PRATIGYA

Campaign for Gender Equality and Safe Abortion

ABORTIONS IN INDIA: KEY INFORMATION

Country Snapshot*

No. of Pregnancies **48.1 million**	Unintended Births **11%, 5.29 million**
Planned Births **43%, 20.68 million**	Induced abortions **33%, 15.6 million**
Miscarriages **14%, 6.73 million**	No. of Live births **54%, 26 million**

*Singh S et al., Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs, New York: Guttmacher Institute, 2018. https://doi.org/10.1363/2018.30009

Singh S. et al., The incidence of abortion and unintended pregnancy in India, 2015, New York: Guttmacher Institute, 2017

1. Number of Abortions and Who provides them

a. The estimated number of abortions in India is 2015 was 15.6 million. [i]
b. Over 95%of all abortions are provided by private sector. [ii]
c. HMIS data for past three years report that public sector provided around 700,000 abortions each year. [iii]
d. There are only estimated 60,000-70,000 legal abortion providers in the country [iv], most of them in urban areas.
e. Only specialist Obgyn's can provide abortion services. For an MBBS doctor to provide abortion services, she/he needs to be trained and certified under the MTP Act. The training requires the MBBS doctor to observe 10 cases, assist 10 cases and independently perform five cases in a govt. hospital or a govt. approved training facility. This training program designed by the govt. is for 12 days.[v]
f. Abortions can be performed only in a facility approved under the MTP Act. As per GoI's response to a RTI query (June 2020) data there are only 16,296 approved sites in the private sector and 25,931 sites in the public sector.

2. Abortion by Method and Gestation

a. 81% of all abortions are performed using medical abortion [vi] drugs (Mifepristone and Misoprostol) which are available in a combi pack. 14% by surgical methods and 5% by methods that are not recommended.
b. A vast majority over 89-91% are estimated to be first trimester abortion i.e. before 12 weeks gestation and only 9-11% are second trimester abortions. [vii]
c. Medical Abortion combi pack is indicated for use only up to 9 weeks gestation by the Drug Controller of India.
d. A MBBS doctor is not allowed to prescribe medical abortion drug. It can be prescribed only by OgGyn's or a doctor certified under the MTP Act.
e. In many states – Rajasthan, Maharashtra, Punjab, Haryana, Tamil Nadu, Madhya Pradesh, chemists are not stocking MA combipack to avoid undue scrutiny and demands for paper work from Drug Inspectors.[viii]

3. Gender Biased Sex Selection and Conflation with PCPNDT Act

a. There is an incorrect understanding that MA combipack can be used for gender biased sex selection. It is approved for use only up to nine weeks gestation. The most widely used test for detecting gender of the fetus is Ultra Sonography (Ultra Sound). Ultra sound can detect the gender of the foetus only around 13-14 weeks gestation and not before that. [ix]
b. Given the amount of coverage around sex selection, the general impression that has been created that all abortions and particularly second trimester abortions are for gender biased sex selection. Which is incorrect.
c. The most recent estimate indicates that annually 460,000 girls are missing at birth each year in the country. [x] This is around 3% of total number of abortions in the country. We condemn the practice of 'sex selection' and it is deplorable. But, also need to understand that 97% of abortions are for genuine reasons permitted under the MTP Act. Sex selection should be addressed as a society but not at the cost of abortions required for genuine reasons.
d. An estimated 15,60,000 second trimester abortions take place in the country annually. For argument sake if we assume all the 460,000 missing girls were due to gender biased abortion in second trimester, 10,80,000 or 70% of all second trimester abortion are for genuine reasons permitted under the MTP Act.
e. PCPNDT Act regulates diagnostics and bans use of diagnostics for sex determination. The MTP Act regulates provision of MTP Services. These are two independent acts which address independent issues. [xi]

4. Impact of Unsafe Abortions

a. Unsafe Abortions contribute to 8% of maternal deaths and is the third largest contributor to maternal mortality. [xii] (MMR 122/100000 live births)
b. 2,400 women die each year due to unsafe abortion.
c. WHO classifies abortions as Safe, Less Safe and Least safe: Abortions are safe [xiii] if they are done with a method recommended by WHO that is appropriate to the pregnancy duration and if the person providing or supporting the abortion is trained. Such abortions can be done using tablets (medical abortion) or a simple outpatient procedure. Abortions are less safe [xiv], when done using outdated methods like sharp curettage even if the provider is trained or if women using tablets do not have access to proper information or to a trained person if they need help. Abortions are dangerous or least safe when they involve ingestion of caustic substances or untrained persons use dangerous methods such as insertion of foreign bodies, or use of traditional concoctions.

5. Rationale for Expanding Provider Base

a. WHO guidelines allow use of trained and qualified non-physicians (Nurses, Mid-wives, Auxiliary-nurse-midwives, practitioners of complimentary system of medicine) to provide first trimester abortions. [xv]
b. Many countries like Sweden, France, Some states of US, Australia, Vietnam, South Africa, Nepal and Bangladesh (for menstrual regulation) allow non-doctor health workers to provide first trimester abortion both surgical and medical. [xvi]
c. Research evidence in India shows that there is no difference in outcomes for women provided abortion service by nurse and Ayush doctor, when compared with certified abortion providers. [xvii]
d. Already Nurses and Ayush doctors in public sector are allowed to perform riskier/invasive procedures like – insertion of IUCD; starting IV line; normal delivery. [xviii] Nurses/ANMs are also permitted to use many allopathic drugs including misoprostol.

6. Rationale for Increasing Gestation limits for all up to 24 weeks

a. 53% of legal cases analysed from June 2016 to April 2019 [xix] were related to women with gestation 20-24 weeks, and the trend seems to continue with 74% of cases analysed between May 2019-August 2020 were related to women with gestation beyond 20 weeks (unpublished report). Hence increasing the gestation limit to 24 weeks will reduce load on legal system.
b. Fetal anomalies are detected between 18-22 weeks due to advancement in technology so increasing it for all upto 24 weeks would make it easier for women who breach the 20 weeks threshold after they discover fetal anomaly and decide to erminate.
c. 20 countries allow for termination upto 24 weeks or more. [xx]

7. Rationale for Permitting Abortion on Request up to 12 weeks

a. Recognises women right over her body
b. Will provide abortion as a right for 80% of abortion seekers in India
c. 66 countries in the world allow abortion as a right in first trimester or more. [xxi]

8. Rationale for No Upper Gestational limit for Survivors of sexual abuse

a. “No upper gestational limit” for termination should be extended to survivors of sexual abuse. Having to carry a pregnancy resulting out of sexual abuse to term can cause mental and physical anguish as well as infringes on the pregnant persons right to life and liberty.
b. Often survivors of sexual abuse get to know of their pregnancy late and they take a much longer time to seek help given the trauma and stigma.
c. 30-35% of all women who sought judicial intervention were survivors of sexual abuse and at 20-24 weeks gestation and 16-20% at 24-28 weeks. [xxii xxiii]
d. Among the 158 cases cases involving sexual abuse, 128 permissions were given in High Courts and some cases viewed pregnancies that resulted from rape as falling within Section 5, noting that rape (especially in the case of minors) constituted a grave threat to mental health of survivor. [xxiv xxv]

9. Rationale for removing Medical Boards

a. Medical Boards should not be constituted and instead the decision should be between the pregnant person and the provider. Decision for termination should be solely between a pregnant person and the provider.
b. Lack of specialised and trained Health care experts, especially at district and block levels in remote areas, constituting medical boards at all levels would ot feasible. Having one medical board in a state will result in delays and increase costs.
c. Medical boards will increase the burden on an already stretched health infrastructure.

10. Rationale for Changes in Terminology/Language

a. Replace ‘Abnormalities’ with “Anomalies” since the term abnormalities reinforces the notion that foetuses with potential disabilities or medical conditions are undesirable.
b. Replacing the term ‘woman’ with ‘pregnant person’ will be gender inclusive. Access to abortion services is necessary for transgender, intersex and gender-diverse persons and not just traditionally termed ‘women’. [xxvi] This inclusion is recommended in line with the 2014 National Legal Services Authority vs Union of India judgement and the Transgender Persons (Protection of Rights Act) 2019. [xxvii]

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