International Research Journal of Pharmacy and Medical Sciences
ISSN (Online): 2581-3277

"Tales of Psychosocial Horror and Hate": Implications for Unmarried Pregnant Indian Women's Safety, Health and Choice of Safe Abortion

Pant, Priyadarshini[1]; Kaur, Harprit, PhD[2]
[1]PhD Scholar, Dept. of Psychology, Punjabi University, Patiala, Punjab, India
[2]Professor – Dept. of Psychology, Punjabi University, Patiala, Punjab, India

Abstract*—Taboos around female sexuality have dominated the psychosocial space and narrowed the understanding of health and hazards for women. Accidental pregnancy, especially in a hostile environment poses various threats for unmarried women's overall health and well-being. The associated psychosocial obstacles turn this life event into crises that have long term mental health consequences. Scared of social judgement and shame, most pregnant unmarried Indian women resort to induced abortions which are highly correlated to maternal mortality, infertility and hospitalizations. Unsafe abortions are dangerous for one's physical, mental, emotional, spiritual, occupational and relational health. This paper attempted to highlight the traumatic psychosocial implications of pregnancy and abortion for unmarried Indian women, utilizing the multiple case study method and illustrating insights from 3 relevant cases. The narrative analysis, indicated potential psychosocial trauma associated with unintended pregnancy and factors that mediated the decision-making process while contemplating the available options for abortion. These findings have important psychosocial implications for women's health, rights, sex education and social reform*

***Keywords*—** *Psychosocial trauma, accidental pregnancy, induced abortions, Indian women's reproductive health*.

I. INTRODUCTION

Pregnancy out of a wedlock is often frowned upon in many cultures including India, where understanding of female sexuality is still limited and for the most part, viewed from a moral compass. Deviations from the socially prescribed gender roles are judged with religious, moral, social, and characterological deficits. This social shaming has widespread consequences for one's interpersonal, intra-personal, academic, occupational, relational and emotional life which presents enormous challenges for unmarried pregnant women in India, making it difficult for them to seek proper medical consultation for the termination of their pregnancies. Socio-cultural attitudes, lack of sexual education and reproductive health, push women to choose induced abortions, overlooking the standard protocol, often performed without proper medical supervision. Induced abortions are highly correlated to maternal mortality, serious reproductive health problems and other major health complications. Bearak et al. (2020) reported that on an average 73.3 million induced (safe and unsafe) abortions were carried out worldwide, each year between 2015 and 2019. They also noted that induced abortions occurred for every 3 out of 10 (29%) of all pregnancies and every 6 out of 10 (61%) of all unintended pregnancies. Ganatara et al. (2017) noted that 1 out of 3 induced abortions were performed in unsafe conditions, jeopardizing maternal health. They also estimated that 45% of all abortions conducted between 2010-2014 were unsafe, almost all of which occurred in developing countries. Say et al. (2014) reported 4.7% – 13.2% maternal deaths caused by unsafe abortions each year. In rural India, the maternal mortality rate for the 10 year period was 785 per 100,000 live births, It was also noted that out of the total 116 reported maternal deaths, 44 (41.9%) were caused by induced septic abortions, the reasons for which were unwanted pregnancies in 22 (50%) cases (Verma et al., 2010). Yokoe et al. (2019) concluded high prevalence of unsafe abortions posing serious dangers for maternal health. They also pointed at Socio-economic vulnerability and inadequate access to healthcare services as potential contributory factors.

The present study aims at understanding the role of various psychosocial barriers associated with the pregnancy of unmarried women in India while highlighting the struggles, traumatic experiences and implications for their decision, relating to mode of termination, overall safety, health and well-being.

II. METHODS

This paper utilizes the multiple case-study method. The sample of the study is (n=3) Indian women who conceived out of a wedlock. These women were in their early and mid 20's, with graduate or postgraduate level of formal education and belonged to middle and high socio-economic urban domicile status. A narrative analysis of the interviews was performed, and the findings were then discussed under relevant framework of extant review of literature in the field.

III. PROCEDURE

A total of 5 cases of unmarried Indian women who underwent induced abortions, for their unintended pregnancies and sought psychotherapy for post termination mental health issues, were approached for the present research. 2 out of 5 women did not give permission and thus the data of the study consists of total (n=3) case reports. An informed consent ensuring voluntary participation was obtained from each patient respectively, during their individual sessions. The case information shared in the paper was first discussed with respective patients and the details mentioned, were approved

Pant, Priyadarshini M, Kaur, Harprit, PhD, ""Tales of Psychosocial Horror and Hate": Implications for Unmarried Pregnant Indian Women's Safety, Health and Choice of Safe Abortion," *International Research Journal of Pharmacy and Medical Sciences (IRJPMS)*, Volume 7, Issue 5, pp. 98-103, 2024.

by each of them. The participants were thanked in the end, for their support.

Information obtained during the clinical interviews was utilized for narrative analysis. The interviews were conducted in the vernacular language and were translated in English for reporting purposes.

Ethical Considerations

This academic endeavour followed all ethical parameters. The participants were assured of confidentiality and were explained that the information would only be utilized for scientific deliberations, intending larger clinical and social good. No risk/harm of any kind was associated with participation. Patients received no remuneration, monetary benefits or incentives of any kind, for their participation.

IV. Case Histories

Case-1:

Ms. H, 28 years old, unmarried, Hindu, formally qualified MBBS Doctor, working as a medical officer in Maharashtra, belonging to upper socio-economic status, lived with her family in an urban area, was referred for psychotherapy after a diagnosis of panic attacks (1-2 attacks a day, total duration of illness -5 months), continuous-deteriorating course and severe socio-occupational dysfunction. On evaluation, she reported having gone through a trauma, which she didn't disclose but reported preoccupation with associated disturbing thoughts & nightmares. The working diagnosis of post traumatic disorder mas made.

In the 4th session, patient very hesitantly opened up about undergoing an abortion (DNC) for 8 weeks long pregnancy, 5 months back, in a far-flung rural place without any medical assistance, compromised sterilization and safety. She reported that a middle-aged man, who conducted the procedure, extorted money, blackmailed, slapped and manhandled her. She suffered infections post the procedure, which she self-medicated for. She reported severe distress arising after the abortion as she constantly worried about infertility, infections and dreaded the catastrophic consequences of social shame and isolation. In her words, “I will lose my job, my hard work will go down the drain, I now anyway have grim prospects of getting married and having a family in the future. I can’t get over the fear of people getting to know about me, out of my head. I’ve witnessed other doctors, including my superiors and colleagues demeaning unmarried women who come to the hospital for abortions. These women are usually a tea time discussion and I too shall be one, I’ll be labelled as a “sex maniac” or an “immoral being.”

She reported feeling lonely as she longed for social support but had none during this difficult time. Fear of privacy, harsh and hostile social judgement, maintenance of a medical record with her personal details and identity proof, pushed her to take a decision that she knew was otherwise very unsafe.

Case -2:

Ms. K, 22 years old, unmarried, Sikh, formally enrolled in B.Tech civil engineering 2nd year belonging to middle socio-economic status, lived alone in a private girls’ hostel in Delhi. Patient was brought into a private nursing home by her hostel mates with the complaints of profuse vaginal bleeding, severe abdominal pain and vomiting. On examination she was found to have a severe infection caused by the remnants of an aborted fetus. The abortion was induced with hormonal pills for an almost 6-week long pregnancy, assisted by non-medical personnel who demanded a huge sum of money from her, which she had to arrange by selling her laptop very cheap and had to lie to her parents, about it being stolen. There were no medical examinations whatsoever (except a urine pregnancy test to diagnose the pregnancy) before or after the procedure to determine right mode of abortion or to ensure the success of the procedure. Patient stabilized after the treatment but suffered reproductive health trauma and infertility. Her parents were made aware by the hospital staff about her medical history while getting their consent for the treatment procedures. They decided to cancel her admission and take her home. Her hostel owners cancelled her accommodation and Institute instituted an enquiry, following disciplinary action against her in the matter.

The case was referred for patient and family counselling. Patient was found to have unprocessed grief, guilt, self-loathing and fear of being disgusted at. In her words, “I will never be able to conceive, I’m an infertile woman, I have no future, No one will marry me, forget marriage, I am left with nothing, no career, no friends, my family won't speak to me, they’ll never forgive me, why am I alive, why didn’t I die, I am a burden, I can never look them in the eye, I am finished”. The patient had severe anxiety and active suicidal ideas for which she was treated by a multidisciplinary psychiatric team.

She reported resorting to unsafe abortion as she didn’t know about the associated grave consequences which indicated lack of reproductive and psycho-sexual education and awareness, extreme fear of social judgement, stigma, fear of family’s reactions and extraordinary shame. During the family counselling sessions, her parents were found to be severely distressed, they exhibited intense expressed emotions (criticism and hostility). Her father said that he wished she would have died as she brought them a bad name and humiliation in society. `` The patient's mother believed that the patient was being punished for her “bad karmas” as God took away her fortune to become a mother. Both the parents firmly believed that the patient was “good for nothing” and had lost the essence of womanhood.

Case-3:

Ms. L, 25 years old, unmarried, Hindu, formally educated as master in economics , working as a school teacher in UP, belonging to upper socio-economic status, living with her family in an urban area, presented for psychotherapy with low mood, lack of energy and interest in previously enjoyable activities for 4 years, frequent headaches (moderate-severe, frequency 2-3 a week, continuous-deteriorating course, not managed even after 1 year of prophylaxis treatment for migraine), significantly decreased sleep and somewhat low appetite (no significant weight changes) for about 1 - 2 years continuous deteriorating course with moderate social-occupational dysfunction. The medical investigations ruled out any medical causes for the existing complaints. During the

Pant, Priyadarshini M, Kaur, Harprit, PhD, ““Tales of Psychosocial Horror and Hate”: Implications for Unmarried Pregnant Indian Women’s Safety, Health and Choice of Safe Abortion,” *International Research Journal of Pharmacy and Medical Sciences (IRJPMS)*, Volume 7, Issue 5, pp. 98-103, 2024.

initial course of therapy, the patient dodged questions about her past, but insisted that the therapist must convince her parents not to find her a groom as she isn't ready to get married. Clinical interviews and findings of psychological tests were suggestive of severe issues with self-concept, mild depressive symptoms and moderate anxiety.

Interviews with her parents revealed that about 4 years earlier, she stopped going to temples or religious places, and didn't participate in religious rituals and functions. She never gave any reasons for this change of behavior and used to get very angry with repeated questions. She didn't go to any functions, especially those involving child-births, didn't carry or play with small babies or children. All these things were starkly different from her pre-morbid personality, which was very religiously inclined, God fearing, friendly, loving and playful towards children. During therapy, the patient had a break-down and she reported having under-gone an induced abortion about 5 years ago, while she was pursuing her final year of graduation and stayed away from her family for her education. She shared about her romantic relationship with one of her classmates, who continuously persuaded her for physical intimacy despite her strict reservations against sexual relationships before marriage. She gave in to his demands as he threatened to leave her. He did not use protection even though that was the patient's primary condition for consent. When she shared with him about the pregnancy, he blamed her for cheating and she was subjected to physical abuse. Fearing social judgement, she went for an induced abortion (3-week pregnancy) carried out with the help of hormonal pills brought by her then partner, from a local chemist. "I didn't know what to expect, I was in a lot of pain, I lost a lot of blood, my stomach hurt a lot, I thought that I'll die but I could not tell anyone, I could not even cry, It wasn't just the baby, I died along with it, My career, character, future, everything, was finished."

Her ex-boyfriend blamed her for being a murderer, sinner and a characterless woman. He quit ties with her. All this coupled with the isolation added to her moral, emotional, ethical agony which left her feeling disgusted and disappointed with herself. She strongly believed that she was unacceptable for any man and that she was perishable in God's eye, for her irreversible sinister acts.

V. RESULTS AND DISCUSSION

The following themes emerged through the narrative analysis of the presented three cases

Harsh, Hostile, Rigid and Limiting Socio-Cultural Beliefs About Women's Sexuality, Unintended Pregnancies and Abortions with Heavy Emotional Tone, Religious and Ethical Code of Conduct and Quick Judgements

As observed in all three cases, social norms and taboos become impediments in a woman's decision-making and discourage her from approaching safe abortion care and add to the trauma. Makleff et al. (2019) noted the impact of stigma on abortion choices and age of unmarried women. Abortion is an integral part of reproductive health care and advancements in medical science provide rather simpler and cost-effective solutions for unplanned pregnancies. There however, still is a great deal of stigma surrounding the topic. There is a sincere need to bring a shift in the social attitudes towards women's sexuality and the limiting ideologies surrounding sexually active unmarried women, unintended pregnancies occurring out of wedlock and women opting for induced abortions. Sexuality is a part of holistic health and well-being and has to be seen that way. The number of unmarried women in India undergoing induced abortions for unintended pregnancies is growing every decade but social taboos about the issue push the matter under the carpet and there aren't many deliberations attempting to encourage open fruitful conversations about the matter. Women shall only be able to opt for the medical care that they deserve when there is a society that respects their sexual choices, well-being and prefers educating them over moral preaching.

Multifaceted Damage and Severe Multidimensional Consequences

The conditions in which the unsafe abortions are carried out are not only hazardous to the woman's physical health but extremely damaging to their personal, social, emotional and spiritual health while putting them in the danger of a wide range of traumatic experiences and exploitation. As noted in all three cases, it scars their sense of self, robs them of their well-being and negatively affects their functioning. Shahbazi (2011) in a qualitative study conducted in Iran concluded that the consequences of unsafe termination of unintended pregnancy were widespread and could be broadly grouped as physical, psychological, socio-political and judicial. Women are subjected to extraordinary punishments like social isolation, intense criticism, violence, extreme labels, interpersonal, academic and occupational consequences. Their pregnancy and abortion tend to take centrality while assessing their capabilities, careers, potential and conduct and negatively influence their overall life.

Limiting Concept of Womanhood, Centrality of Gender Stereotypes and Overemphasis on Procreation

The three cases, especially the second one, offer a peek into the restrictive, damaging, and derogatory view of womanhood. A female's sexual attractiveness, ability to perform gender stereotypical roles like, taking care of family members selflessly, adherence to socially prescribed behaviours and above all, getting married, child bearing and child rearing are considered central for a woman. Often, in Indian culture, women aren't considered "whole" if they for any reason are single or can't conceive. Grey (2017) explains the detailed historical fore bearings of profound stigma against women's infertility and presents a painful yet comprehensive understanding of immense social pressures for women coming from all walks of life to become mothers and its relationship with the rapidly growing infertility treatment market in contemporary India. Patel et al. (2018) conducted a cross - sectional study on Indian couples undergoing fertility treatments with a diagnosis of primary infertility. They attempted to understand the socio-cultural determinants of infertility stress in the sample. The findings of the study cited

Pant, Priyadarshini M, Kaur, Harprit, PhD, ""Tales of Psychosocial Horror and Hate": Implications for Unmarried Pregnant Indian Women's Safety, Health and Choice of Safe Abortion," *International Research Journal of Pharmacy and Medical Sciences (IRJPMS)*, Volume 7, Issue 5, pp. 98-103, 2024.

social coercion to be one of the main contributors for stress in patients suffering from infertility and emphasized the importance of interventions designed to address social attitudes towards infertility.

Lack of Adequate Sexual and Reproductive Health Education for Equipping Women to Become Informed Decision Makers

The second and third case highlight the status of psycho-sexual and reproductive health education in our country, Shankar et al. (2017) conducted a study in Pune, India, to assess reproductive health awareness and the most preferred source of sexual health information, amongst adolescent girls of a government school in an urban slum. The findings suggested that 80% of the respondents were unaware of the physiological changes related to secondary sexual characteristics in both the genders; most participants did not know about contraceptive measures and less than 30% of the participants had awareness about contraception; understanding of pre-marital sex predominantly revolved around social-shame, bad character and was perceived as a matter of humiliation for the family for 57% of participants, only 9 % were aware of urinary tract infections (UTIs) and 22% had an idea of Sexually transmitted diseases (STIs) like HIV as a health concern associated with sexual activities. 70% of the respondents reported feeling uncomfortable discussing sexual health concerns with parents and only preferred discussing the matters with their friends and class-mates, who also had a limited understanding and lack of adequate education. There is an urgent need to empower women's understanding of reproductive health.

Unprocessed Complicated Grief, Shame, Guilt, Trauma, Isolation and Serious Mental Health Related Problems

Most pronounced part of the verbalizations in all the cases involved severe emotional turmoil. Bradshaw et al. (2003) reported significant levels of depressive symptoms, anxiety, sexual dysfunction in women, post abortion and also noted that abortion could be seen as a form of emotional trauma. Fergussen et al. (2006) suggested that abortion in young women can negatively impact their mental health.

VI. LIMITATIONS, IMPLICATIONS AND FUTURE DIRECTIONS

Sample of the present study (n=3) is a small sample size, which remains both as a limitation as well as an inspiration to pursue future work in this direction. This area warrants more psycho-social attention pertaining to theoretical advancements and practical applications to bring about a desirable socio-cultural reform directed at promoting improved health and well-being of women. The following are some applications and research directions for further research in this area.

Building age-specific, effective and comprehensive educational modules for pre-teen, teen, adolescent and adult women across the country to equip them with medical, psychological, social, spiritual understanding of reproductive health, hazards, precautions, preventions and treatment: Ismail et al. (2015) noted that the role of adequate sexual education programs cannot be emphasized enough but the various socio-cultural obstacles like strong social stigma, and controversies make the delivery of such programs difficult and somewhat impossible, leaving the vulnerabilities understated. Some of the major negative impacts of poor reproductive health awareness are: unintended pregnancies in women (married or unmarried), unsafe abortions, sexually transmitted infections and sexual violence (WHO, 2010).

Educational and awareness programs aiming at decreasing the intense emotional tone, social taboo, ethical and moral obligatory baggage associated with women's reproductive health, out of wedlock pregnancy and induced abortions are required. Khubchandani et al. (2014) while emphasizing the need for a much-needed policy reform for sexual education in India rightly said, "we are bound by our culture, but isn't, "science" the culture," of modernity?"

Advertising accessible medical health care options for reproductive health related concerns including abortions in order to bring it in the public's awareness and at the same time initiate social conversations. Grimes et al. (2006) rightly calls unsafe abortions as a "preventable pandemic".

Need for appropriate training and sensitization of medical professionals and assisting staff. Sjöström et al. (2014) conducted a study on the medical students' attitudes and perceptions on abortion in Maharashtra. The research findings revealed that about one quarter of the research participants believed abortion to be a morally incorrect act, one fifth of the respondents considered abortions to be unacceptable for unmarried women and one quarter of the respondents strongly believed that partner or spouse's approval for abortion was necessary. The researchers noted that most participants understood the potential health hazards associated with unsafe abortions but only 13% of them had any relevant clinical experience of dealing with abortions. This study highlights the need to train the medical students as unbiased, non-judgmental, approachable professionals who are able to assist the patients with not only their medical knowledge and skill but also with a much-needed human touch that shall improve the doctor-patient relationship and prove to be a prominent agent of change in promoting women's sexual and reproductive health.

Facilitating emotional and psychological health check-up pre and post abortions: Women go through an emotional turmoil before and after the abortions and this could continue to affect their well-being for a longer while. Akdag et. al (2019) reported high levels of anxiety, depression and need for social support amongst women going through therapeutic abortions. Timely interventions could predict proper management.

Need based referrals to mental health professionals should be made for processing grief, overcoming shame, guilt, fear and other emotions that might be infesting a patient's mind.

Development of standard emotional first-aid psychotherapy and counselling protocols to assist women who undergo termination of pregnancies (Upadhyay et al., 2010), noted the utility of counselling for handling abortion related distress and described some psychotherapeutic approaches that could be utilized as a framework for abortion counselling.

A revision of legal statements that can clearly state the law for abortions among unmarried/single women is the need of

Pant, Priyadarshini M, Kaur, Harprit, PhD, ""Tales of Psychosocial Horror and Hate": Implications for Unmarried Pregnant Indian Women's Safety, Health and Choice of Safe Abortion," *International Research Journal of Pharmacy and Medical Sciences (IRJPMS)*, Volume 7, Issue 5, pp. 98-103, 2024.

the hour. The current law in the country does not specifically mention much about single or unmarried women, seeking abortions for unintended pregnancies. Restrictive and ambiguous laws have a potential to be misused and this can foster unethical, illegal practices and people's inclination to seek those services. A law reform in this area shall support women empowerment, prevent the unnecessary associated traumas and encourage women to seek the right kind of help whenever needed. Varkey et al. (2000) in a study conducted on a rural community of South India, highlighted the high prevalence of unsafe abortions and preference for untrained providers among women, for their induced abortions. Researchers further noted the lack of legal understanding regarding abortion laws and disparity of available services in rural areas. Latt et al. (2019) confirmed a strong link between abortion laws and maternal mortality. They noted that a legal system with clear, flexible, pro-women abortion laws can bring down the high rates of maternal mortality.

Legal and social efforts are needed to eliminate the illegal set-ups for eradicating the unethical practices, quacks and pseudo-professionals offering various health care services especially the gray market of abortions for unmarried women.

VII. SUMMARY AND CONCLUSION

Pregnancy is a significant life event involving an increased sense of responsibility. Unplanned pregnancy can be stressful, especially in cultures that do not consider it appropriate or deem it sinful. Sadly, even after technological advancement and rapid steps towards globalization, perception of women's sexuality, reproductive health and functioning, remain mostly patriarchal, narrow and stereotypical in India. Poor awareness, lack of education, enormous taboo around the subject, are some of the major barriers for unmarried Indian women, to seek safe termination of unintended pregnancy.

Crippling fear, arising from harsh socio-cultural judgements against pregnancy out of a wedlock, forces unmarried women to opt for induced abortions which are a potential threat for their safety, security, health and well-being. There is a need for a socio-cultural, legal and educational reform to address this burning issue that can be achieved by appropriate individual, group, government and non-government endeavours, directed at addressing the various concerns associated with the matter. Haddat et al. (2009) noted the crucial importance of proper sexual and reproductive health education, adequate understanding of and access to effective contraception, facilities for safe abortions, a women health friendly legal system and well-timed interventions for abortion related complications, for preventing almost every abortion related death and disability.

REFERENCES

[1]. Akdag Topal, C., & Terzioglu, F. (2019). Assessment of depression, anxiety, and social support in the context of therapeutic abortion. *Perspectives in psychiatric care*, *55*(4), 618-623. https://doi.org/10.1111/ppc.12380

[2]. Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., ... & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*, *8*(9), 1152-1161. https://doi.org/10.1016/S2214-109X(20)30315-6

[3]. Bhattacharya, S., Mukherjee, G., Mistri, P., & Pati, S. (2010). Safe abortion–Still a neglected scenario: a study of septic abortions in a tertiary hospital of Rural India. *Online Journal of Health and Allied Sciences*, *9*(2).

[4]. Bradshaw, Z., & Slade, P. (2003). The effects of induced abortion on emotional experiences and relationships: a critical review of the literature. *Clinical psychology review*, *23*(7), 929-958. https://doi.org/10.1016/j.cpr.2003.09.001

[5]. Fergusson, D. M., John Horwood, L., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry*, *47*(1), 16-24. https://doi.org/10.1111/j.1469-7610.2005.01538.x

[6]. Ganatra, B., Gerdts, C., Rossier, C., Johnson Jr, B. R., Tunçalp, Ö., Assifi, A., ... & Alkema, L. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *The Lancet*, *390*(10110), 2372-2381. https://doi.org/ 10.1016/S0140-6736(17)31794-4

[7]. Geneva: WHO; 2006. WHO. Defining sexual health. [Google Scholar]

[8]. Geneva: WHO; 2010. World Health Organization. Measuring sexual health: Conceptual and practical considerations. [Google Scholar]

[9]. Grey, D. J. (2017). 'She Gets the Taunts and Bears the Blame': Infertility in Contemporary India. In *The Palgrave Handbook of Infertility in History* (pp. 241-262). Palgrave Macmillan, London.

[10]. Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., & Shah, I. H. (2006). Unsafe abortion: the preventable pandemic. *The lancet*, *368*(9550), 1908-1919. https://doi.org/ 10.1016/S0140-6736(06)69481-6

[11]. Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality. *Reviews in obstetrics and gynecology*, *2*(2), 122. PMCID: PMC2709326

[12]. Ismail, S., Shajahan, A., Rao, T. S., & Wylie, K. (2015). Adolescent sex education in India: Current perspectives. *Indian journal of psychiatry*, *57*(4), 333. https://doi.org/10.4103/0019-5545.171843

[13]. Jain, V., Saha, S. C., Bagga, R., & Gopalan, S. (2004). Unsafe abortion: a neglected tragedy. Review from a tertiary care hospital in India. *Journal of Obstetrics and Gynaecology Research*, *30*(3), 197-201. https://doi.org/10.1111/j.1447-0756.2004.00183.x

[14]. Khubchandani, J., Clark, J., & Kumar, R. (2014). Beyond controversies: Sexuality education for adolescents in India. *Journal of family medicine and primary care*, *3*(3), 175. https://doi.org/ 10.4103/2249-4863.141588

[15]. Latt, S. M., Milner, A., & Kavanagh, A. (2019). Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries. *BMC women's health*, *19*(1), 1-9. https://doi.org/10.1186/s12905-018-0705-y.

[16]. Makleff, S., Wilkins, R., Wachsmann, H., Gupta, D., Wachira, M., Bunde, W., ... & Baum, S. E. (2019). Exploring stigma and social norms in women's abortion experiences and their expectations of care. *Sexual and reproductive health matters*, *27*(3), 50-64. https://doi.org/ 10.1080/26410397.2019.1661753

[17]. Patel, A., Sharma, P. S. V. N., Kumar, P., & Binu, V. S. (2018). Sociocultural determinants of infertility stress in patients undergoing fertility treatments. *Journal of human reproductive sciences*, *11*(2), 172. https://doi.org/10.4103/jhrs.JHRS_134_17

[18]. Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A. B., Daniels, J., ... & Alkema, L. (2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet global health*, *2*(6), e323-e333. https://doi.org/10.1016/S2214-109X(14)70227-X

[19]. Shahbazi, S. (2012). The consequences of unsafe abortion: a qualitative study. *Journal of advanced nursing*, *68*(6), 1247-1255. https://doi.org/10.1111/j.1365-2648.2011.05826.x

[20]. Shankar, P., Dudeja, P., Gadekar, T., & Mukherji, S. (2017). Reproductive health awareness among adolescent girls of a government school in an urban slum of Pune City. *Medical Journal of Dr. DY Patil University*, *10*(2), 133. https://www.mjdrdypu.org/text.asp?2017/10/2/133/202101

[21]. Singh, S., & Maddow-Zimet, I. (2016). Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *BJOG: An International Journal of Obstetrics & Gynaecology*, *123*(9), 1489-1498. https://doi.org/10.1111/1471-0528.13552

[22]. Sjöström, S., Essén, B., Sydén, F., Gemzell-Danielsson, K., & Klingberg-Allvin, M. (2014). Medical students' attitudes and perceptions on abortion: a cross-sectional survey among medical interns in Maharastra, India. *Contraception*, *90*(1), 42-46. https://doi.org/10.1016/j.contraception.2014.02.005.

[23]. Upadhyay, U. D., Cockrill, K., & Freedman, L. R. (2010). Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient education and counseling*, *81*(3), 415-421. https://doi.org/10.1016/j.pec.2010.08.026

[24]. Varkey, P., Balakrishna, P. P., Prasad, J. H., Abraham, S., & Joseph, A. (2000). The reality of unsafe abortion in a rural community in South India. *Reproductive Health Matters*, *8*(16), 83-91. http://doi.org/10.1016/s0968-8080(00)90190-3

[25]. Verma, Kavita, Abraham Thomas, Arun Sharma, Aruna Dhar, and Vishal Bhambri. "Maternal mortality in rural India: a hospital based, 10 year retrospective analysis." *Journal of Obstetrics and Gynaecology Research* 27, no. 4 (2001): 183-187. https://doi.org/10.1111/j.1447-0756.2001.tb01249.x

[26]. Yokoe, R., Rowe, R., Choudhury, S. S., Rani, A., Zahir, F., & Nair, M. (2019). Unsafe abortion and abortion-related death among 1.8 million women in India. *BMJ global health*, *4*(3), e001491. https://doi.org/10.1136/bmjgh-2019-001491.