISCUSSION

The barriers to universal reproductive healthcare access, especially in third-world countries, where abortion remains stigmatized and unsafe practices persist due to inadequate training, legal restrictions, and cultural taboos. The study aligns with findings in global health literature that underscore how stigma, legal frameworks, and cultural norms impact women's access to safe abortion services.[30,31]

Our findings support previous research by highlighting how societal stigma around abortion compels women to seek clandestine procedures, often conducted by untrained individuals, leading to higher health risks.[32] This not only mirrors broader public health concerns but reinforces the notion that restrictive policies inadvertently increase unsafe practices, as indicated by studies in countries with similar socio-cultural environments.[33] These studies document the frequency of unsafe abortions and the associated health complications, emphasizing the critical role of trained health professionals and accessible reproductive health services to mitigate these risks.

The necessity for cultural sensitivity and intellectual awareness among healthcare professionals is paramount in managing abortion-related stigma, as noted by Kumar et al. Professionals must recognize their biases and the diverse experiences of women who resort to unsafe abortions, as these are influenced by desperation and limited access to resources.[34] Moreover, the ongoing legal and moral controversies surrounding abortion create an environment where policies often restrict safe access, despite evidence that illegal or heavily restricted abortion leads to greater maternal morbidity and mortality.[35]

In light of these findings, our study supports the advocacy for community-based interventions, such as those led by ASHA and Anganwadi workers, which can be instrumental in raising awareness and providing education on reproductive health at the grassroots level. Public health campaigns promoting contraception, sex education, and safe abortion services, as outlined by the WHO, are vital for reducing abortion-related mortality and morbidity.[36]

In agreement with this study, many public health experts argue for legalizing abortion as a measure to enhance women's health autonomy and reduce unsafe practices. Research underscores that restrictive laws do not reduce abortion rates but rather drive women toward unsafe alternatives.[37] Therefore, to protect women's health, there is a need for both policy reforms and professional guidelines that allow medical practitioners to provide safe, accessible abortion options based on individual health needs and preferences.

There are few limitations of the study. This study was a qualitative descriptive study confined to Muslim women in Haldwani city of Nainital district. Further, the respondents were ever-married women in the age group 15-49 years having at least one child less than two years of age. This helped in including young mothers with recent experience and memories around the reproductive trajectory. This though resulted in having rich narratives from mothers but it makes the study high context-specific and so is the limitation of the study.

CONCLUSION

The present study argues to understand the structural violence around unsafe abortion. women continue to put their life at risk by adopting unsafe ways of abortion practices, due to a lack of access to healthcare facilities such as qualified doctors, medicines at the governmental facility, and proper counselling by healthcare professionals. Moreover, abortion remained taboo in Indian society therefore people do not want to talk about it. The stigma around abortion forces women to adopt locally harmful ways of abortion as they want to hide their identity. The narrative also reflects that women show that they have internalized the hegemonic discourse around abortion which wants to keep the issue of abortion under the four walls of the home. This pushes them into the vicious cycle of unsafe abortion practices. Therefore, to stop unsafe abortion practices there is a need to educate people about the issues of reproductive health, particularly the issues of unsafe abortion practices and their effect on the health of women. With a culturally sensitive approach, women can be facilitated to begin by sharing the experiences of others in the community with abortion and eventually end up expressing their own abortion experiences. As a result, the stories could serve as a form of abortion catharsis. This agency of women must be triggered to take on the experiences and agony of unsafe abortions carried out under the guise of secrecy and community sanctions. These women have a huge opportunity to work alongside public health professionals to find, list, and reduce unsafe abortions while also promoting safe abortion services.

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