REVIEW ARTICLE

Induced Abortion across the World and Evolution of Medical Termination of Pregnancy Law in India: A Review

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Abstract

Induced abortion is in the world for a long time. It is an ancient universal practice and has gained attention for different reasons at different points in time. It depicts termination of pregnancy by artificial means and having political, religious, cultural, and social reflections. Laws on abortion vary across the world. Some countries are highly progressive in-laws and provide it on request, while others ban it. The liberalization of medical termination of pregnancy (MTP) law is a matter of intense controversy and in some countries, there is a challenge to already existing liberal laws. Access to abortion is considered as a women's right, human right, reproductive right, and health right by the proabortion movement group, support to the life of embryo (embryo right) is provided by antiabortion movement group. Induced abortion has been used as a method of fertility regulation and it is a key tool in population policies. It is an important subject for demographers and health professionals. Safe and unsafe abortions are the center of discussion in many countries. This article provides knowledge on the definition, grounds of abortion, the status of induced abortion around the world, unsafe abortion, and literature review of medical termination of pregnancy in India.

Keywords: Abortion grounds, Global abortion law, Induced abortion, Medical termination of pregnancy law, Unsafe abortion.

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Introduction

Induced abortions are recorded throughout history around the world. In the year 2020, almost 73 million induced abortions were performed worldwide.[1] The estimated rate of abortion is 38 per 1,000 reproductive age women of 15–44 years in low-income group countries, 44 in middle-income group countries, and 15 in high-income group countries,[2] and it is directly related to unintended pregnancy rate. Unintended pregnancies are highest in the countries where induced abortions are restricted and lower in countries with liberal laws.[2] Though the global trend of unintended pregnancy is on the decline but the abortion rate is found to increase after 2005.[2]

Induced abortion is defined as deliberate action performed by a provider to end the unintended pregnancy. Almost every country allows abortion under at least some circumstances. There are few (only four) countries where induced abortions are completely banned, not allowed under any circumstances, and in some other countries even it is considered as a crime.[3,4] The legal policies, regulations, and recommendations vary with countries, which indirectly reflects the religious, social, and political forces.

Classification of Induced Abortion

Induced abortion is recommended to be carried out in a legal framework in a decided gestational limit by specified method at the designated place by the eligible provider,[5] and can be classified as legal and illegal abortion. Legal abortion is defined as a procedure permitted by law, and termination of pregnancy is performed by a licensed physician, or properly licensed mid-level practitioner working under the supervision of a licensed physician.[6] The specifications about provider, place, and methodology are laid down to prevent and eliminate illegal and unsafe abortion. According to World Health Organization (WHO), abortions are divided into safe and unsafe. All legal abortions are not always safe but all illegal abortions are considered unsafe. The abortions can be divided into safe, less safe, and least safe abortions, depending on technic and training of the provider. The last two categories of abortion are considered as unsafe abortions, wherein recommended method or qualification of provider is suboptimal.[7]

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Legal Aspects of Abortion

Induced abortion is always subject to a gestational age limit. Though most frequently in the first trimester, it can be provided throughout the gestation.[8] The rules and regulations become stringent as gestational age increases. An extended service of induced abortion is provided when the maternal life is in danger, in case of rape, and in cases of delayed detection of fetal malformation. The gestational limit varies according to the country, most countries provide it up to 12 weeks, but it is extended to 18 weeks (Sweden), 20 weeks (The Netherlands), and 24 weeks (United Kingdom and India).[8]

Authorizations are required for legal abortions, in cases of abortion under 18 years, authorization from a parent, guardian, other adults, or the commission is required, according to the country's norm. Some countries require a partner's consent if she is in the union. To end the pregnancy for medical reasons, medical approval is essential, which can be either physician or psychiatrist. Abortion

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after rape requires legal authorization from either prosecutor/judge, police, or medical report. Thus, requisition of authorization is one of the barriers to avail induced abortion in certain countries. Not only this, but there are myriad of regulations for a legal abortion, specifically on socioeconomic, and on-demand categories, such as gestational age limits, compulsory waiting period, a judicial authorization, husband's consent, compulsory testing for scan, or human immunodeficiency virus or sexually transmitted disease checkup is required depending on the country's induced abortion law and regulations.[4] That makes varied legal frameworks.

The grounds on which abortion is permitted are (1) to save the life of a woman, (2) to preserve a woman's physical health, (3) to preserve a woman's mental health, (4) in case of rape or incest, (5) in cases of fetal impairments, (6) for economic or social reasons, (7) on request.[9] The grounds are diverse for different regions and countries. The most widely used ground for termination of pregnancy in developed countries is socioeconomic and upon request. In the majority of the developing countries, it is restricted to certain grounds like saving the life of a woman and preserving mental and physical health.[10]

The legal status of medical termination of pregnancy (MTP) has a continuum, from total prohibition to liberal laws. Here, the most restrictive refers to the countries which do not permit abortion on any grounds, to save maternal life is the only indication. This is done either explicitly or under the general criminal law of the principle of necessity. The less restrictive means abortion is permitted to preserve a woman's physical or mental health or in case of rape/incest or on the ground of fetal impairment. The least restrictive means permission for abortion on wide grounds like socioeconomic and upon request. Overall, abortions are most liberal in most developed countries and Table 1 mentions different categories of induced abortion across the world.[1] Most of the African countries, Latin America, and the Caribbean countries follow the most restrictive laws, Asian countries have more permissive laws, and the most permissive laws are found in Europe, North America, and Oceania. Thus, laws are diverse across the world.[8] In the past two decades, many countries have changed their abortion law and expanded the legal grounds for induced abortion, explaining the global trend towards liberalization of law, although few countries have tightened their restrictions.

The association between restrictive laws and unsafe abortions is well documented.[11–13] The most industrialized countries allow abortions without much restriction, and the less industrialized country has strict laws. It is found that unsafe abortions are more than three times higher in countries with restrictive laws than in countries with less restrictive laws.[13] Unsafe abortion is defined by the WHO as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. It even includes abortions provided by substandard methods or methods which are inappropriate for that particular duration of pregnancy.[14] The conditions, such as lack of preabortion counseling or advice, abortion induced by an unskilled provider, in unhygienic conditions, or by a health practitioner outside officials/inadequate health facilities constitute unsafe abortions. Self-induced abortions by traditional medications, hazardous substances, or by insertion of an object, violent abdominal massage are a type of unsafe abortions. A medical abortion if prescribed incorrectly or medication issued by a pharmacist with no or incorrect instructions and without follow-up also are features of unsafe abortion, which puts the life of a woman at risk. The WHO mentions that the legality of abortion across the world has either little or no effect on the number of abortions performed every year, but it does affect the safety of abortion.[2]

Table 1 depicts the state of legal abortion on different grounds and its availability on development grounds of the country.[4] Nearly all countries (98%) permit abortion to save a pregnant woman's life. The life-threatening conditions are not specified and it is at the discretion of the abortion-providing authority. Seventy-two percent of countries allowed abortion to preserve a woman's physical health and 69% for mental health. Sixty-one percent accepted abortion for fetal impairment and also for rape and incest. Thirty-seven percent of countries allowed abortion for economic or social reasons, and 34% of allowed abortion upon request. The provider of an illegal abortion could be held criminally liable in 95% of the country.[12] Table 2 mentions indications of induced abortion in the developing and developed world.

Methods for Induced Abortion

The method commonly utilized to carry out first-trimester abortion is medical (nonsurgical) in a majority of cases, other methods are menstrual regulation, manual vacuum aspiration, suction and evacuation, dilation, and curettage. The choice of procedure depends on gestational age, professional skills, and technical support. In the second trimester of pregnancy, the medical method is most widely practiced, replacing other methods like dilation and evacuation or hysterotomy. Misoprostol tablet, a wonder drug for MTP, has different dosages according to gestational age. The regulations of this drug depend on the country, which is from liberal to tightly controlled for MTP usage.[8] These medical methods are patients friendly as it is associated with less stigma, less personal involvement, and more neutral medical act with less risk to woman's health, and fewer complications. Globally, Induced abortion care is usually interwoven with postabortion care in form of contraceptive counseling, family planning education, and acceptance to prevent future abortions.

India and MTP Law Evolution

India is amongst the first few countries to legalize abortion. The act for the provision of termination of pregnancy is known as the

Table 1: Induced abortion category across the globe

Category	*Legal grounds*	*Countries*	*Approximately reproductive women in million (%)*	*MTP law*
1	Prohibited	24	90 (5)	Severe restrictiveness
2	To save a woman's life	42	360 (22)	Most restrictive
3	Preserve health	91	211 (13)	Less restrictive
4	Socioeconomic	13	386 (23)	Least restrictive
5	On request (GA* varies)	73	616 (37)	Liberal

Table 2: Number and percentage of countries and development groups with legal grounds for abortion

Legal grounds	*To save a woman's life*	*To preserve a woman's health*	*To preserve a woman's physical health*	*To preserve a woman's mental health*	*In cases of intellectual or cognitive disability of the woman*	*In cases of incest*	*In cases of rape*	*In cases of fetal impairment*	*For economic or social reasons*	*On request*	*Other legal grounds*
No of countries	193	141	141	136	76	102	119	120	73	67	38
Percentage	98.0	71.6	71.6	69.0	38.6	51.8	60.4	60.9	37.1	34.0	19.3
Developed world	95.9	91.8	91.8	89.8	79.6	83.7	87.8	87.8	83.7	77.6	30.6
Less developed world	98.6	64.9	64.9	62.2	25.0	41.2	51.4	52.0	21.6	19.6	15.5
Least developed world	100.0	57.4	57.4	51.1	17.0	44.7	51.1	51.1	12.8	12.8	23.4

(*Courtesy*: United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Policies 2017: abortion laws and policies)

medical termination of pregnancy (MTP) Act, 1971.[15] The law was formed to reduce the instances of illegal abortions. It was enacted to encourage family planning and population control. Before 1971, termination of pregnancy through induced abortion was considered a crime and punishable offense (permitted only to save the life of the woman). This led women to resort to abortion secretly, by an unskilled provider or not in the best of situations and methods, resulting in higher complications, morbidity, and mortality. Hence, MTP law was enforced in 1972 except in Jammu and Kashmir. It was amended in 1975 and 2002 to have more access for women in the private sector and to facilitate better implementation. In the year 2003, regulations were formed and prescribed forms for recording the opinion of the registered medical practitioners, reporting to a chief medical officer (CMO), and maintaining records. In the year 2014, a further amendment in the law was proposed, which was passed in 2021 by parliament. Table 3 mentions the formation of MTP law in India. Table 4 mentions the forward progress and evolution of the law.[16–18]

The current abortion policy is towards the improvement of availability, accessibility, and safety of induced abortion. But still, difficulties faced are due to uneven expansion of facilities and uncertified centers in large states. The available services at primary health centers are a medical method of abortion in the first trimester and manual vacuum aspiration up to 8 weeks. Abortion up to 12 weeks is permitted at a primary health center (PHC 24 × 7 days) and at a community health center, and up to 20 weeks are permitted at a district hospital or a private hospital certified by a district-level committee.

The new Act 2021 needs the setting up of medical boards in every state and Union territory (UT), consisting of a gynecologist, pediatrician, radiologist, or sonologist and any other members as proposed by that state or UT. Each board would contribute to diagnosing substantial fetal "abnormalities" that necessitate termination of pregnancy after a 24-week gestation period. Medical boards make a form of third-party authorization.

Advantages

As 8–10% of maternal deaths are due to unsafe abortions,[19,20] the amendment would help to reduce maternal mortality. The amended law would allow the removal of the fetus at an advanced stage of pregnancy. Some of the fetal abnormalities are detected after 20 weeks of gestation. The amendment addresses such a medical complication. It would help a woman who wishes to make individual choices from their perspectives and predicaments, thus providing reproductive rights and gender justice, and it will reduce the burden on the judiciary (cases beyond 20 weeks). The new amendment keeps pace with advancing technology.

Disadvantage

There are a few problems anticipated with the current amendment of the MTP Bill, such as the overwhelming deficit of specialist availability, especially in rural, and scheduled areas, which might make it difficult to constitute boards as contemplated under the MTP Bill. Even sustainability of medical board in each state and union territory is a challenge. The preference for a male child may keep sex determination centers active despite their illegal status. There are concerns that a more liberal abortion law can aggravate it. There may be a need of subjecting a woman for multiple investigations to determine whether termination can be opted,

Table 3: Enactment of medical termination of pregnancy (MTP) law, India

Year	*Grounds*	*Specification for provider*	*Space designated*	*Consent*	*Period of gestation and opining doctors*
1971 MTP Act 1972 The act Enforced except in Jammu and Kashmir 1975 Rules and regulations are formed	• Risk to the life of pregnant woman • Grave injury to her physical or mental health • Substantial risk to the mental or physical health of unborn • Cause of pregnancy is either rape or Failure of male/female contraception in married couple	Only RMP • Medical qualification under the state medical council act, 3 years of experience at the time of implication of law. • Whose name is in the state medical register, Training or experience as per MTP rules* (6 months horsemanship, 1 year training in OBGYN clinic, holding degree or 25 cases assisted/5 cases performed in approved place)#	All government hospitals, Private sector having government approval* Up to 8 weeks of gestation: at primary health center, up to 12 weeks: community health center or PHC 24 x 7 hours 20 weeks; District health center *Form B for approval certificate	Only of Pregnant woman >18 years, <18 years or mentally ill-consent of guardian or parents *Form C	Up to 20 weeks *Form I/II/III, reporting form A Admission form

RMP, registered medical professional; *Further information refers to reference no. 16; #Last clause for termination up to 12 weeks

Table 4: Evolution of MTP law in India

Year	*MTP law changes*
2002 amendment	MTP act was amended to facilitate better implementation and increase access for woman in the private health sector. Strict penalties for unsafe abortions were introduced. The term lunatic was substituted with mentally ill person. The process of approval of a private place to district level was consented.
2002–03 MTP rules and regulations	MTP rules were refined in terms of (1) composition and tenure of district-level committee, (2) specific guidelines for equipments, drugs, facilities, and referral linkage at approved places were laid down, (3) periodic inspection of private places to verify safety and hygienic conditions was addressed, (4) cancellation or suspension of certificate of approval for deficiency or defect found on CMO inspection was approved. The register maintained for TOP should be retained for a period of 5 years and monthly reports to be sent to CMO of the district.
2014	MTP amendment bill proposed.
2020–21 amendment	Loksabha and Rajyasabha passed the Bill in 2020 and in 2021, respectively, that is Amendment Bill 2020. Amendment salient features: • Enhancing the upper gestation limit to 24 weeks for special categories of women which include survivors of rape, victims of incest, minors, change of marital status during ongoing pregnancy (widowhood and divorce), fetal malformations which may result in seriously handicapped life later and other vulnerable (differently able) women. • Opinion of one MTP provider up to 20 weeks of pregnancy and two providers between 20 and 24 weeks of gestation • Upper gestation limit not to apply in cases of substantial fetal anomalies diagnosed by medical board. • Name and other particulars of woman shall not be revealed except to a person authorized in any law • Law will cover unmarried women for unintended pregnancies and the ground of contraception has been extended to women and her partner.
Road ahead	This is not yet out for public domain and procedures around it are to be formulated. It needs calling for setting up of medical board in every states and union territory. The clarification on time frame for the opinion and examination for MTP after 24 weeks, which is subject to a state level medical board approval.

MTP, medical termination of pregnancy; CMO, chief medical officer; TOP, termination of pregnancy

where there could be a violation of their dignity and privacy. In the absence of any time limit for the Medical Board's decisions, the concerned party may have to seek a court for expeditious disposal. Fast-track courts need to be set up to deal with the disputes arising under the Act.

Future Directions

There are certain points, which could be considered in the future like the inclusion of an anesthetist and psychiatrist committee to address concerns surrounding the administration of anesthesia and a mental well-being of the woman. Those belonging to the transgender community should also be brought within the ambit of this Bill. Even with the inclusion of the Indian medicine system (Ayurveda, Siddha, Unani, or Homeopathy), nurses and auxiliary nurse midwives were suggested with claws to increase legal MTP providers.

Conclusion

There is a trend towards the liberalization of abortion law globally, more in industrialized countries. With the expansion of the grounds

on which women can avail of abortions, the quality and safety of abortion care have improved, and so is maternal survival. The growth of medical abortion has transformed abortion practices and postabortion care. It is directly related to the safety of the act and is also associated with fewer risks and less severe complications.

Although, the right to abortion is not universally recognized and it is being punished socially and legally in some of the countries. Abortion is still a widespread stigma. The diversity of law and practices of induced abortion across the globe has resulted in differences in frequency, methodology, consequences on women's life and health. Abortions around the world reflect unwanted pregnancies, contraceptive uptake problems, contraceptive failures, and different socioeconomic strata. The risk associated with unsafe abortion reflects social inequalities. The downward trend of abortion globally suggests stronger sexual health, reproductive health, and adolescent health.

Along with the world, the Indian MTP law has shown progressiveness and stands among industrialized nations with highly progressive law. The recent amendment is towards the safety and well-being of women, allowing legal abortions on a broad range of therapeutic, humanitarian, and social grounds. Thus, with a human face, it will ensure dignity, autonomy, confidentiality, and justice for a needy woman.

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References

1. Bearak J, Popinchalk A, Ganatra B, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. Lancet Glob Health 2020;8(9):e1152–e1161. DOI: 10.1016/S2214-109X(20)30315-6.
2. Unintended pregnancy and abortion worldwide fact sheet. Available from: https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide [Accessed July 2020].
3. Christin-Maitre S, Bouchard P, Spitz IM. Medical termination of pregnancy. N Engl J Med 2000;342(13):946–956. DOI: 10.1056/NEJM200003303421307.
4. United Nations, Department of Economic and Social Affairs, Population Division. World Population Policies 2017: abortion laws and policies. 2019. Available from: https://www.un.org/en/development/desa/population/publications/pdf/policy/World_Population_Policies_2019_Highlights.pdf.
5. Safe abortion: technical and policy guidance for health systems. 2012. World Health Organisation. Available from: https://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.
6. Pazol K, Zane SB, Parker WY, et al. Abortion surveillance–United States, 2007 [published correction appears in MMWR Surveill Summ 2011;60(10):315]. MMWR Surveill Summ 2011;60(1):1–42. PMID: 21346710.
7. Ganatra B, Gerdts C, Rossier C, et al. Global, regional, and subregional classification of abortions by safety, 2010-2014: estimates from a Bayesian hierarchical model [published correction appears in Lancet. 2017;390(10110):2346]. Lancet 2017;390(10110):2372–2381. DOI: 10.1016/S0140-6736(17)31794-4.
8. Guillaume A, Rossier C. L'avortement dans le monde. État des lieux des législations, mesures, tendances et conséquences. Population 2018;73(2):225–322. DOI: 10.3917/popu.1802.0225.
9. Berer M. Abortion law and policy around the world: In search of decriminalization. Health Hum Rights 2017;19(1):13–27. PMID: 28630538; PMCID: PMC5473035.
10. Marc B, Vangeenderhuysen C. Medical ethics: abortion. In: Payne-James J, Byard RW, editors. Encyclopedia of forensic and legal medicine. 2nd ed. Oxford: Elsevier; 2015. p. 3126. ISBN: 9780128000342.
11. The World's abortion laws, center for reproductive rights. Available from: https://maps.reproductiverights.org/worldabortionlaws.
12. United Nations, Department of Economics and Social Affairs, Population Division. World population policies 2017: abortion laws and policies. 2017. Available from: https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesa_pd_2020_world_population_pol.
13. Johnson BR, Mishra V, Lavelanet AF, et al. A global database of abortion laws, policies, health standards and guidelines. Bull World Health Organ 2017;95(7):542–544. DOI: 10.2471/BLT.17.197442.
14. Grimes DA, Benson J, Singh S, et al. Unsafe abortion: the preventable pandemic. Lancet (London) 2006;368(9550):1908–1919. DOI: 10.1016/S0140-6736(06)69481-6.
15. MTP ACT, Ministry of Health and Family Welfare, Government of India. 1971. Available from: https://main.mohfw.gov.in/acts-rules-and-standards-health-sector/acts/mtp-act-1971.
16. Barua A, Rastogi A, Deepa V, et al. The MTP 2020 amendment bill: anti-rights subjectivity. Sex Reprod Health Matters 2020;28(1):1795447. DOI: 10.1080/26410397.2020.1795447.
17. Ministry of Health and Family Welfare, Government of India. Ensuring access to safe abortion and addressing gender biased sex selection. 2015. Available from: https://www.ipasdevelopmentfoundation.org/resourceFiles/78201905090047.pdf.
18. The medical termination of pregnancy – eGazette. 2021. Available from: https://egazette.nic.in/WriteReadData/2021/226130.pdf.
19. Armo M, Babbar K, Thakur H, et al. Maternal morbidity due to unsafe medical abortion in rural practice is just the tip of the iceberg: is it really preventable. Int J Reprod Contracept Obs Gynecol 2017;4(1): 56–60. DOI: 10.5455/2320-1770.ijrcog20150211.
20. Yokoe R, Rowe R, Choudhury SS, et al. Unsafe abortion and abortion-related death among 1.8 million women in India. BMJ Glob Health 2019;4(3):001491. DOI: 10.1136/bmjgh-2019-001491.