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Abortions in India: Myths, Facts and Reality

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India's recently amended Medical Termination of Pregnancy Act is quite progressive on paper but its translation into practice makes abortion as inaccessible in the country as in many of the most restrictive states in the US.

The Roe v Wade judgement in the United States in July 2022, which restricts American women's right to abortion, has generated much discussion in India. Indeed, it even prompted Smriti Irani to compare women's right to abortion in the US with that in India and declare that while the West is curtailing abortion rights, India is leading the way, giving a new meaning to *nari shakti* (women's power). This statement is only partly true—while our law, not ideal, upholds women's right to safe abortion in a range of situations, access to abortion remains compromised in India, just as it is in parts of the US. Here we explain why.

India's abortion law in theory

India's Medical Termination of Pregnancy (MTP) Act was passed in 1971. It allowed for the medical termination of pregnancies by gynaecologists or other registered medical practitioners who had been certified to carry out the procedure. Other conditions were also imposed. The law allowed for termination up to 12 weeks of pregnancy with the opinion of one registered medical practitioner, and up to 20 weeks of pregnancy with the opinion of two. Abortion was not permitted on demand, except in the following situations—if the pregnancy involved a risk to life; if it threatened to have serious consequences on the woman's physical or mental health; if it was caused by rape; if it resulted from contraceptive failure; or if there were indications that the new-born child would suffer from physical or mental abnormalities.

The Act also prescribed that abortions could only be performed at approved centres. On consent, although several recent authors have argued otherwise, the law is clear—termination rests only on the consent of the woman herself, not her husband, partner, or family member. The only exceptions were for those under 18 and those who were mentally challenged. Both groups required their guardian's consent. Moreover, a woman's right to privacy was explicitly guarded.

> After 2002, the Act was further amended in 2021, at which time the gestational age limit was extended to 24 weeks, still, however, with the consent of two physicians, and beyond 24 weeks if certified by a government-notified medical board.

At the turn of this century, medical methods of abortion (MMA) (mifepristone followed by misoprostol) became available, making it safer and simpler to terminate pregnancy. Perhaps acknowledging the simpler procedures, the Act was amended in 2002 and became more liberal. It expanded the range of facilities in which pregnancies could be terminated by medical means to include locations such as out-patient clinics, provided that physical access to an approved centre was available in case of an emergency.

After 2002, the Act was further amended in 2021, at which time the gestational age limit was extended to 24 weeks, still, however, with the consent of two physicians, and beyond 24 weeks if certified by a government-notified medical board. Adolescents are now considered a vulnerable group and may access abortion for up to 24 weeks under selected conditions and with the permission of two doctors, but they continue to require their guardian's consent.

So India's MTP Act is forward looking in many ways. It respects women's privacy, it allows for abortion in a wide range of circumstances, it is available in a multitude of facilities, and most important, it guarantees a woman's privacy, and it does not require the consent of anyone but the (adult) woman herself, although it continues to deny unmarried adolescents services without their guardian's consent.

Access to safe abortion in practice

The most recent estimate (2015) of abortions conducted in India suggested that 15.6 million pregnancies were terminated annually, translating to a rate of 47 abortions per 1,000 women of reproductive age. Just one in four of these abortions were provided in either public or private health facilities, while the majority—three in four—were done through self-use of MMA (Singh et al. 2018). Why do

not women avail themselves of the services guaranteed to them in the Act and opt for potentially less safe abortions?

For one, not all women are aware of their right to safe abortion services, and fewer still know where to access them. Young abortion seekers, in particular, are unaware of their entitlements. For example, research conducted by the IPAS Development Foundation (IDF) among rural young women in Assam and Madhya Pradesh in 2019 showed that less than a quarter (22%) of them were aware that abortion could be legally accessed. As a result, many, especially the unmarried, delayed their abortions, and/or sought multiple and potentially unsafe methods to terminate their pregnancy.

> There is limited access to abortion care in health facilities, particularly in the public sector. Many public health facilities do not offer abortion services because they do not have qualified staff and/or necessary equipment.

One study of unmarried abortion seekers found that as many as a quarter of them had delayed their abortion into the second trimester of pregnancy, many fearing disclosure (Kalyanwala et al. 2010). Adult women also faced constraints—using data from a community-based study of factors associated with delayed abortion-seeking among women in rural Maharashtra and Rajasthan, research highlighted the limited access to early abortion, unsuccessful prior attempts to terminate pregnancy, and the distance from the facility in which abortion was performed as key factors associated with second trimester abortion, even after controlling for confounding factors (Zavier et al. 2012).

Even among those who were aware about abortion, acquiring it was challenging (Singh et al. 2018). There is limited access to abortion care in health facilities, particularly in the public sector. Many public health facilities do not offer abortion services because they do not have qualified staff and/or necessary equipment. When services are available, rights violations are rampant. In many instances, providers require the consent of the woman's husband, clearly violating the law. In many instances, women report discomfort, with providers mocking or asking probing questions on the reasons for the unintended pregnancy.

Many providers demand exorbitant sums of money to conduct the abortion, with rates increasing with every week of gestation. And, in many cases, women are coerced to accept a post-abortion contraceptive method as a condition for the performance of a safe abortion, or because, in our patriarchal setting, the family has discovered (again contradicting the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994) that a woman is carrying an unwanted female foetus. Rural and poor women are particularly affected by these facility-based obstacles, while resort to sex-selective abortion is more likely undertaken among the better-off.

> Many chemists do not provide adequate information to their clients—they themselves have little knowledge of the protocol-- and do not supply all the information to the women, their husbands or partners who purchase [medical abortion] pills.

Most rural and poor abortion-seekers therefore prefer or are forced to procure medical abortion pills, without a prescription and without advice from a physician, from a medical shop and perform their own abortions using these. MMA is a safe and effective method of abortion if done correctly. This means that mifepristone is consumed on Day 1, followed by misoprostol on Day 3; and abortion may take place at any time in the following two weeks or so. Bleeding is normal unless excessive (more than five pads in a day), and the method is effective only (or for the most part) in the first trimester of pregnancy.

Many chemists do not provide adequate information to their clients—they themselves have little knowledge of the protocol and do not supply all the information to the women, their husbands or partners who purchase the pills. As a result, women may take the pills out of sequence, and may not be able to distinguish between the normal, common process for an MMA (bleeding, non-immediate evacuation of products, and so on) and complications that require treatment in a health facility.

Is India really 'Leading the Way'?

In summary, the MTP Act, with its amendments, is more likely to respect women's reproductive rights than the laws of many states in the US, especially after the recent ruling. But the implementation of the law and its translation into practice makes abortion as inaccessible in India as in many of the most restrictive states in the US.

Three in four abortion seekers in India must seek their abortions outside of the legal framework. Services are not easily available, the quality of care is indifferent, the emphasis on requiring the consent of only the abortion seeker is ignored, and coercion takes place in

many instances. This includes requiring post-abortion contraception as a condition for abortion, and forcing unwilling women to undergo sex-selective abortions.

Efforts to inform women about their legal right to access abortion and the services to which these rights entitle them are subdued at best. The poor, the young, the unmarried, and those in rural areas are particularly disadvantaged. Hence, the wide schism that persists in India between what is legally required and what takes place in practice suggests that Indian women are no better off than women in the US when it comes to accessing safe abortions.

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