Kaleidoscope
Championing Reproductive Justice
Centered Health Systems

THE ABORTION LANDSCAPE IN TAMIL NADU

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Rural Women's Social Education Centre (RUWSEC)
61, Karumarapakkam Village, Veerapuram (Post)
Thirukazhukundram (Via) Chengalpattu District,
Tamil Nadu, South India-603109.
Phone: 044-29542751 / Mobile: +91 98429 19110
Email: ruwsec.tn@gmail.com ; project@ruwsec.org
Website: www.ruwsec.org

In Collaboration with:
ARROW, Malaysia – Kaleidoscope Project

Production Team:
Writers:
Dr. T.K. Sundari Ravindran, Dr. Bhuvaneswari Sunil
Mr. Nesar Ahmad, Dr. Lata Ramaseshan, Dr. P. Balasubramanian
Dr. R. Bhavani, Mrs. V. Revathy

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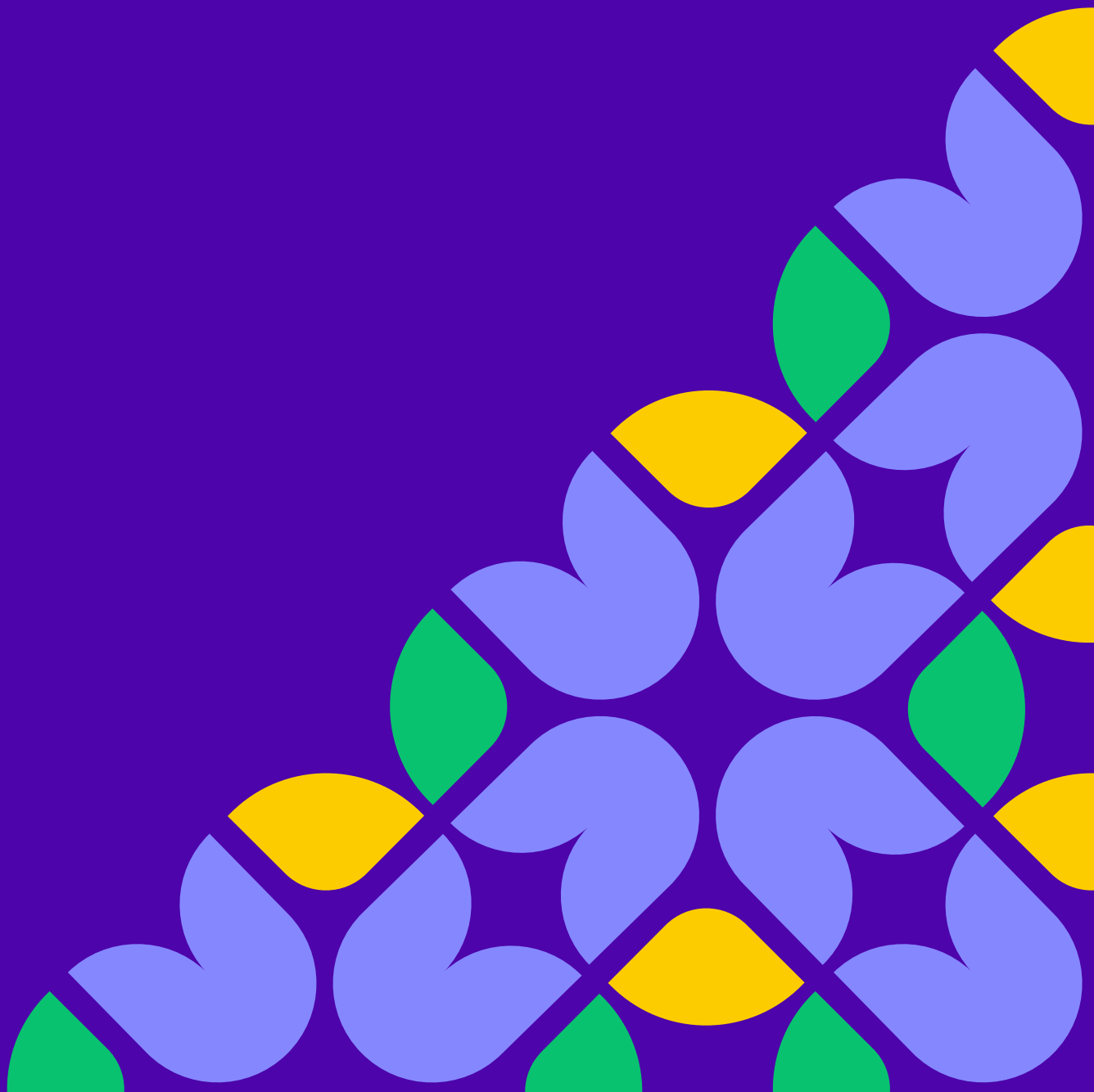

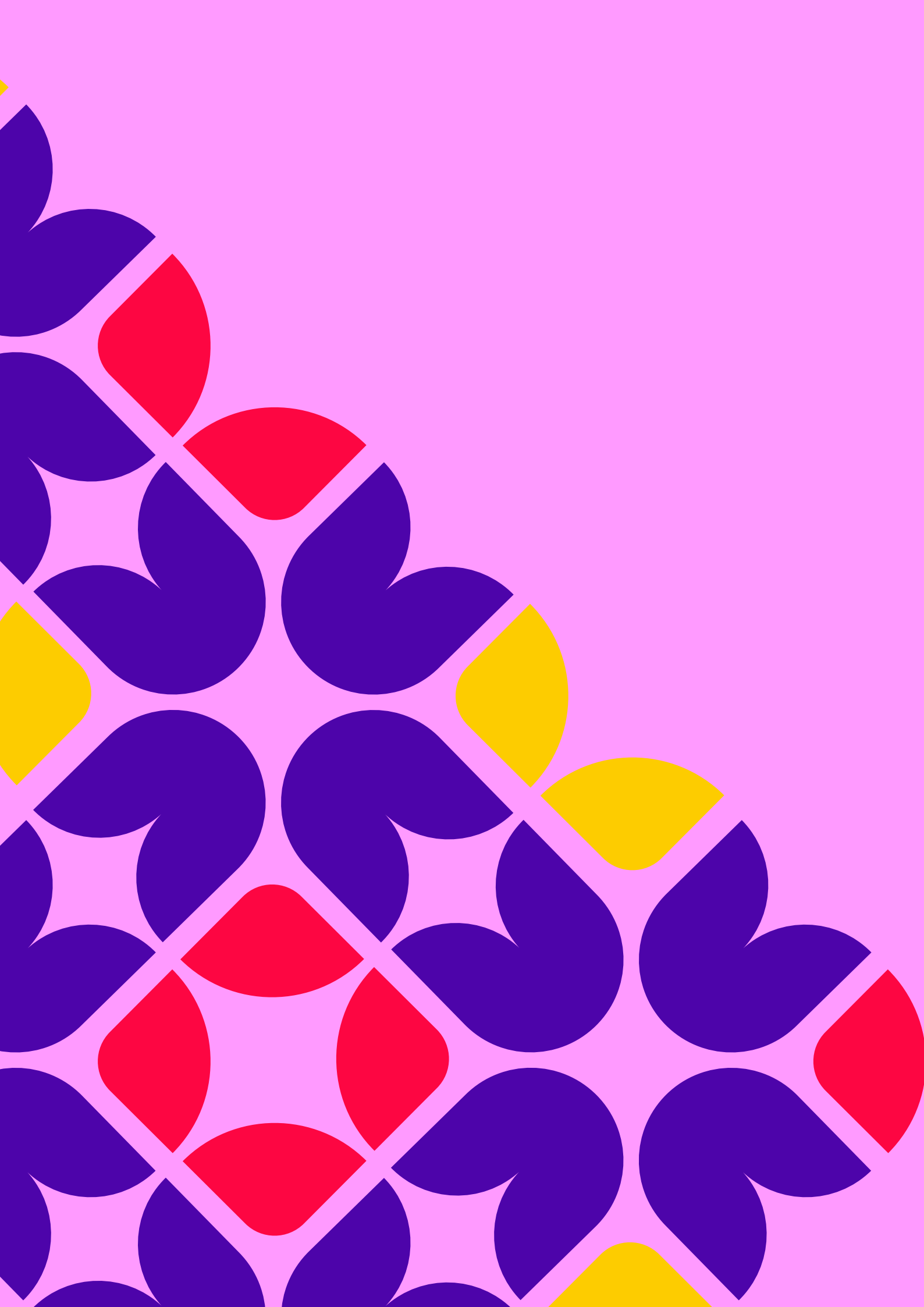

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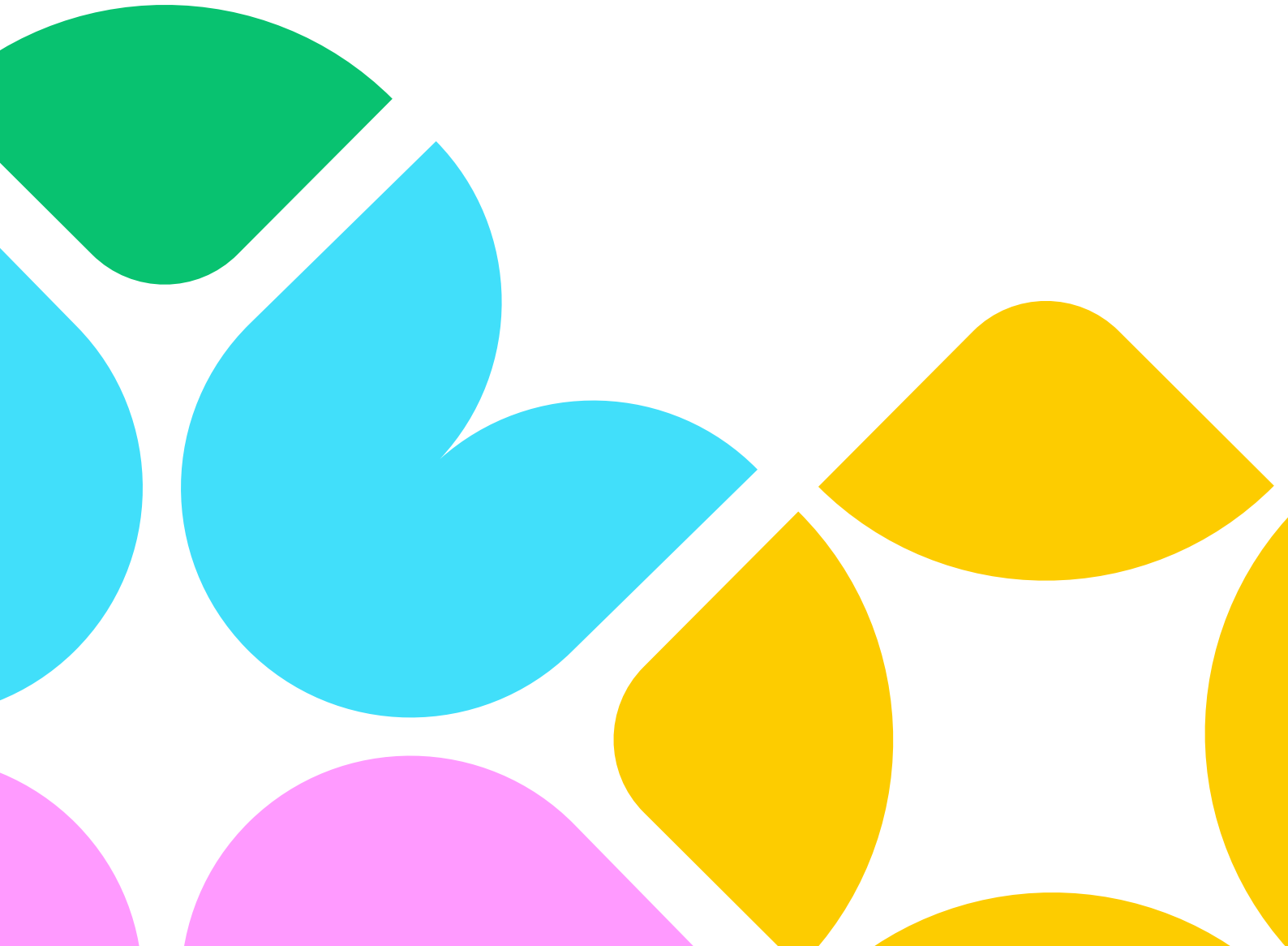
RUWSEC Team



Content

Chart 1

Graph 1

Graph 2

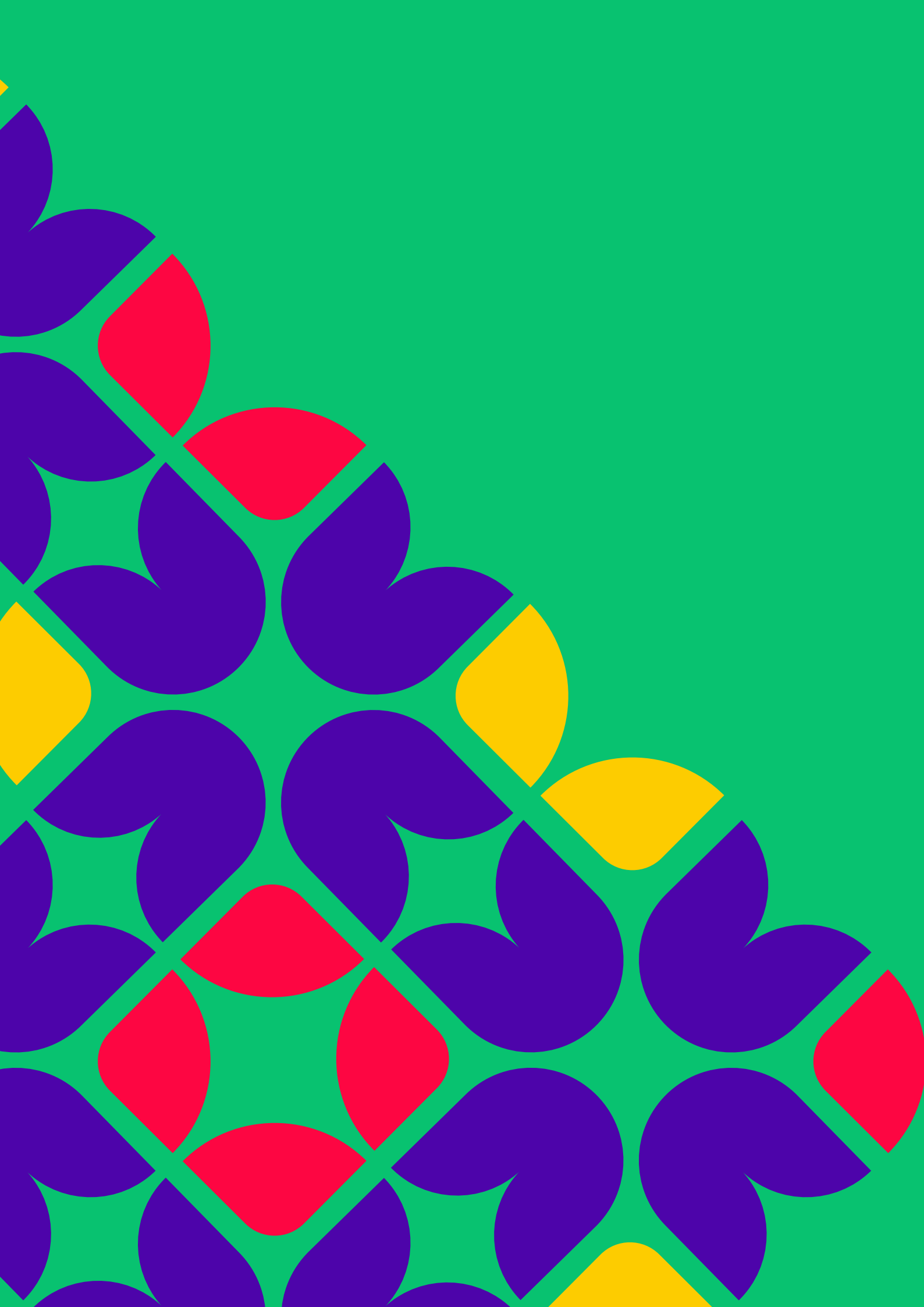
Graph 3

Graph 4

Graph 5

Graph 6

Reference



Chapter 1

Background and State Profile

1.1 Introduction

Kaleidoscope is a transnational initiative by organizations in the Global South working for sexual and reproductive health, rights, and justice (SRHRJ). The Initiative's vision is "A world where people who can get pregnant, including youth and those from the most marginalized groups, can exercise their rights and access quality, safe, affordable, and comprehensive abortion care within just and inclusive health systems without experiencing stigma, discrimination, or violence. The Initiative adopts a systems approach to advancing high-quality, safe, and comprehensive abortion care as an integral component of achieving the objective of universal access to SRHRJ.

The Kaleidoscope Initiative is led by a Consortium of four organizations: The Mobilizing Activists Around Medical Abortion (MAMA) Network, Kenya; the Women's Global Network for Reproductive Rights (WGNRR); the Global Fund for Women (GFW); and the Asian-Pacific Resource and Research Centre for Women (ARROW). The Consortium works through partners in four countries: Benin and Kenya in Africa, and India and Nepal in South Asia. The Kaleidoscope's India partners include CommonHealth – Coalition for Reproductive Health and Safe Abortion, working at the national level; SAHAJ, working in Gujarat and Maharashtra; and Rural Women's Social Education Centre (RUWSEC), working in six districts of Tamil Nadu, viz., Chengalpattu, Dharmapuri, Kancheepuram.

This document synthesizes the baseline reports prepared by RUWSEC during the first year of the Kaleidoscope Initiative, on various facets of the abortion landscape in Tamil Nadu.

Rural Women's Social Education Centre (RUWSEC) is a non-governmental women's organisation founded in 1981 and based in the Chengalpattu district, Tamil Nadu. RUWSEC works to promote women's well-being through empowerment, with a strong focus on gender equality and sexual and reproductive health and rights (SRHR). The organisation primarily works with women, adolescents, and young people from poor and marginalised rural communities, particularly Dalit communities, supporting them to gain greater control over their bodies, health, and lives.

RUWSEC's programmes focus on improving community health and well-being, promoting comprehensive sexual and reproductive health education for adolescents and youth, supporting the SRHR of women, and preventing intimate partner violence. Through community capacity building, healthcare services, research, and advocacy, RUWSEC empowers individuals and communities to become informed, confident, and active participants in social change and local governance.

The findings from this synthesis are viewed as an input to planning for activities for the years 2026-

2029 that would contribute to enabling access to comprehensive abortion care in public facilities for the most marginalized groups. The document is organised into four chapters. In addition to providing a brief background, this Chapter describes the data sources used in this document. It then presents a profile of Tamil Nadu, focusing on its health system context and reproductive health situation. Chapters two and three constitute the core of the document. Chapter two describes the abortion landscape in Tamil Nadu. In contrast, Chapter Three provides an overview of the landscape in the six intervention districts, drawing on district-level official data and stakeholder consultation perspectives. The final Chapter draws on the findings to make recommendations for changes that will help enhance women's access to safe abortion in Tamil Nadu and their reproductive health and rights.

1.2. Data sources used in the report

S.No	Data Sources	Key Information
1	Report on the abortion scenario in Tamil Nadu prepared by RUWSEC, 2025. The above report was based on secondary data, review of studies on abortion in India and Tamil Nadu, and Health and Family Welfare Statistics published by the Government of Tamil Nadu.	The background information on Tamil Nadu contained in this Chapter and Tamil Nadu's abortion landscape in Chapter 2 are based on this report.
2	Policies and Budget for Access to Safe Abortion Services in Tamil Nadu. Prepared by RUWSEC, 2025. The above report was based on an analysis of the NHM Programme Implementation Plan and Record of Proceedings for 2020-2025, with a focus on RCH and CAC allocation and expenditure patterns.	The data on budgetary allocations and expenditures for Comprehensive Abortion Care (CAC) in Chapter 2 is based on this report.
3	Analysis of Family Welfare Monthly Bulletin, April 2020 – March 2025, and National Family Health Survey: Tamil Nadu (NFHS-5, 2019–21)	The data on MTPs presented in Chapter 3 are based on medical termination of pregnancy data from the state and the six intervention districts.
4	Reports of state and district launches and stakeholder consultations of the Kaleidoscope programme, June-December 2025, prepared by RUWSEC, 2025.	The summary of key SRHR concerns and issues raised by stakeholders at the state and district levels in the six intervention districts, presented in Chapter 3, is based on seven reports: one at the state level and six at the district level.
5	Report on Stakeholder Mapping Analysis in Tamil Nadu, RUWSEC, 2025. This report was based on an analysis of web-based sources, print and electronic media sources, including social media.	The information presented in Chapter 3 on the positions of different stakeholders on abortion at the district and state levels, their levels of influence, power, and interest in CAC, is based on this report.

1.3 An Overview of The Socio-Demographic, Economic, And Health Systems Situation In The State

This section presents the overall demographic characteristics, the economic and social performance, and the public health systems and polices for the state of Tamil Nadu.

1.3.1 Demographic Characteristics

According to the 2026 population projections, Tamil Nadu is the seventh-largest state in India, accounting for approximately 5.43% of the Indian population. It has a population of 77.55 million, with 38.65 million males and 38.89 million females. The state's projected urban population is 55.29 per cent of the total population. Table 1 presents key projected demographic indicators for the state.

Table 1: Demographic indicators, Tamil Nadu

Indicators	2021-2025 (Projections)		2026 - 2030 (Projections)	
	Tamil Nadu	India	Tamil Nadu	India
Population growth rate	3.0	9.0	1.4	7.3
Crude Birth Rate (CBR)	11.6	16.0	10.6	14.4
Crude Death Rate (CDR)	8.5	7.0	9.1	7.1
Infant Mortality Rate (IMR)	19	35.3	18	32.3
Under-5 mortality rate	22	46.7	21	42.8
Total Fertility Rate (TFR)	1.54	1.94	1.52	1.81
Life expectancy at birth of males	70.90	69.37	71.7	70.37
Life expectancy at birth of females	75.04	72.66	75.84	73.66

Source: [1]

Tamil Nadu has a slower rate of population growth and lower fertility and birth rates than the national average. The health outcomes are better in Tamil Nadu, with lower infant and under-5 mortality rates, alongside higher life expectancy for both men and women. As per the 2011 Census, 20% of the state's population belonged to the Scheduled Castes (SCs), and 1% to the Scheduled Tribes (STs). [2]

1.3.2 Socio-economic situation

Tamil Nadu's per capita income of ₹2.78 lakh in the 2022-23 fiscal year was 1.6 times the national average, ranking fourth among states. According to the National Multidimensional Poverty Index (MPI) calculated by NITI Aayog, Tamil Nadu has seen a significant decline in its poverty rate. The Head Count Ratio (Proportion of the population that is multidimensionally poor) has reduced from 36.5% in 2005-06 to 1.4% in 2022-23. [3]

Tamil Nadu has a better educational status than the national average across all indicators. In 2023-24, the state had a literacy rate of 85.5% among people aged seven and above. [4] In 2024-25, the Gross Enrolment Ratio (GER) in Tamil Nadu was 54.3% for foundational level (Pre-primary to Class 2), 91.7% in preparatory level (Class 3 to Class 5), 97.6% in middle schools (Class 6 to Class 8), and 89.4% in secondary schools (Class 9 to Class 12). Tamil Nadu ranks first among major states in the country, with a 47% GER in higher education, compared to the national average of 28.6%. [5] At all these levels, girls' enrolment ratio is higher than boys', with a Gender Parity Index of 1.0 at the foundational, preparatory, and middle school levels, and 1.1 at the secondary level. [5]

1.3.3 Gender-based inequalities

Tamil Nadu's sex ratio at birth (SRB), a lower value indicating a greater extent of gender-biased prenatal sex selection, was 933 females per 1000 males in 2021-23, higher than the national average of 917. [6]

Findings from NFHS-5 (2019–21) highlight persistent gender and caste-based disparities in employment and economic inclusion. Only 42.8% of women aged 15–49 was employed in the year preceding the survey, compared with 83.5% of men aged 15–54, indicating limited access to paid work for women. Access to financial resources remains limited, particularly among marginalized caste groups. While more than 90% of women across all groups have a bank account, only 21.1% of SC, 16.3% of ST, and 16.8% of OBC women have ever taken loans from microcredit programs. [7]

Limited access to employment, credit, assets, and digital resources continues to reinforce structural inequities in financial autonomy and participation. Gender gaps persist in asset ownership as well. 60.4% of men, compared with 47% of women, own a house alone or jointly, and 26.3% of men, compared with 21.9% of women, own or co-own land. In an increasingly digital environment, access to personal mobile phones remains unequal. 81.2% of urban and 68% of rural women reported having a phone they use themselves. In comparison, the proportion is even lower among marginalized caste groups—54.7% of ST, 67.9% of SC, and 78.1% of OBC women. [7]

The NFHS-5 (2019-2021) data for Tamil Nadu reveal notable social and gender disparities in nutritional outcomes. Men report a significantly higher daily intake of pulses and beans (27 percentage points higher) and dark green leafy vegetables (around 32 points higher) compared to women, indicating better access to protein- and iron-rich foods. Women, on the other hand, consume milk or curd slightly more often than men (about 4 points higher), reflecting a gendered dietary pattern leaning more toward dairy products. Nutritional inequities are also evident across caste groups, with a higher proportion of Scheduled Caste (4.7%) and Scheduled Tribe (3.9%) women suffering from severe anaemia compared to women from OBC (3.0%) and other communities (3.7%). [7]

Gender-based violence is a serious concern in Tamil Nadu, reflecting deep-rooted gender discrimination and unequal power relations. According to NFHS-5, 41.1% of women in the state have ever experienced physical or sexual violence. In most cases (78.8%), the perpetrator is the husband, followed by the mother or stepmother (25.2%) and the father or stepfather (13.9%). [7]

In recent years, many flagship initiatives addressing women have been introduced in the state. Some of them, such as Vidiyal Payanam (Journey towards a new dawn), Pudhumai Penn (New Age Woman), and Kalaignar Magalir Urimai Thittam (Kalaignar's Women's Rights Scheme), have aimed to improve women's access to transportation, microfinance, education, and government schemes. [8]

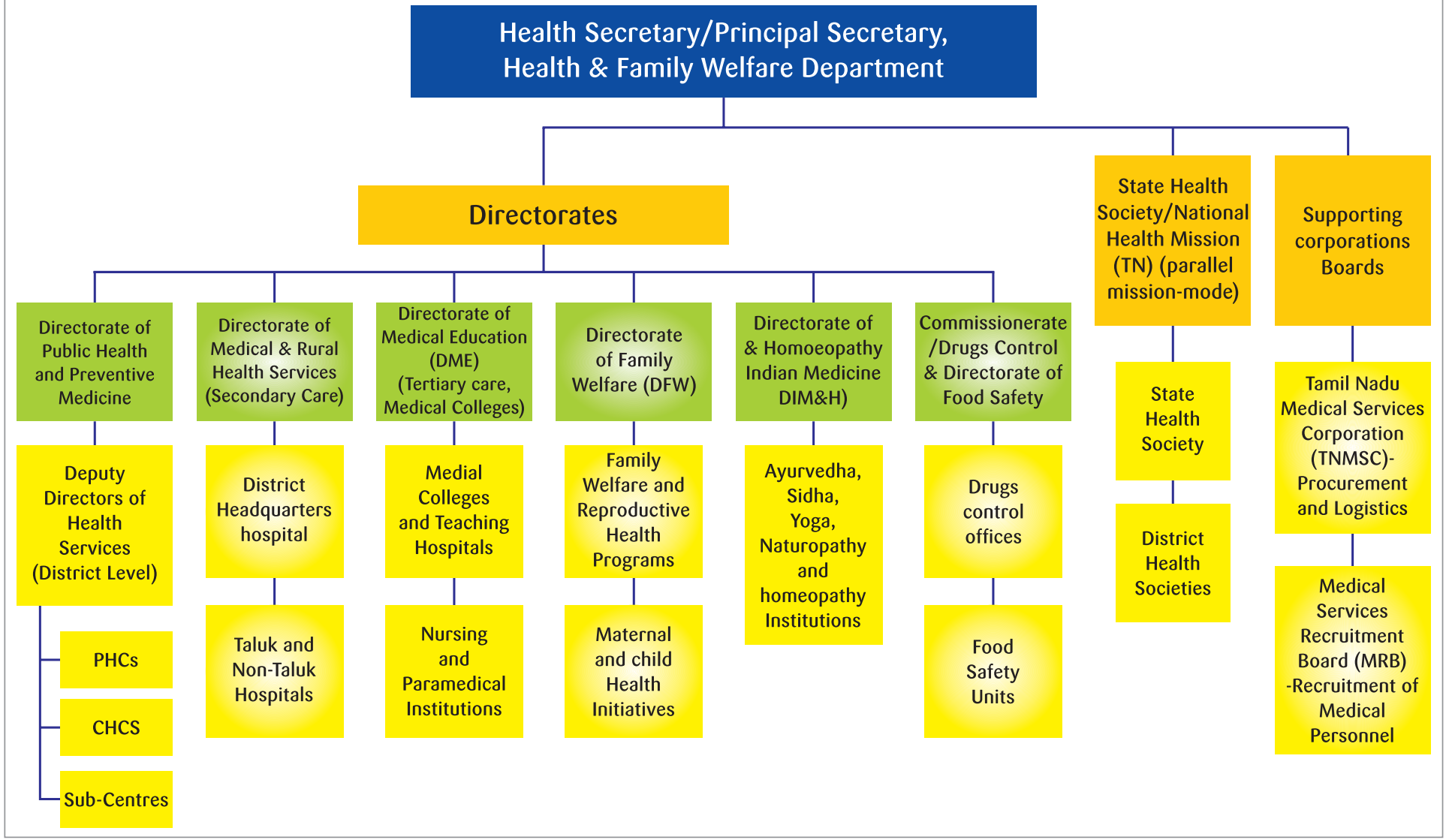
1.3.4 Health System and Policy Context

Some of the earlier research conducted in Tamil Nadu to understand the functioning of the public health system highlights that Tamil Nadu's dedicated public health cadre at the district level is a unique feature among Indian states. [9-10] This cadre-driven model, supported by the Tamil Nadu Public Health Act, 1939, has provided the legal and policy scaffolding necessary to sustain a health-focused development process and ensure effective devolution of resources between state and local bodies. [11]

Tamil Nadu's public health system has the unique distinction of being organized into six major directorates, in addition to autonomous entities such as the Tamil Nadu Medical Services Corporation. Its decentralized organization offers the state's public health system the potential for administrative efficiency. At the same time, there is also the risk of fragmentation and challenges in providing coordinated services, because services at different levels are under the jurisdiction of different directorates.

In each district, Medical College Hospitals and their affiliates function as tertiary-level institutions and come under the Directorate of Medical Education. Taluk (sub-district) Hospitals, Non-Taluk Hospitals, and District Headquarters Hospitals, which operate at the secondary level, are administered by the Directorate of Medical and Rural Health Services.

Figure 1: Organogram of the Health and Family Welfare Department, Tamil Nadu, India



Source: https://tnhealth.tn.gov.in/tngovin/dms/dms.php

Community Health Centres (CHCs), Primary Health Centres (PHCs), and Health Sub-Centres (HSCs) serve at the primary level, administered by the Directorate of Public Health and Preventive Medicine. In urban areas, there are urban PHCs and health posts. Additionally, outreach activities are carried out through Mobile Medical Units (MMUs). A stand-alone Directorate of Health and Family Welfare is responsible for delivering maternal and child healthcare, and contraceptive and safe abortion services.

Despite robust infrastructure compared to other Indian states, the state has scope for improvement in human resources and the population-to-bed ratio if the public sector alone is considered. The state's doctor-population ratio in the public sector is 1:20,018 as compared to the WHO-recommended ratio of 1:1000. [12] The current bed-to-population ratio in the public sector is 1:2534 persons [12], falling short of the Indian Public Health Standards (IPHS) 2022, which set 1 bed per 1000 population, and the WHO recommendation of 3 beds per 1000 population.

The Tamil Nadu State Health Policy Vision 2030 marks a progressive step toward the Right to Health. It outlines a systems-based approach that focuses on comprehensive improvements across infrastructure, service delivery, governance, and equity, aligned with Sustainable Development Goal 3 – Good health and well-being. The policy advocates that women's health concerns extend beyond maternal issues and require mainstream attention within health systems. It also highlights women's empowerment as a critical determinant of better population health. [8]

The health agenda to address gaps in health care delivery is addressed through the Makkalai Thedi Maruthuvam (MTM) (Medical care at people's doorstep) programme, a home-based service launched in 2021 to tackle non-communicable diseases such as hypertension and diabetes. A 2024 study by the State Planning Commission found that MTM has achieved deeper penetration in rural areas and among SC/ST communities. Importantly, it has reached a higher proportion of women than men—82.49% vs. 79% for hypertension screening, and 81% vs. 77% for diabetes. Among those screened for hypertension, 50% of women received doorstep services compared to 40% of men, indicating a deliberate effort to overcome barriers faced by rural and marginalised women. While participation in cancer screenings under MTM remains low (only 4% for oral, cervical, and breast cancers), the programme marks a step toward inclusive health care. [13]

1.4. Reproductive health situation

Tamil Nadu presents a mixed picture in terms of the reproductive health status of women aged 15-49 years, with remarkable achievements in some areas and limited progress with respect to a range of other reproductive health indicators. Table 2 presents key reproductive health indicators for Tamil Nadu in 2019-21. [7, 14]

Tamil Nadu's Total Fertility Rate (TFR) has been declining steadily over the years, reflecting a widespread preference for smaller families and the success of family planning efforts. According to the various rounds of NFHS, the fertility rate in Tamil Nadu declined from 2.5 in 1990-1992 to 2.2 in 1998-99, and 1.76 in 2019-21. Although the median age at marriage is 22 years, 13% of women aged 20–24 was married before reaching the legal minimum age of 18 years.

Table 2: Key Indicators of Reproductive Health, Tamil Nadu and India, NFHS-5 (2019-2021) [7]

Indicators	Tamil Nadu [7]	India [14]
Fertility		
Total Fertility Rate (TFR)	1.8 children per woman	1.99 children per woman
TFR (Urban)	1.6 children per woman	1.63 children per woman
TFR (Rural)	1.9 children per woman	2.14 children per woman
Total Wanted Fertility Rate	1.6 children per woman	1.6 children per woman
Marriage		
Median age at first marriage among women aged 25-29 years	22.0 years	18.8 years
Women aged 20-24 years married before attaining the legal minimum age of 18 years.	13%	23%
Pregnancy and births		
Teenage pregnancy: young women aged 15-19 who have begun childbearing	6.3%	6.8%
Median interval between births	35.6 months	32.7 months
Contraceptive prevalence and unmet need for contraception		
Contraceptive prevalence rate - Any modern method	65.5%	56.4%
Spacing	7.6%	18.3%
Limiting	57.9%	38.2%
Unmet need for family planning	7.5%	9.4%
Spacing	3.0%	4.0%
Limiting	4.5%	5.4%

About 6.3% of women aged 15–19 have already had a live birth or are pregnant with their first child. The proportion of women who have started childbearing increases sharply from 2% at age 17 to 19% by age 19, suggesting early initiation of childbearing among a section of adolescents. [7].

1.4.1 Maternal Health

Government policies in Tamil Nadu have placed sustained emphasis on maternal and child health (MCH), as reflected in its strong performance across key MCH indicators. According to NFHS-5, the state achieved 90.4% full immunisation coverage, 99.6% of institutional births—of which 66.9% occurred in public facilities—and timely postnatal care for 93.2% of mothers and 94.4% of children within two days of delivery.

The state's Maternal Mortality Ratio (MMR), as reported by the Sample Registration System (SRS), has declined from 97 per 100,000 live births in 2007-09 to 35 per 100,000 births in 2021-23. [15] Tamil Nadu has consistently maintained a significantly lower MMR than the national average, with the latest figures showing a 60% gap. A recent study of 79 maternal deaths in Chengalpattu (2017–2022) showed that 64.6% of deaths were due to direct obstetric causes. Sepsis accounted for 17.6%. Unsafe abortion-related complications accounted for 3.9%. [16]

Significant disparities persist in maternal healthcare access, quality, and outcomes. NFHS-5 data (2019-21) reveal wide inter-district variations in the utilisation of public-sector facilities – ranging from 85.8% in Tiruvannamalai district to 39.4% in Kanyakumari. Caesarean rates range from 27.7% to 68.3%, indicating variability in obstetric practices and raising concerns about adherence to standard clinical guidelines, governance of private-sector practices, and out-of-pocket expenditures for private deliveries. [7]

1.4.2 Contraceptive and other Reproductive Health Care

Contraception

The contraceptive prevalence rate (CPR) in Tamil Nadu has increased from 53% during 2015-16 (NFHS-4) to 66 % during 2019-21 (NFHS-5). Female sterilisation remains the most widely used method, rising by eight percentage points from 49% to 58% between the two survey rounds and accounting for the highest share of modern contraceptive use. [7] Among modern spacing methods, intrauterine devices (IUDs) are the most common (5%), followed by condoms (2%). Other methods include the emergency contraceptive pill (0.3 %), injectables (0.2 %), and male vasectomy (0.1 %). The contraceptive method-mix in Tamil Nadu highlights the limited male responsibility for contraception and underscores persistent gender norms that place the responsibility for contraception primarily on women.

Other reproductive health conditions

Few studies on health care access for women beyond maternal health have received less attention. NFHS-5 data reveal that only 9.8% of women have undergone cervical cancer screening, and a mere 5.6% have had breast cancer examinations—highlighting a significant gap in preventive care for reproductive health issues beyond maternal health. [7]

Chapter 2
The abortion landscape in Tamil Nadu

Forty-three percent of pregnancies in Tamil Nadu in 2015 were estimated to be unintended [17]. While some women continue with unintended pregnancies, many women have no option but to seek an abortion and will require access to safe abortion services. Universal access to safe abortion services would affirm women's right to reproductive autonomy and support their health, dignity, and well-being. This section examines the abortion situation in Tamil Nadu, including the state's policy commitment, the availability and utilization of abortion services, and the barriers to access.

2.1 Policy commitments and budgetary allocations for safe abortion in Tamil Nadu

2.1.1 Supportive policy environment

The Medical Termination of Pregnancy (Amendment) Act, 2021, applies to all the states of India. The MTP Act permits abortion up to 20 weeks with the opinion of one registered medical practitioner in cases of risk to the woman's health, rape, incest, or contraceptive failure—applicable to both married and unmarried women. Between 20 and 24 weeks, abortion is allowed with the approval of two medical practitioners, to survivors of sexual assault, minors, and women with physical disabilities. Beyond 24 weeks, termination is permitted only in cases of substantial foetal abnormalities, as certified by a state-level Medical Board. The Act also upholds the woman's autonomy by requiring only her consent if she is an adult, while minors or mentally ill women need guardian consent. Confidentiality of the woman's identity and medical details is mandated, and abortions must be performed by qualified registered medical practitioners in government-approved facilities. [18]

Tamil Nadu's commitment to safe abortion services was first articulated in 1995 through Government Order (GO) Ms. No. 353 issued by the Health and Family Welfare Department. This directive sought to position safe abortion within the broader maternal and child health and family welfare framework, with an emphasis on promoting institutional care and skilled delivery. [17, 19]

By 2007, under the National Health Mission, the state began training and approving providers to offer safe abortion services. Manual Vacuum Aspiration (MVA) techniques were introduced during RCH Phase I (1997–2002) as pilot efforts across five districts. These were later scaled up during RCH Phase II to all block-level Primary Health Centres (PHCs), aiming to reduce unsafe abortions and, in turn, maternal mortality and morbidity. [9, 20] A safe abortion policy was drafted in 2011-12, but this was never formally adopted.

However, the proposed safe abortion policy from 2011–12 was never formally adopted. The various years (post 2011-12) of the Record of Proceedings (ROPs) of the PIPs mention the comprehensive abortion care services for MVA kits and training of providers.

Following the 2021 Amendment to the MTP Act, Tamil Nadu set up 32 Medical Boards to handle Medical Termination of Pregnancy (MTP) cases. [21] Although the MTP Act mandates Medical Boards only for pregnancies beyond 24 weeks, a Government Order specifies that these boards are to examine cases referred by the courts for pregnancies beyond 20 weeks. There is thus a

discrepancy between the legal threshold set by the Act and the operational scope defined by the state's administrative order.

The Tamil Nadu Health and Family Welfare Policy Note (2025–26) describes comprehensive abortion care (CAC) as having a woman-centred approach. It includes safe abortion, post-abortion care, and family planning. The policy states that safe abortion is available up to 24 weeks under the MTP Act, and beyond 24 weeks in cases of substantial foetal anomalies, with approval from permanent medical boards. The policy also proposes a 12-day training programme for Medical Officers on CAC. This training covers safe and high-quality abortion care, reproductive rights, legal aspects, counselling skills, clinical assessment, and infection prevention. [22]

In consonance with the supportive policy environment, results from a stakeholder mapping exercise also pointed to the presence of state-level civil society organizations and professional organizations

Stakeholder consultations in six districts evidenced broad-based support for CAC among policymakers within the health sector, senior obstetrician/ gynaecologists, and other public-sector service providers. Many service providers articulated access to safe abortion as an issue of bodily autonomy and human rights. A similar view was expressed by community-based organizations working for women's empowerment and prevention of violence against women and girls, as well as those working on health education.

2.1.2 Budgetary allocations and expenditures for CAC

Budgetary allocations for CAC and Family Planning at the state level are drawn from the Reproductive and Child Health (RCH) budget, funded by the Government of India through the National Health Mission (NHM). The total approved budget for the NHM in Tamil Nadu has declined by over 13%, from Rs. 3929.20 crores in 2022-23 to Rs. 3410.30 crores in 2025-26. The decline will be steeper if adjusted for the state's average retail inflation (CPI) of more than 5% during this period.[1] This decline in Tamil Nadu's NHM budget occurred despite increases in the central government's NHM budget and in Tamil Nadu's total health sector budget over the last three years.[2] Available data show low budget utilization at 81.23% in 2022-23 and 75.21% in 2023-24. The declining NHM budget in the state and the high level of underutilization of that budget indicate a lower priority accorded to the programme in Tamil Nadu.

Over the years, more than 50% of the total NHM budget in Tamil Nadu has been allocated to Health System Strengthening (HSS). A considerable share of the NHM budget also goes towards Infrastructure Maintenance (IM), which increased from about 14.66% in 2022-23 to 16.32% in 2025-26. The share of Reproductive and Child Health (RCH) in the NHM budget, which includes Comprehensive Abortion Care among others, has declined from about 14% in 2022-23 to about 10% in 2025-26. The RCH budget also declined in absolute terms, from Rs. 538.69 crores in 2022-23 to Rs. 355.29 crores in 2025-26.

[1]Calculated from the retail inflation data given in TN Economic Survey 2024-25, available on: https://financedept.tn.gov.in/en/my-documents/2020/07/ES-TN-Book.pdf [3]
[2]https://prsindia.org/files/budget/budget_state/tamil-nadu/2025/TN_Budget_Analysis_2025-26.pdf [23]

Table 3 presents the total budget allocated for CAC in Tamil Nadu during 2022-23 and 2025-26.

Table 3: Budget for Comprehensive Abortion Care (CAC) and Family Planning under NHM in Tamil Nadu (Rs. Lakhs and proportion of RCH budget)

	2022-23		2023-24		2024-25		2025-26	
	Budget Proposed	Budget Approved	Budget Proposed	Budget Approved	Budget Proposed	Budget Approved	Budget Proposed	Budget Approved
Comprehensive Abortion Care	178.4 (0.32%)	193.6 (0.36%)	178.4 (0.34%)	193.6 (0.37%)	86.12 (0.25%)	86.12 (0.25%)	124.92 (0.34%)	120.94 (0.34%)
Family Planning	3900.87 (6.95%)	3656.33 (6.79%)	3900.87 (7.43%)	3656.33 (6.91%)	2516.12 (7.22%)	2516.12 (7.22%)	2711.46 (7.48%)	2711.46 (7.48%)

Source: RoPs and Supplementary RoPs of NHM Tamil Nadu[3]

[3]Proposed and approved amounts include amounts proposed and approved in Supplementary RoPs.

As shown in the table above, family planning services account for about 7% of the total RCH budget, while CAC accounts for less than 0.5%. The modest amount allocated for CAC has declined between 2022-23 and 2025-26. Although the data on MTP show an increasing trend in recent years (see Graph 2), the budget for CAC in 2025-26 remains lower than the approved budget for CAC in 2022-23. Family Planning services under the RCH component of the NHM have also seen a decline in the budget over the years. The total family planning budget under NHM in the state has declined from Rs. 36.56 crores to Rs. 27.11 crores during 2022-23 to 2025-26.

Components and Targets of the CAC Programme

The CAC budget is used to provide necessary drugs (MMA Combi pack/Mifepristone and Misoprostol) and equipment (Manual Vacuum Aspiration/ Electrical Vacuum Aspiration), and to provide MTP training to medical officers and obstetrician/ gynaecologists in all public health facilities. It was targeted to equip 722 public health facilities (PHCs and CHCs) with the necessary drugs and equipment, and train 725 medical officers in MTP in the year 2022-23. The same targets were set for the years 2023-24, 2024-25, and 2025-26. In other words, 100% of the public health facilities are equipped with drugs and equipment, and 725 MOs are trained each year. The RoP 2024-26, however, does not mention the number of public health facilities; it only mentions the percentage (100%).

Table 4: Details of CAC Budget for the years 2024-25 and 2025-26 (Rs)

Item	Unit	No. of units	Per unit Cost (Rs.)	Total (Rs.)
MVA Kits	Number	600	2600	1560000
MMA Kits	Number	31429	35	1100015
MTP Training	Batch of 5	5	57750	288750
MMA Training	Batch of 8 for 3 days each	65	37980	2468700
Printing for and registers				518000
MTP Foam boards	Number	28	3000	84000
Block-level one-day sensitization workshops on Safe Abortion Services for VHN/UHN, MLHP, Staff Nurses (RCH), ANMs, and ASHAs	Number	388	10000	3880000
Total				98,99,465

Source: RoP and Supplementary RoP of TN NHM for the year 2024-26[4]

[4]Total budget for one year as per the details comes to about Rs. 99 lakhs and Rs. 198 lakhs for two years which is almost same as the total CAC budgets for the years 2024-25 and 2025-26.

As the table above shows, the budget clearly specifies the number of drugs and the number of CAC training sessions to be conducted for medical officers in the state. It also provides for the Block-level one-day sensitization workshops on Safe Abortion Services for Village Health Nurses and Urban Health Nurses, Mid-level Health Providers (MLHPs), Staff Nurses (RCH), Auxiliary Nurse Midwives (ANMs), and Accredited Social Health Activists (ASHAs). No such details, however, are available for the CAC budget for the years 2022-23 and 2023-24. It only says that Rs 178.40 lakhs is approved for MVA & procurement, CAC Medical Officer training, and Information, Education and Communication (IEC), and Rs 15.20 Lakhs for the procurement of Digital Foam Board 3' x 2' size for Safe Abortion each year. Since the RoP only mentions the approved budget and head-wise expenditures under the NHM are unavailable, it is difficult to determine the actual CAC spending in Tamil Nadu. However, as previously noted, the NHM expenditure data for 2022-23 and 2023-24 indicate poor utilization of approved NHM budgets, which may also be the case for CAC budgets.

There is, however, some information on CAC/MTP and MMA training in the Health and Family Welfare Department's Policy Note for the years 2024-25[5] and 2025-26. The Policy Note for the year 2025-26 mentions two types of training for the Medical Officers:

- A 12-day training of Medical Officers on Comprehensive Abortion Care / Medical Termination of Pregnancy
- A 3-day training for the Medical Officers on the Medical Method of Abortion

As per the Policy Note, 378 Medical Officers (MOs) and 555 Medical Officers (of PHCs and UPHCS) were trained in the Medical Method of Abortion between 2023 and 2025. Further, 334 and 244 MOs underwent the 12-day CAC/MTP training in 2023-24 and 2024-25, respectively. Data on the training for the current year (2025-26) are not yet available.

[5]https://cms.tn.gov.in/cms_migrated/document/docfiles/hfw_e_pn_2023_24.pdf [24

2.1.3 The Administrative Set-up for Medical Termination of Pregnancy

One of the goals of the Family Welfare Programme in Tamil Nadu is to provide Comprehensive Abortion Care to prevent maternal and infant mortality. A Joint Director (MTP) in the Directorate of Family Welfare (DoFW-TN) under the Department of Health and Family Welfare is responsible for the provision of CAC services at the state level. The Joint Director (MTP) is assisted by the Deputy Director (Demography) and the Deputy Director (Inspection)[6].

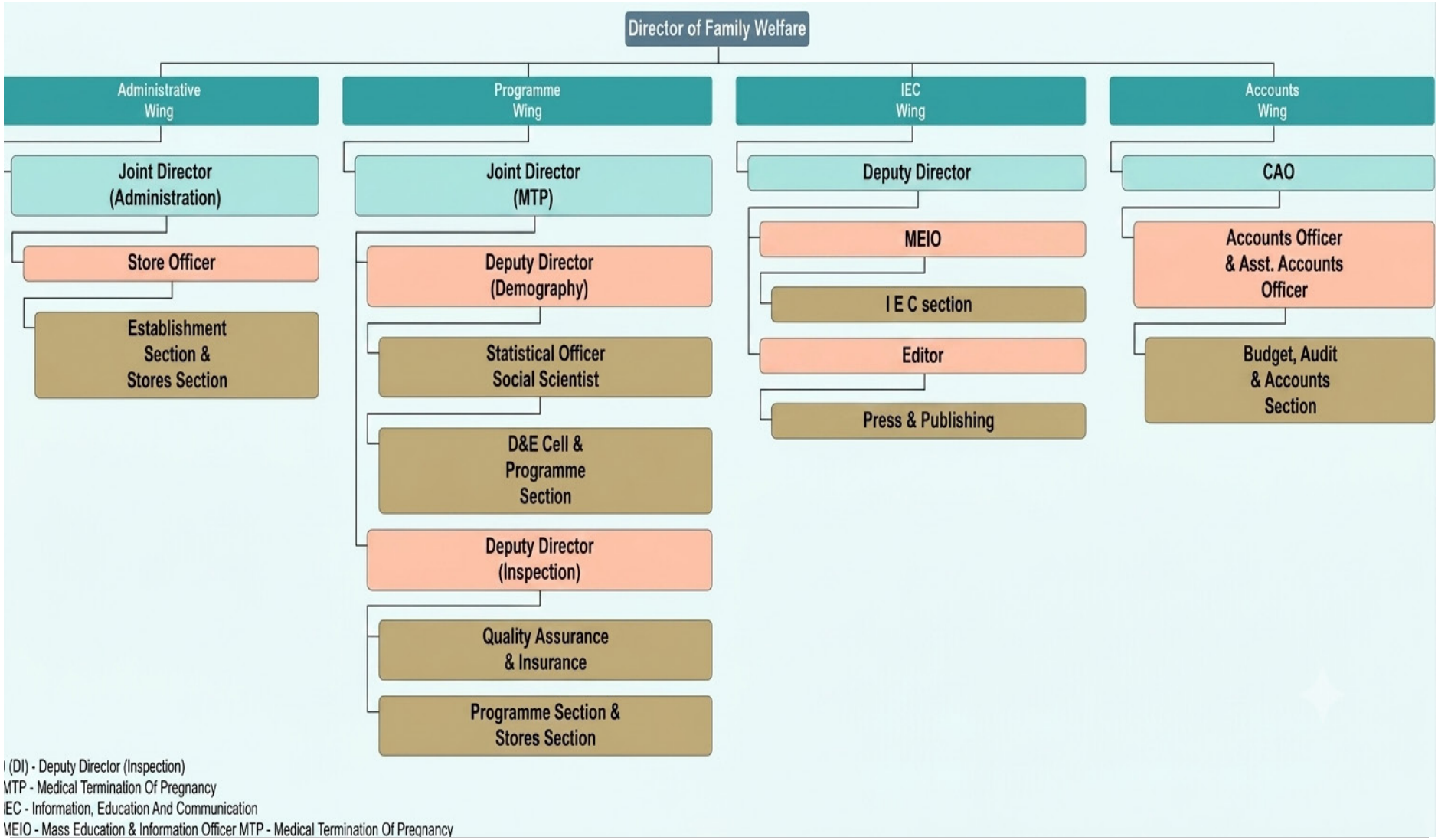
There are also District Level Committees for the approval of private nursing homes for performing MTPs in the state.

According to the DoFW-TN website, family planning and CAC services are provided through 108 urban family welfare centres, 110 postpartum centres, 193 urban health posts, 382 rural family welfare centres, 2581 approved nursing homes, and 27 voluntary organisations.[25] The website lists several methods of abortion available in public health facilities. These include Medical Vacuum Aspiration (MVA), Medical Methods of Abortion (MMA), Electronic Vacuum Aspiration (EVA), and other approved techniques. Services must be available for up to 12 weeks of pregnancy at all government PHCs and for up to 20 weeks at postpartum centres and urban family welfare centres. When trained providers or essential equipment are not available at the primary level, women are referred to secondary or tertiary care institutions. [25] However, a study by the Guttmacher Institute (2018) found that 56% CHCs and 29% public hospitals offered no abortion related services in the state of Tamil Nadu[7].

[6]https://tnhealth.tn.gov.in/tngovin/dfw/dfw.php [25]

[7]https://www.guttmacher.org/fact-sheet/provision-abortion-and-postabortion-services-tamil-nadu-2015 [26]

Chart 1: Organisational Structure of the Directorate of Family Welfare

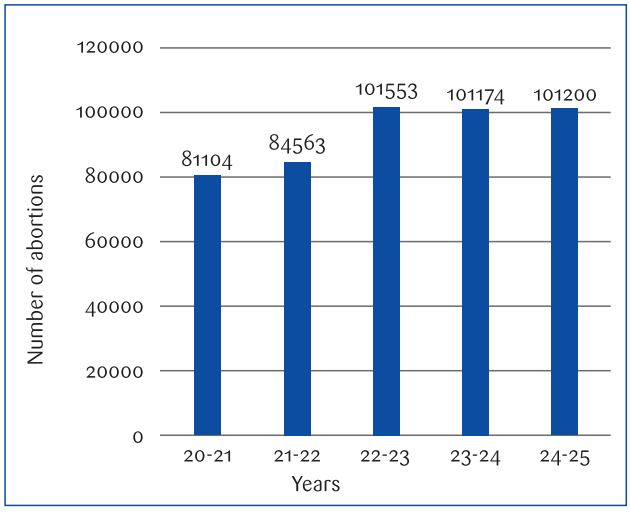


Source: https://tnhealth.tn.gov.in/tngovin/dms/dms.php

2.2. Abortion incidence

The reported number of abortions during 2020-21 and 2024-25, according to official statistics, increased from 81104 to 101200. [27] There are reasons to believe that these official figures are significant underestimates. According to the Guttmacher Institute study (2015), the number of induced abortions in Tamil Nadu was 7,07,900, of which approximately 228,600 induced abortions, or 32% of abortions in the state, occurred in healthcare facilities. [17] When we compare the two sources of data, the official figures (about 1.01 lakh annually) appear to represent only around 44% of the estimated 2.28 lakh facility-based abortions reported in the 2015 Guttmacher study. In other words, roughly 56%, or about 1.27 lakh facility-based abortions, are likely not being captured in official reports.

An estimated abortion rate (number of abortions per 1000 women of reproductive age 15-49 years) for various districts of Tamil Nadu, based on the mid-year election projection of the 2023 population and the abortions reported in 2023, indicates that only a few districts have an abortion rate of 6.1 or above. Most districts exhibit an abortion rate below 6 per 1000 women within the reproductive age group of 15-49 years. This may again be an underestimate, because the Guttmacher study estimated an abortion rate of 33 in 2015.



Graph 1: Number of abortions reported in Tamil Nadu between April '20 to March '25

2.3. Reasons for Abortion

According to NFHS-5, the top two reasons for women in rural Tamil Nadu to undergo abortion were unplanned pregnancy (38.4%) and health not permitting a pregnancy (31.6%). On the other hand, for urban women in Tamil Nadu, health issues were the most important reason (29.4%), followed by unplanned pregnancy (18%), and economic reasons (13.5%). In both urban and rural areas, a tiny percentage of women said they had an abortion after sex determination, because the foetus was female (1.6%) or male (0.8%).[7] In other studies conducted in Tamil Nadu, the main reasons emerged to be spacing or unwanted pregnancy, non-consensual sex, and sexual violence. Pregnancy was unwanted due to cultural beliefs, economic conditions, and marital status, and these were reasons why women chose to have abortions. [28-29]

2.4. Facilities Providing Abortion Services

According to government reports, 5227 health facilities were providing safe abortion services in Tamil Nadu during 2024-25 [17]. This included 2581 approved private hospitals, 27 voluntary organizations, 36 government medical college hospitals, 230 district and sub-district government hospitals, 2353 CHCs, PHCs, and UPHCs.

The data reveal a significant concentration of abortion service provision in private and tertiary-level public facilities. Of the total reported MTPs in the monthly Family Welfare Bulletin (March 2025), 67.2% were performed in 2,581 approved private hospitals, while 1.2% were attributed to 27 voluntary organizations, [27] an annual average of only 26 abortions per private facility and 44 per voluntary organization. Thus, while private facilities dominate numerically, caseloads in individual health facilities remain modest.

Table 5: Total number of institutions authorised to provide abortion and estimated average per annum abortions per facility for 2024-2025.

Health Facilities	Total number of institutions	Average per annum abortion load per institution (24-25)
Medical College hospitals	36	360
District HQ & Government Hospitals	230	57
CHCs, PHCs &UPHCs	2353	3
Voluntary organisations	27	44
Approved Private hospitals	2581	26
Total Institutions	5227	19

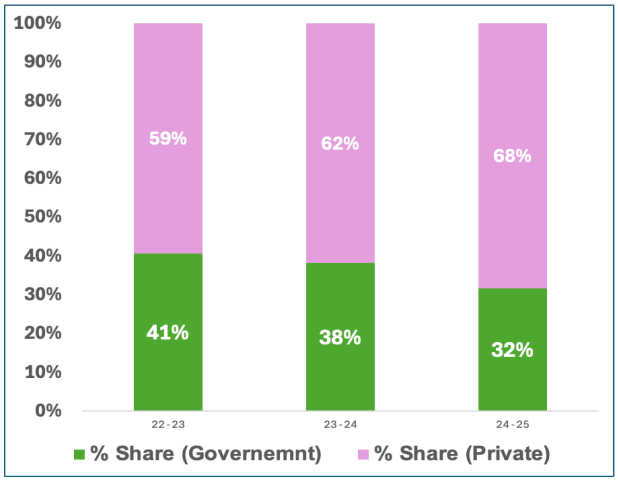
Source: Estimated from [27], March 2025 issue

In the public sector, medical college hospitals carry the highest burden, with an average of 360 abortions per year, followed by district headquarters hospitals at 57 per year. In contrast, CHCs and PHCs report the lowest numbers, indicating that safe abortion services are largely unavailable at the primary care level.

According to official figures from the Government of Tamil Nadu (Graph 2), abortion services in public facilities declined from 41% in 2022-23 to 32% in 2024-25, with a concomitant increase in the share of the private health sector. [27]

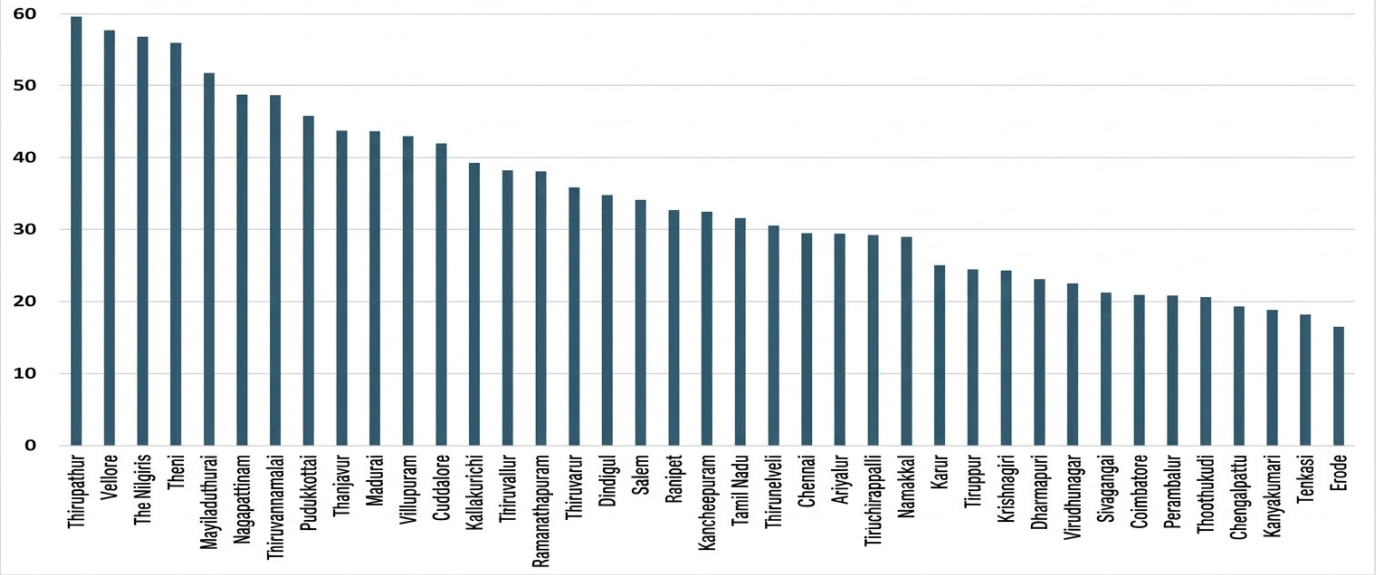
Brander et al. (2025) highlight that in several states of India, including Tamil Nadu, nurses and doctors in public facilities reportedly shame patients seeking abortion [30]. Women in an earlier study likewise raised concerns regarding the quality of care, denial, delays, potential verbal abuse, or harassment. Abortion-seekers who were unmarried women or minor girls feared being reported to the police by health providers, further contributing to their reluctance to seek abortion services in public hospitals. [29]

However, there are inter-district variations in public sector provision. An analysis of public-sector provision of MTP services across districts (Graph3) for the period April 2024 to March 2025 shows that the public sector accounts for more than 50% of the MTPs in five districts: Tirupathur, Vellore, The Nilgiris, Theni, and Mayiladuthurai. In contrast, less than 20% of the MTPs occurred in public health facilities in four districts: Erode, Tenkasi, Kanyakumari, and Chengalpattu.[27]



Graph 2: % share of reported abortions conducted by government and private facilities

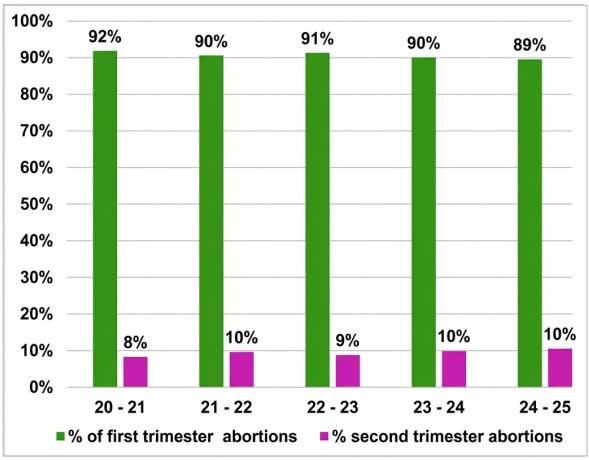
This pattern points to a systemic limitation in access: abortion services are concentrated in urban, higher-level institutions, leaving rural and peripheral areas underserved. This finding is corroborated by a study in Kancheepuram district, which found that out of 123 facilities authorized under the MTP Act (73 government and 50 private), only 42 (16 government and 26 private) provided abortion services, and all were in urban areas. [31]



Graph 3: District-wise share (in %) of total reported MTPs conducted in public facilities

2.5. Timing of Abortion

Based on the data (Graph 4) from the past five years, [27] approximately 90% of abortions in Tamil Nadu occur during the first trimester and the rest in the second trimester. The 2015 Guttmacher Institute study also reported that 92% the abortions in Tamil Nadu were first-trimester abortions. [17] One hundred and two abortions, or 0.1% of all reported abortions in 2024-25, took place at 24 weeks or after. About a third (32%) of these were in government facilities, and 68% occurred in private health facilities. [27]



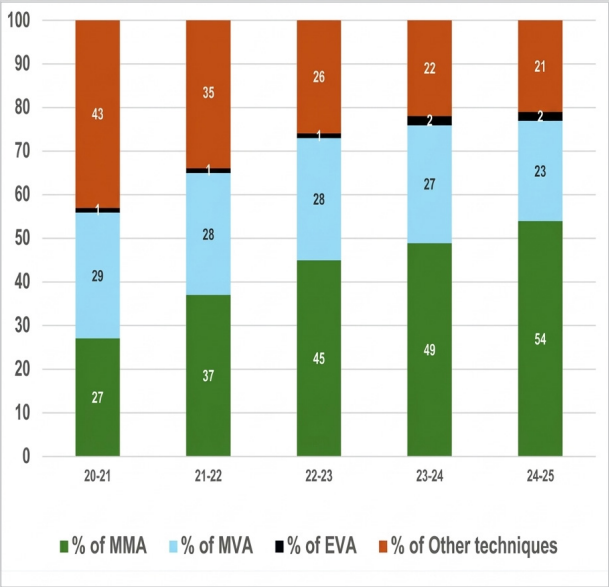
Graph 4: Percentage of first (upto 12 weeks) and second (12-24 weeks) Trimester Abortions [27]

2.6. Abortion Methods

Abortion methods available from health facilities include medical methods of abortion (MMA), Manual Vacuum Aspiration (MVA), Electrical Vacuum Aspiration (EVA), and 'other techniques', consisting of the less safe and invasive Dilatation and Curettage (D&C) and Dilatation and Evacuation (D&E) procedures.

Over the past five years, (Graph 5) medical methods of abortion (MMA) has become the predominant mode of pregnancy termination, with their usage steadily increasing.

As per the Department of Family Welfare, Government of Tamil Nadu [27], the share of MMA rose from 27% in 2020-21 to 54% in 2024-25. While Electrical Vacuum Aspiration (EVA) remains a less preferred method, MVA use fluctuated between 23% and 28% between 2020-21 and 2024-25. It may be noted that the proportion of abortions performed using Dilatation and Evacuation (D&E) or Dilatation and Curettage (D&C) techniques ('other techniques'), both considered to be invasive and riskier methods, declined steeply from 43% to 21% during the same period. [27] However, there are considerable inter-district variations in the mix of abortion methods used. D&E and D&C account for between 31 and 59% of all abortions in five districts: Chennai, Pudukkottai, Ramanathapuram, Tirunelveli, and Thanjavur. [27]



Graph 5: Percentage share of various methods of abortion conducted from April 2020 to March 2025 [27]

Self-managed abortions (SMA) through the direct purchase of medication from chemists is a prevalent practice in Tamil Nadu and other Indian states.[17] In Tamil Nadu alone, approximately 20.5 per 1000 women aged 15-49 sought medical abortion outside facilities, comprising 62.6% of all abortions recorded in 2015. [32] While some women use the medical abortion pills as indicated and succeed in having an abortion without complications, others do not have adequate information about the appropriate dosage for their gestational age. They may use inadequate dosages of the medical abortion pills without medical supervision, even in the second trimester. Anaemic women and those with other health conditions are at risk of complications when using SMAs without proper guidance and information from the provider. [28-29]

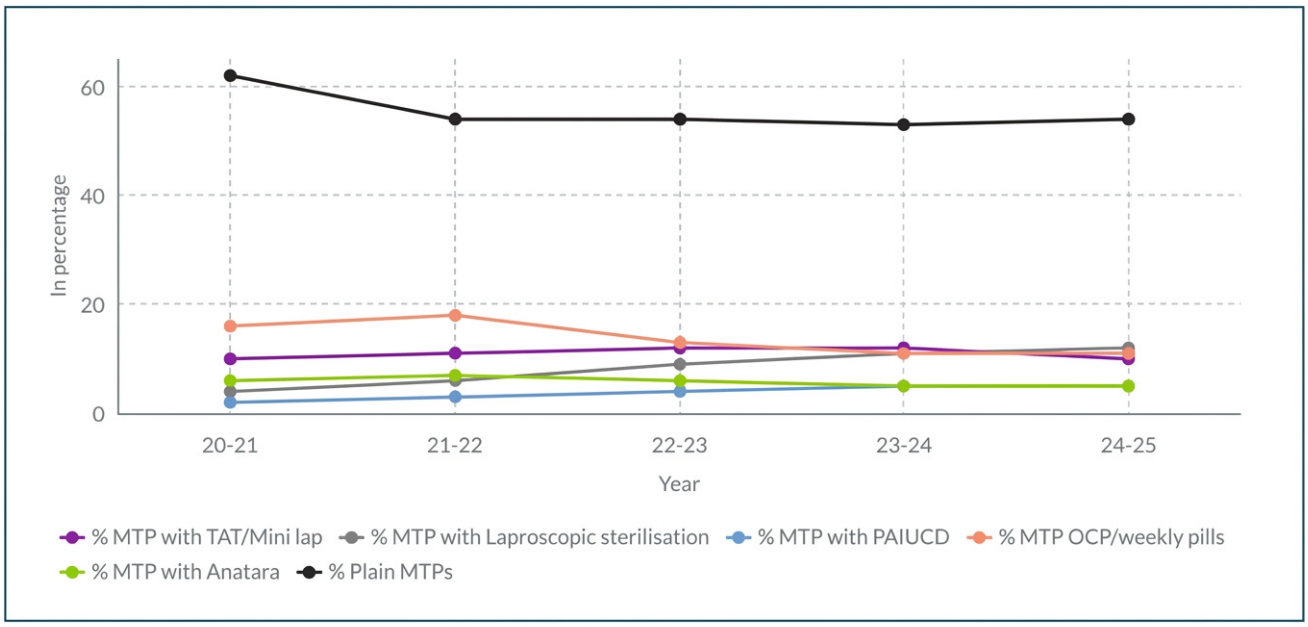
2.7. Post-abortion care

2.7.1 Healthcare for post-abortion complications

According to NFHS-5, 6.7% rural women and 5.9% urban women endured post-abortion complications during 2019-21. [7] The Guttmacher study found approximately 183,300 women received treatment in 2015 for complications arising from induced abortion or miscarriage. Of these, just 14% accessed care through public health facilities, while 86% turned to private providers. Among women who used medical MMA, 33% reported an incomplete abortion. Around 27% experienced prolonged bleeding, likely due to self-managed abortion using MMA. Another 23% faced incomplete abortion after undergoing other procedures. Additionally, 12% of women reported infections, 7% had sepsis, 6% suffered injuries, and 3% experienced shock. [17] According to the same study, only 2% of public hospitals in Tamil Nadu were equipped to manage abortion complications or later-term abortions. A recent study (2024) on SMAs reported that none of the women who had a self-managed abortion developed post-abortion complications. Even so, they visited a health facility to confirm completion (73%), or due to concerns about bleeding (46%) and/or cramping (29%). Healthcare seeking after a self-managed abortion without complications has been attributed to a lack of information about self-managing abortion, which led to fear of complications or side effects when they had cramping or bleeding. [33]

2.7.2 Post Abortion Contraception

Among the reported abortions (Graph 6), an average of 55% of medical terminations in Tamil Nadu during 2020-2025 were not followed by post-abortion contraception. Post-abortion contraceptive uptake for oral contraceptive pills has declined during 2020-21 to 2024-25 but remains the relatively most common method prescribed (between 11% and 16%) during the same period. Medical terminations with transabdominal tubectomy and laparoscopic sterilization each account for 10-12%, indicating that women tended to use permanent contraception after abortion. Antara and IUCD have very low uptake rates, at 5-7% each. [27]



Graph 6: Post abortion contraception uptake for the period Apr' 20 to Mar' 25 [27]

2.8. Barriers to safe abortion service access

Barriers to women's access to safe abortion services in Tamil Nadu exist at the individual level, interpersonal and community level, and systemic level. While rural women may face more barriers, urban women from various marginalized groups are also affected and need policy and program attention.

Stakeholder consultations as well as studies identify spousal control over women's reproductive decisions and lack of information on a range of issues as the most significant barriers.

2.8.1 Lack of information

Almost half a century after the MTP Act was passed, many women are unaware of the legal status of abortion, even in a state like Tamil Nadu with high levels of female literacy. According to one study, there were conflicting perceptions among women about the legality of abortion. Formal and informal women leaders, such as Self-help group leaders, Anganwadi workers, and traditional birth attendants, were aware that abortion was legal under specific circumstances. Some women in the community believed that abortion is illegal in India, punishable by imprisonment. Others had some facts right but not all: they thought that abortion was legal for up to two months of gestation (MTP is permitted up to five months of gestation), if there was a foetal abnormality, if the pregnancy was too soon after the previous childbirth or posed a risk to the mother's life. [29]

2.8.2 Stigma

A rapid assessment study in the Chengalpattu district of Tamil Nadu reported strong stigma and negative attitudes towards abortion among some groups of women and among community leaders. Local leaders and older women supported abortion as essential healthcare for women. Still, they believed that women seeking abortions were

likely to be humiliated, gossiped about, considered immoral, and unlikely to receive any support from their peers and family members. In contrast, younger women across castes considered an unintended pregnancy as entirely within the power of a woman to avoid, and an abortion to terminate an unintended pregnancy as unjustifiable. [29]

2.8.3 Negative propaganda by anti-abortion groups

Tamil Nadu has recently witnessed the emergence of anti-abortion groups that seek to negatively influence public sentiments on the acceptability of abortions as essential reproductive healthcare. A preliminary stakeholder mapping exercise in 2025 by RUWSEC found that several Catholic institutions, including colleges in many parts of Tamil Nadu, have constituted "pro-life" youth groups. There are also NGOs engaged in anti-abortion work. For example, Life for All works to alleviate injustices towards women and children, takes an openly anti-abortion stance, and runs a helpline for pregnant women to discourage abortions. The Society for the Protection of the Unborn Child conducts awareness programs on the negative consequences of abortion and on natural fertility control [34]. Uyirkkural has developed short videos with images and false statistics aimed at promoting negative attitudes toward abortions [29].

Unfortunately, the concerns about gender-biased sex selection in some parts of Tamil Nadu have led to the emergence of the Campaign against Sex-Selective Abortion (CASSA), which strongly opposes all second-trimester abortions, presuming that all of these are aimed at the selective abortion of the female foetus [29].

2.8.4 Availability of abortion services

Data on the availability and distribution of abortion facilities in Tamil Nadu (see Table 5) suggest that, despite legal authorization, many public facilities at the primary level do not offer abortion services. Availability of safe abortion services in the public sector often remains restricted to urban centres and higher-level rural institutions. This gap may be due to a lack of trained providers, inadequate infrastructure, or social and administrative barriers. The absence of services at the primary level places a disproportionate burden on women in rural areas, who must travel long distances to seek care. A mapping exercise of the abortion facilities by women from different parts of Tamil Nadu suggests that only first-trimester abortions are provided to married women, predominantly at tertiary-level institutions. [28-29]

2.8.5 Unhelpful provider attitudes

Unhelpful provider attitudes towards the provision of abortion services compound the challenges posed by the limited and uneven availability of public sector services. A 2021 study covering four states, including Tamil Nadu, reported that while some providers believed that a woman should be provided abortion under all circumstances approved by law, others were of the view that abortion should be provided only with parental consent, husband's consent, or acceptance of contraception. Some government doctors and Auxiliary Nurse Midwives felt that abortion cannot be provided for cases of marital rape, or a newly married woman with contraceptive failure, or a married woman who was pregnant when her husband was away. Providers also framed personal objections to abortion in

medical or health terms, though these were rooted in moral beliefs about abortion and women's roles. [35]

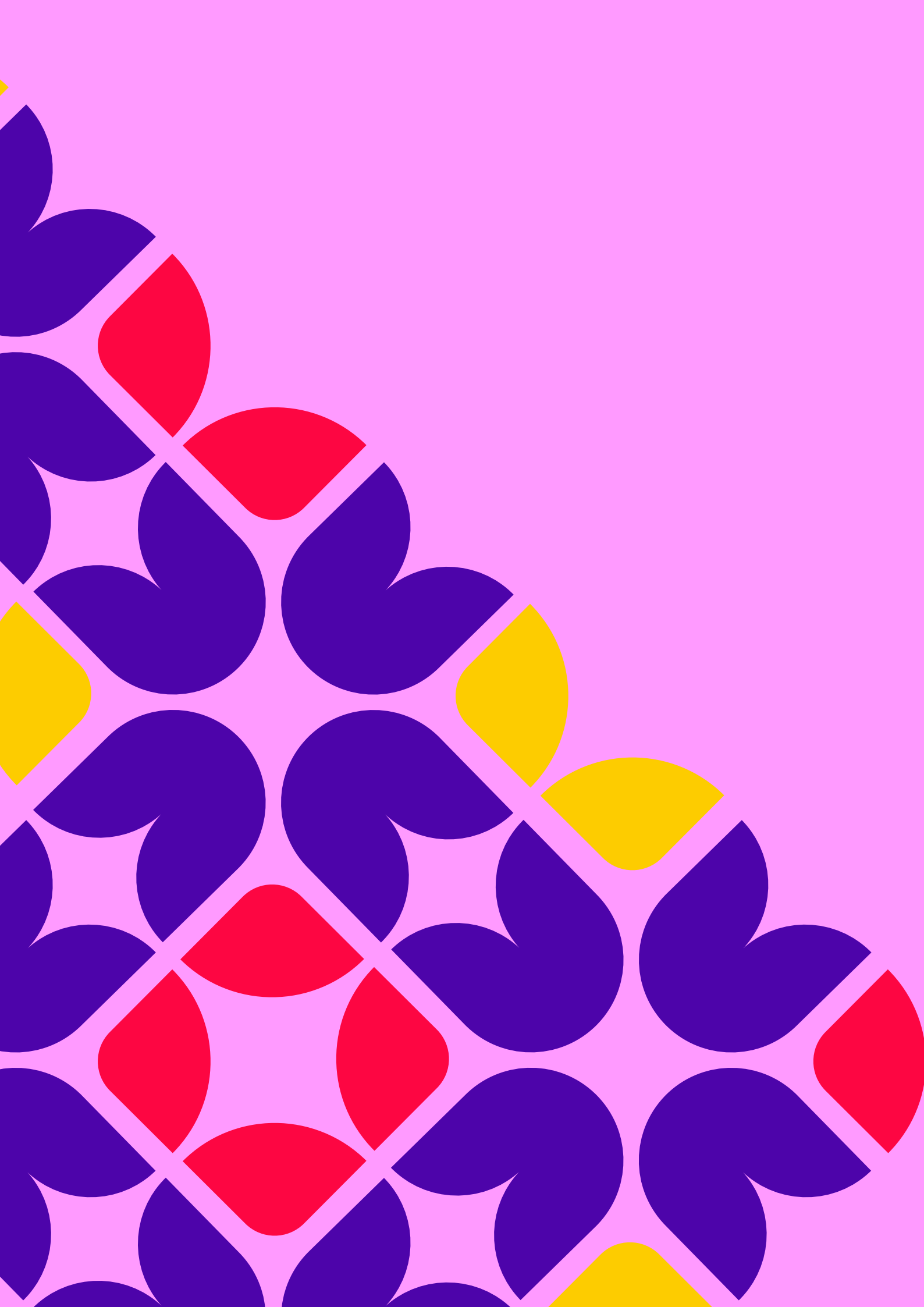
Fear of prosecution under the PC&PNDT Act leads many private providers to deny second-trimester abortions. Private providers in Chennai covered by the 2021 study referred women with pregnancies of 12-14 weeks to government hospitals or required another signatory as a witness to provide services, "to avoid trouble." However, this is not stipulated by the MTP Act. [35]

Providers' judgmental attitudes often denied unmarried women's access to safe abortions, according to studies as well as stakeholder consultations.

2.8.6 Shortage of medical abortion drugs for self-managed abortion (SMA)

The limited availability of abortion services in the public sector and the high cost of abortion services in the private sector leave many women with no option except self-managed abortion using medical abortion pills. Women also fear stigma and discrimination from healthcare providers, as well as judgment from their communities. Some worry that visiting an abortion clinic might expose their decision to others. [33] The success of self-managed abortions within their social circles has made this option feel safer and more familiar. Many are also uncomfortable with clinical procedures and prefer medical abortion. [33]

However, a 2019 study indicated a shortage of MA pills at pharmacies. Of 200 chemists in Tamil Nadu, only 2% reported stocking MA pills; 65% complained that MA pills were overregulated compared to other Schedule H drugs. Using a mystery client shopping approach without a prescription, the study found that only 8% stocked MA pills, and the rest did not. [36] Newspaper reports from Tamil Nadu have documented instances where pharmacies were sealed following sting operations by government officials posing as customers seeking MA pills, particularly in the aftermath of maternal deaths. I some districts, health departments have issued oral advisories during meetings with pharmacy owners' associations, instructing them not to sell MA pills without a valid prescription. However, these actions appear to be reactive and sporadic, triggered primarily by maternal deaths believed to have been caused by self-managed abortions using MA pills, and limited to select districts, rather than part of a coordinated, state-wide regulatory effort. [37-39]



Chapter 3

The abortion situation in the six intervention districts: An overview

In this chapter, we provide an overview of the maternal health and abortion situation in the six districts of Tamil Nadu where the Kaleidoscope Initiative aims to work. These districts include Chengalpattu, Dharmapuri, Kanchipuram, Perambalur, Theni and Thoothukkudi. It may be noted that in the table below, data for Chengalpattu is included in the data for Kanchipuram district, since Kanchipuram district has been recently bifurcated into Kanchipuram and Chengalpattu districts.

3.1. Reproductive health situation in the intervention districts

3.1.1 Birth order and delivery care characteristics

Table 6: Birth order and delivery care characteristics in intervention districts of Tamil Nadu [7]

Birth order and delivery characteristics by district* (2019-21)					
District	Percentage of births order 3 or more	Percentage of last births receiving antenatal care from doctor	Percentage of births in a health facility	Percentage of births in a public facility	Percentage of women receiving postnatal care from health personnel within two days of delivery
Tamil Nadu	9.8	86.8	99.8	66.9	92.4
Dharmapuri	26.3	88.9	99.6	73	97.9
Kanchipuram[1]	4.6	77.2	100	68.5	85.4
Perambalur	13.7	95.5	100	69.5	88.7
Theni	8.4	91.5	100	81.7	97.1
Thoothukkudi	5.4	80	100	59.1	94.3

Note: *Percentage of births during the 3 years preceding the survey of birth order 3 or more, percentage of women who had a live birth in the 5 years preceding the survey by antenatal care (ANC) provider during pregnancy for the most recent live birth, and percentage of women who had a live birth in the 5 years preceding the survey for the most recent birth.

[1]Kanchipuram district was bifurcated on 29 November 2019, resulting in the formation of Chengalpattu district as a separate administrative unit.

Table 6 presents the data on birth order and delivery care characteristics of women in the intervention districts and Tamil Nadu from NFHS 5, 2019-21. The percentage of births to mothers with birth order three or more varies considerably across the intervention districts.

Dharmapuri (26.3%) and Perambalur (13.7%) districts report the highest percentages, which are substantially higher than the state average (9.8%). This trend suggests gaps in the availability, accessibility, or utilisation of effective contraceptive methods, as well as limited access to timely counselling on contraceptive methods. In addition, socio-cultural factors such as early marriage, preferences for larger families, or a desire for male children may contribute to continued childbearing in these districts. Furthermore, higher-order births may place additional economic and caregiving burdens on women and households, particularly in socioeconomically vulnerable communities.

3.1.2 Contraceptive prevalence rates

Table 7: Contraceptive Prevalence Rate (NFHS 2019-21) in intervention districts of Tamil Nadu [7]

Contraceptive prevalence rate 2019-21			
Districts	Any method	Modern method	Spacing method
Tamil Nadu	69	65.5	7.6
Dharmapuri	70	68	7
Kancheepuram	69	67.3	7.5
Perambalur	63	58.8	10.1
Theni	71	67.1	11
Thoothukkudi	68	63.8	11.3

It is seen from Table 7 that about 66 per cent of currently married women in the reproductive age group in Tamil Nadu were using a modern method of contraceptives. Among the selected districts, Dharmapuri (68%) and Kancheepuram (67.3%) reported higher use of modern methods than the state average, followed by Theni (67.1%). Thoothukkudi (63.8%) recorded a slightly lower level, while Perambalur (58.8%) had the lowest prevalence of modern contraceptive use. In contrast, the use of spacing methods was higher in Theni (11%), Thoothukkudi (11.3%), and Perambalur (10.1%) than the state average, whereas Dharmapuri (7%) and Kancheepuram (7.5%) were closer to it.

Although the use of modern contraceptive methods in Tamil Nadu is relatively high, special attention should be given to districts such as Perambalur, where the prevalence is lower than the state average.

3.1.3 Unmet need for contraception

Table 8: District-wise Unmet Need for Contraception among Married Women (15–49 years) in Selected Intervention Districts of Tamil Nadu, NFHS-5 (2019–21) [7]

Unmet need for contraception 2019-21				
District	Total unmet need	Unmet need for spacing	Unmet need for limiting	Number of women
Tamil Nadu	7.5	3	4.5	18,472
Dharmapuri	8.5	3.5	5	431
Kancheepuram	7.2	4.2	3	1,063
Perambalur	11.4	3.1	8.3	139
Theni	7.3	3.5	3.9	380
Thoothukkudi	8.1	3	5.1	477

The NFHS-5 (2019–21) data of Tamil Nadu on unmet need for contraception show variations across the selected districts (Table 8). The overall unmet need for contraception in the state was 7.5%, with 3% for spacing and 4.5% for limiting. Among the districts, Perambalur reported the highest total unmet need (11.4%), largely driven by a high unmet need for limiting (8.3%), indicating that many women who wish to stop childbearing are not using contraception. It is noteworthy that, unlike the other districts studied, Perambalur does not have a government medical college hospital, which may partly contribute to the higher unmet need for limiting. Dharmapuri (8.5%) and Thoothukkudi (8.1%) also showed relatively higher unmet need, while Theni (7.3%) and Kancheepuram (7.2%) were closer to the state average, though Kancheepuram has a higher unmet need for spacing (4.2%). These findings clearly point out district-level disparities in access to and utilization of family welfare services, underscoring the need for context-specific strategies to address gaps in contraceptive provision [7].

3.2. The abortion situation in the intervention districts

As seen from Table 9, Perambalur (16.3%) and Dharmapuri (12%) districts reported substantially higher percentages of second-trimester MTPs than the state average of 8.2%. This may be an indication of significant challenges in accessing abortion services. In contrast, districts such as Kancheepuram (1.1%), Thoothukkudi (3.9%), and Chengalpattu (4.7%) show relatively lower percentages of second-trimester MTPs.

Table 9: Distribution of Medical Termination of Pregnancy (MTP) Cases by Gestational Duration in Selected Intervention Districts of Tamil Nadu, Family Welfare Bulletin, April 2024 – March 2025 [27]

No of MTP Cases done by Duration of pregnancy					
S.no	District	First Trimester [Up to 12 weeks]	Second Trimester [12 to 20 weeks]	Total	% Of 2nd Trimester to total MTP
1	Tamil Nadu	74468	6636	81104	8.2
2	Chengalpattu	1136	56	1192	4.7
3	Dharmapuri	1962	268	2230	12
4	Kancheepuram	517	6	523	1.1
5	Perambalur	568	111	679	16.3
6	Theni	1004	80	1084	7.4
7	Thoothukkudi	1791	73	1864	3.9

3.2.1 Method-wise distribution of MTP Cases

Table 10: Method-wise Distribution of Medical Termination of Pregnancy (MTP) Cases in Tamil Nadu and the selected interventional Districts, Family Welfare Bulletin, April 2024 – March 2025 [27]

District/ Period April 24-March 25	Total MTPs	% Total MTP to state Share	% share of MMA to total MTP	% share of MVA to total MTP	% share of EVA to total MTP	% share of Others to total MTP
Tamil Nadu	101200	100.0	53.8	23.4	1.9	20.8
Thoothukkudi	2862	2.8	65.9	15.5	0.3	18.3
Perambalur	1819	1.8	60.0	29.0	0.0	10.9
Chengalpattu	3251	3.2	48.0	19.6	8.4	24.0
Dharmapuri	2646	2.6	52.7	22.9	0.8	23.7
Kancheepuram	838	0.8	59.1	13.0	7.5	20.4
Theni	1253	1.2	50.4	32.2	0.0	17.5

It is clear from Table 10 that Medical Methods of Abortion (MMA) accounted for the largest share (53.8%) of all abortions. Manual Vacuum Aspiration (MVA) contributed 23.4% of total abortions. Electric Vacuum Aspiration (EVA) represented only 1.9%, suggesting limited use of this technology. Other methods accounted for 20.8%, which may include dilation and curettage or other procedures, depending on reporting practices.

By district, MMA was particularly prominent in Thoothukkudi (65.9%), Perambalur (60.0%), and Kancheepuram (59.1%). Chengalpattu (48.0%) and Theni (50.4%) showed comparatively lower shares of medication abortion and a greater reliance on surgical methods. Manual Vacuum Aspiration is most frequently used in Theni (32.2%) and Perambalur (29.0%). Electric Vacuum Aspiration remains limited overall, though relatively higher

use is observed in Chengalpattu (8.4%) and Kancheepuram (7.5%), which may reflect better availability of equipment or trained providers in these districts.

Another important point is that a high percentage of abortions are reported under "other methods" in districts such as Chengalpattu (24.0%) and Dharmapuri (23.7%), possibly because of the continued use of older procedural techniques. The results clearly indicate that strengthening provider capacity and ensuring the availability of a range of safe abortion methods can help improve access to quality abortion care.

3.2.2 Post-abortion contraception

Table 11: Contraceptive Method Adoption among Women Undergoing MTP in public facilities in Tamil Nadu, Family Welfare Bulletin, April 2024 – March 2025 [27]

District/ Period April 24-March 25	Total MTPs	% MTP with TAT/Mini Lap	% MTP with Laparo-scopic sterilisation	% MTP with PAIUCD	% MTP with OCP / Weekly pills (Chaya)	% MTP with Condoms	% MTP with Antara	% MTPs without contra-ception	%MTPs With permanent contra-ception	% MTPs with temporary contra-ception
Tamil Nadu	101200	9.8	12.1	5.0	10.6	3.2	4.9	54.4	21.9	23.7
Thoothukkudi	2862	6.6	8.0	3.0	3.1	2.9	1.8	74.5	14.7	10.8
Perambalur	1819	16.2	6.4	6.0	5.8	0.5	5.3	59.8	22.6	17.8
Chengalpattu	3251	6.8	14.5	2.7	14.5	1.2	2.1	58.2	21.3	20.5
Dharmapuri	2646	12.7	16.7	2.2	6.7	0.9	3.2	57.6	29.4	13.0
Kancheepuram	838	16.6	16.9	6.6	5.5	0.6	2.5	51.3	33.5	15.2
Theni	1253	13.8	10.5	3.3	22.7	7.1	17.6	24.9	24.3	50.8

Table 11 shows a considerable variation across the selected districts in Tamil Nadu in post-abortion contraception uptake (April 2024–March 2025). Of the total abortions reported in the state during this period, 54.4% women did not adopt any contraceptive methods, indicating a significant gap in post-abortion family planning services. Only 21.9% adopted permanent methods (tubectomy or mini-lap/laparoscopic sterilisation), and 23.7% adopted reversible methods. Among the districts, Thoothukkudi reported the highest percentage of MTPs without adoption of post-abortion contraception (74.5%), followed by Perambalur (59.8%) and Chengalpattu (58.2%), suggesting limited integration of post-abortion contraceptive counselling and services. In contrast, Theni showed relatively better uptake of reversible methods of contraception (50.8%), especially oral contraceptive pills (22.7%), Antara injections (17.6%), and condoms (7.1%), while only 24.9% of MTPs occurred without contraception. Kancheepuram and Dharmapuri reported comparatively higher levels of permanent contraception uptake (33.5% and 29.4% respectively). Overall, the findings highlight the need to strengthen post-abortion contraceptive counselling and access to contraceptive methods, particularly in districts with high levels of MTPs without contraception, to reduce repeat unintended pregnancies and abortion.

3.3. Findings from stakeholder consultations on key concerns related to maternal health and safe abortion services [40]

3.3.1 Some details about the consultations

As a part of the Kaleidoscope Initiative, stakeholder consultations were held at the state level and in the six intervention districts, alongside the state and district launches of the initiative. The consultation meetings were strategically designed as structured platforms to situate the project within each district and build local ownership. They aimed to generate dialogue with healthcare providers, frontline workers, community representatives, adolescents, and civil society organizations to surface district-specific realities related to abortion and women's rights.

Representatives from diverse stakeholder groups—including government departments, public health activists, civil society organizations (CSOs), women's rights activists, project partners, and media professionals—participated in both state- and district-level stakeholder consultation meetings. The involvement of these varied groups served as a key indicator of effective multi-stakeholder engagement, cross-sectoral collaboration, and the Kaleidoscope Initiative's relevance at district and state levels. The details of the consultation meetings held are provided in Table 12.

The seven stakeholder consultations were a rich source of information on the key concerns related to maternal health and safe abortion in the state and the intervention districts. Despite the diversity across the six districts evidenced in the data provided in the previous sections, participants in the stakeholder consultations consistently underscored the importance of ensuring access to safe and legal abortion services, which they believed is critical to safeguarding women's health, autonomy, and dignity, and to preventing avoidable maternal mortality and morbidity.

Table 12: Schedule of Kaleidoscope Project Stakeholder Consultation Meetings [40]

S.no	Date	Place	Stakeholder Consultation	Number of Participants
1	June 14 2025	Chennai	Tamil Nadu State – Level Consultation Meeting	49 Participants (7 State health Department officials, 3 Public Health Researchers, 6 Health Care Providers, 2 Panchayat Raj Representatives,29 NGO Representatives) and 2 Youth volunteers)
2	July 21 2025	Chengalpattu	Chengalpattu District Consultation Meeting	61 Participants (9 District health Department officials, 3 Panchayat Raj Representatives, 8 Health Care Providers, 8 Community Women, 7 Youth volunteers, 3 media persons, and 23 NGO representatives)
3	August 20 2025	Dharmapuri	Dharmapuri District Consultation Meeting	64 Participants (4 District health Department officials, 1 MLA, 35 NGO Representative, 3 Health Care Providers, 7 Media persons, 12 Community Women, and 2 Youth volunteers)
4	September 24 2025	Perambalur	Perambalur District Consultation Meeting	80 Participants (12 District health Department officials, 2 Police officers, 46 NGO representatives, 12 Health Care Providers, and 8 Community Women)

S.no	Date	Place	Stakeholder Consultation	Number of Participants
5	October 30 2025	Kanchipuram	Kanchipuram District Consultation Meeting	54 Participants (14 District health Department officials, 4 Panchayat Raj Institution Representatives, 8 Health Care Providers 27 NGO representatives, 6 Youth volunteers)
6	November 20 2025	Theni	Theni District Consultation Meeting	59 Participants (12 District health Department officials, 5 Youth health volunteers) 24 Health Care Providers, 6 Panchayat Raj Institution Representative, and 12 NGO representatives)
7	December 30 2025	Thoothukkudi	Thoothukkudi District Consultation Meeting	62 Participants (16 District health Department officials, 28 NGO representatives, 4 Panchayat Raj Institution Representatives, and 6 Youth volunteers)

3.3.2 Key concerns raised

Declining Child Sex Ratio

During the consultations, some participants expressed concerns regarding the declining child sex ratio and the possibility that expanding access to abortion services could contribute to sex-selective practices and further worsen gender imbalance.

In response to these concerns, it was clarified that since foetal sex determination through diagnostic procedures is possible only in the second trimester of pregnancy, sex-selective abortion is typically associated with procedures conducted in the second trimester. In contrast, the Kaleidoscope initiative focuses specifically on strengthening access to safe abortion services during the first trimester of pregnancy. At this early stage, foetal sex determination is not possible, and therefore the risk of sex-selective abortion does not arise. Strengthening first-trimester abortion services was also highlighted as an important strategy for enabling early care-seeking, minimising health risks, and supporting women in making informed reproductive choices.

Teenage Pregnancy

In district-level consultations, stakeholders highlighted teenage pregnancy, both outside and within marriage, as a major concern. Pregnancies among girls aged 18 and slightly above, although legally permissible, are still medically risky due to incomplete physical maturity. Adolescent mothers are particularly vulnerable to health complications such as anaemia, low birth weight of infants, and other pregnancy-related risks. Stakeholders from Perambalur reported that many adolescent girls enter pregnancy in a poor nutritional status. Early pregnancy further increases their nutritional requirements, which, if unmet, can negatively affect both maternal health and foetal development.

The underlying reasons for teenage pregnancy, as reported in the consultations, were early marriage and the near-absence of comprehensive sexuality education in schools. Although conception and reproductive anatomy were part of the high school curriculum, teachers rarely taught these topics in class. Among adult married women, women's inability to refuse sexual intercourse, as well as husbands' reluctance to take responsibility for pregnancy prevention and use of contraception, were essential contributors to unwanted pregnancies. Because of their husbands' unwillingness to use contraception or permit their wives' use of reversible contraceptive methods, while at the same time insisting on unprotected sexual intercourse, women who were contraindicated for sterilization often presented at health facilities for repeat abortions.

Misconceptions about reversible contraceptives and a lack of male responsibility for pregnancy prevention

Limited awareness and misconceptions about reversible contraceptive methods were reported to be responsible for their limited use, contributing to unplanned pregnancies and the need for abortion services. The disproportionate responsibility for pregnancy prevention on women, with minimal male participation, was highlighted. Methods such as condoms and vasectomy, despite being simple, safe, and effective, are rarely accepted among men. Misconceptions surrounding vasectomy, particularly the belief that it leads to loss of sexual ability or impotence, continue to discourage its adoption, and reinforce gender imbalances in reproductive health responsibilities.

Women's lack of power over reproductive decisions and awareness gaps about legal and safe abortion services

Women frontline workers and women community leaders identified women's lack of power to decide whether or not to continue with a pregnancy as a barrier to seeking early safe abortion services.

Many stakeholders also spoke about significant gaps in women's awareness regarding the legal status of abortion and the availability of safe abortion services. Discussions revealed that many women were unaware that abortion is legally permitted under specific conditions and that safe abortion services are available in government health facilities free of cost. This lack of awareness was identified as one of the key barriers preventing women from accessing timely and appropriate care.

Participants also noted that many women were unfamiliar with safer and less invasive abortion methods, such as medical methods of abortion (abortion pills) and manual vacuum aspiration (MVA). Instead, there was a widespread misconception that abortion procedures primarily involve surgical interventions such as dilation and curettage (D&C). As a result, many women either delayed seeking care or relied on incorrect information regarding available options.

Civil Society Organizations (CSOs) working with survivors of child sexual abuse opined that information on early and non-invasive abortions would have helped many survivors terminate their unwanted pregnancy and prevented them from having to go through the trauma of childbirth.

Socio-Cultural Barriers to Timely Access to Safe Abortion Services

Persistent gaps in reproductive health awareness, compounded by deeply rooted socio-cultural stigma, continue to affect women's access to safe abortion services.

Stakeholders from the districts reported that fear of stigma and gossip from the local community prevented women from disclosing their pregnancy even to their spouses and household members and contributed to difficulties in seeking first-trimester abortions.

Participants further stressed that abortion is often stigmatized and morally framed in communities as "killing the foetus," which contributes to fear, secrecy, and reluctance to seek safe services. Such perceptions can discourage women from accessing formal healthcare facilities and may push them toward unsafe alternatives. Single women, young widows, and women of advanced reproductive age were especially affected by stigma because of the taboo associated with sexual activity among women of these groups.

Delayed Access to First-Trimester Abortion Due to Health Factors

Certain health conditions, such as Polycystic Ovarian Disorders (PCOD), thyroid disorders, and anaemia, contributed to delays in the early detection of pregnancy. Irregular menstrual cycles associated with PCOD and thyroid disorders may make it difficult for women to recognise missed periods. At the same time, general health complications and fatigue related to anaemia may also contribute to delayed awareness of pregnancy.

Gaps in Availability of Abortion Services at the Primary Health Centre Level

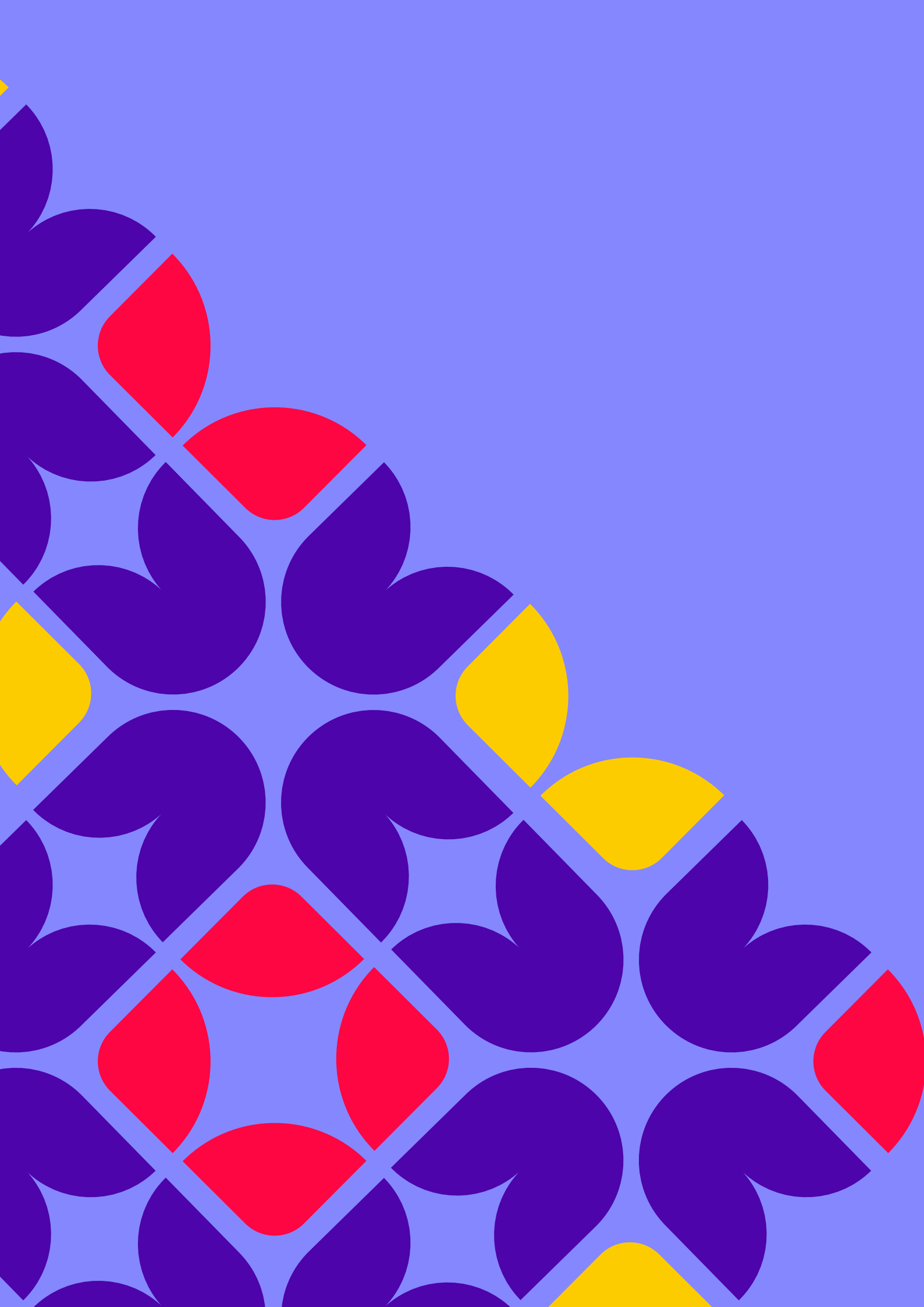
Representatives of community-based organizations (CBOs) and women leaders noted that MMA was often unavailable at the primary care level. Participants noted that although PHCs are intended to serve as the first point of contact for reproductive health services, the lack of consistent availability of MMA pills often compels women to travel to higher-level health facilities or private clinics to obtain abortion services. For many women, especially those from economically disadvantaged backgrounds, this creates financial and logistical challenges, including transportation costs, loss of wages, and delays in seeking care.

The limited availability of abortion medications at the PHC level may lead some women to seek services from untrained providers or rely on informal sources for abortion pills, which can pose potential health risks if used without appropriate medical guidance. Such barriers can delay access to safe abortion services and increase the likelihood of complications.

Provider attitudes

Providers' judgmental attitudes often denied unmarried women's access to safe abortions, according to stakeholder consultations. Community-based organizations (CBOs) representatives described instances of denial even when the unmarried woman was accompanied to the health facility by a CBO worker. However, marital status was not an issue according to the MTP Act. Frontline workers as well as service providers often lacked an understanding of women's limited power to make reproductive decisions within marriage. They tended to be harsh to women who presented for repeated abortions, viewing them as irresponsible for not using a contraceptive method.

The discussions highlighted that respectful care in government hospitals plays a crucial role in encouraging women to seek timely abortion services. Negative attitudes, judgmental behaviour, or breaches of confidentiality may discourage women from approaching formal health facilities and may lead them to delay care or seek unsafe alternatives. Participants therefore stressed the need for healthcare providers to maintain professional, empathetic, and respectful interactions with abortion seekers to build trust in the public health system.



Chapter 4

CONCLUSIONS AND RECOMMENDATIONS

The study findings indicate that Tamil Nadu has a supportive policy environment for implementing CAC. However, budgetary allocations for CAC under the NHM have been declining in recent years, even as the number of reported MTPs in the approved health facilities (according to official figures) has been rising. So, it is essential to increase the state NHM budget. Secondly, the actual expenditure under the NHM programme has also been low, at just 81.23% of the approved budget in 2022-23 and 75.21% in 2023-24. To reduce unspent balances in the approved CAC budget, it is important to conduct regular monitoring and review of expenditures to identify delays early and ensure the efficient use of allocated resources.

There is a heavy demand to provide safe abortion services at the primary and secondary level public health facilities. The study found that not all CHCs, sub-district and district hospitals are providing safe abortion services. The uncertain availability of abortion services in public health facilities poses a great barrier for poor and marginalised women to access safe abortion services. Many women are forced to opt for private facilities, which involve heavy out-of-pocket expenditure, or are forced to continue the pregnancy. A publicly accessible, district-wise directory of public facilities offering safe abortion services, along with the range of services available at each facility, should be developed to improve transparency and access.

Capacity-building of healthcare providers is critical to expanding service coverage. All medical officers at PHCs should be trained to prescribe medical abortion (MA). At the same time, doctors at CHCs should be equipped to both prescribe MA and perform Manual Vacuum Aspiration (MVA) procedures. At the community level, frontline workers—including Village Health Nurses (VHNs), Anganwadi Workers (AWWs), counsellors, and RKSK members—should be trained to disseminate accurate information on the legality of abortion, available methods, and referral pathways.

A well-structured referral system should be established to ensure that women seeking abortion services are directed to appropriate facilities promptly. Strengthening referral mechanisms will help prevent delays in accessing safe services and ensure continuity of care across different levels of the healthcare system. Clear and reliable guidance should be made available to individuals seeking abortion services to help them navigate the process safely and confidently. Such guidance should clearly outline when and from whom to seek information and help, and where to seek safe abortion services.

The review highlights the persistence of stigma, discrimination, and denial of abortion services within public health facilities, underscoring the need for systemic and programmatic improvements. It is essential to review and strengthen the information available to healthcare providers, ensuring they are updated with recent advancements in abortion methods and current MTP guidelines. Capacity-building initiatives for both providers and frontline workers (FLWs) must integrate Value-Clarification and Action Transformation (VCAT) modules that promote positive, non-judgmental attitudes toward women seeking abortion, thereby fostering respectful, stigma-free care across all public health institutions.

The study found that almost half the women receiving MTP services do not adopt post-abortion contraception. It is therefore imperative to ensure that every woman receives counselling on the full range of contraceptive choices immediately after abortion, with emphasis on informed decision-making and voluntary acceptance.

Strengthening information and counselling services on contraception in public health facilities is necessary to support informed contraceptive decisions and prevent unintended pregnancies. Outreach services should focus on improving awareness of reproductive health and access to modern contraceptive methods for young couples.

Introducing comprehensive sexuality education for adolescents and young people in schools and communities is essential to encourage responsible decision-making among adolescents. It can help prevent unintended and teenage pregnancies while promoting informed choices among young people. Adolescents and young women must have access to accurate information on how to prevent unintended pregnancies and how to access contraception.

Women must be encouraged and empowered to make their own informed decisions about their bodies in choosing contraception and abortion. An equal, shared responsibility among spouses should be promoted to enable informed family planning decisions. It must be ensured that unintended pregnancies are directed toward safe, legal services.

Men should be actively included in SRHR awareness programmes. Their involvement can help women make informed reproductive health decisions and help protect women's health and rights. Awareness programmes should also promote vasectomy as a responsible family planning method, particularly in cases where women may not be medically eligible for sterilisation.

Community awareness of safe and legal abortion services should be strengthened by improving knowledge of the MTP Act, available methods, and the availability of services in government facilities. Above all, to break the myths and misconceptions about abortion, it is recommended to implement community-based awareness and sensitisation workshops that normalise discussions around pregnancy and reproductive health. Engaging local leaders, frontline health workers, youth groups and women's groups to promote supportive attitudes and confidentiality can help reduce judgment and misinformation. A social media campaign is also necessary to educate people that abortion is a woman's right.

In conclusion, prioritising investments in capacity building, continuous provider training, and harmonised policy implementation can help bridge the gap between legal entitlements and actual access to services. As part of the way forward, the Government of Tamil Nadu needs to remain proactive in strengthening access to safe abortion services and increasing the uptake of long-acting contraceptives across the state. These actions are crucial to sustaining the momentum built over the years, positioning Tamil Nadu as a leader in public health. By continuing to prioritise women's reproductive rights and choices, the state could further reduce maternal mortality and set a practical example for others. The efforts already underway, combined with focused strategies to close remaining gaps, can make Tamil Nadu a model for comprehensive, rights-based reproductive healthcare in India.

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RUWSEC

Rural Women's Social Education Centre

Kaleidoscope

Championing Reproductive Justice Centered Health Systems