Jus Corpus Law Journal

Open Access Law Journal – Copyright © 2025 – ISSN 2582-7820

Editor-in-Chief – Prof. (Dr.) Rhishikesh Dave; Publisher – Ayush Pandey

Bridging the Gaps in Abortion Access: Amendments to the MTP Act and the Potential of Telemedicine

Veerjot Kaur[a]

[a]University Institute of Legal Studies, Panjab University, Chandigarh, India

Received 18 February 2025; *Accepted* 19 March 2025; *Published* 24 March 2025

Access to safe abortion remains a critical issue in India, despite progressive amendments to the Medical Termination of Pregnancy (MTP) Act. The 2021 amendments aimed to expand legal abortion services, extending gestational limits and recognizing the rights of special categories, yet significant gaps persist. Rural-urban disparities, provider shortages, and societal stigma continue to hinder comprehensive abortion care. In this evolving landscape, telemedicine emerges as a transformative tool, offering a viable solution to bridge these gaps. The COVID-19 pandemic underscored its potential, enabling remote consultations and reducing delays in accessing abortion pills. However, regulatory ambiguities and technological limitations pose challenges to its full-scale implementation. This paper explores how recent amendments to the MTP Act have shaped abortion care in India and examines the role of telemedicine in enhancing accessibility, particularly for marginalized communities. By addressing policy barriers and leveraging digital healthcare, India can move toward a more inclusive reproductive health framework. The integration of telemedicine in abortion care, if supported by clear guidelines and robust infrastructure, can be a game-changer in ensuring safe, timely, and stigma-free access to abortion services.

Keywords: *medical termination of pregnancy (mtp) act, abortion access, telemedicine, safe abortion services.*

INTRODUCTION

The laws related to abortion vary from country to country due to the complex interplay of societal norms, religious beliefs, legal frameworks and women's rights. Women have used many methods of birth control and abortion throughout history. Since abortion is not only a techno-medical issue, but the fulcrum of a much broader ideological conflict in which the fundamental definitions of the family, the state, motherhood, and young women's sexuality are questioned, these practices have sparked strong moral, ethical, political, and legal arguments.[1] Women have sought an abortion, also known as pregnancy termination, either publicly or covertly, but societal and legal constraints have restricted their access to services.

Termination of Pregnancy as defined by Section 2(e) of The Medical Termination of Pregnancy (Amendment) Act, 2021 means a procedure to terminate a pregnancy by using medical or surgical methods.[2] Women in nations like India frequently lack the freedom to choose when to engage in sexual activity that could result in pregnancy and to stay unmarried even after marriage. They may not even have the power to choose whether or not to carry on with the pregnancy.[3] Compared to wealthy and urban women, rural and impoverished women are more likely to receive subpar medical care. Regardless of whether abortion is legal or not, these social disparities are crucial factors in determining access to safe abortion care. Both women and public health services are burdened by this disparity in access to safe abortion.[4]

UNDERSTANDING THE MTP ACT AND ITS AMENDMENTS

Evolution of the MTP Act: Abortion law in India, which was governed by the Indian Penal Code of 1862 and the Code of Criminal Procedure of 1898 until 1971, has its roots in 19th-century British law, which made abortion a crime punishable for both the mother and the abortionist unless it was performed to save the woman's life.[5] Between 1960 and 1980, abortion laws were liberalised around the world and consequently, the Shantilal Shah Committee analysed the concept of abortion from various socio-cultural, legal, and medical

[1] Veerjot Kaur, 'Abortion Laws in India' (*Lawful Legal*, 20 August 2024) <https://lawfullegal.in/abortion-laws-in-india/> accessed 09 February 2025
[2] The Medical Termination of Pregnancy (Amendment) Act 2021, s 2(e)
[3] Trishi Anand et al., 'Abortion Laws In India: A Critical Analysis' (2022) 7(6) International Journal of Mechanical Engineering <https://kalaharijournals.com/resources/JUNE-10.pdf> accessed 09 February 2025
[4] *Ibid*
[5] R. Chhabra and S.C. Nuna, *Abortion in India*: *An Overview* (Veerendra Printers 1994)

perspectives.[6] The committee recommended legalising abortion to prevent maternal morbidity and mortality on compassionate and medical grounds.[7] This led to the passage of the MTP Act in 1971. The statute has been amended twice since its inception: once in 2002 and again in 2021.

THE 2021 AMENDMENT: EXPANDING ACCESS

To provide universal access to comprehensive care, the new Medical Termination of Pregnancy (Amendment) Act 2021 broadens access to safe and legal abortion services on therapeutic, eugenic, humanitarian, and social grounds.[8] The table below shows the significant changes brought by this amendment of 2021:[9] **Three circumstances for pregnancy termination are listed in Section 3 of the modified Principal Act:[10]**

1. A single RMP has the authority to end a pregnancy that is less than 20 weeks if they feel that the woman's life or significant physical or mental health would be in danger, or if there is a significant chance that the unborn child will have severe physical or mental abnormalities. Rape-related pregnancies are also seen as serious harm to the mental health of the expectant mother.

2. For cases where the pregnancy remains longer than 20 weeks but less than 24 weeks, two RMPs can terminate the pregnancy on the opinion made in good faith by both RMPs. The anguish caused by the pregnancy is presumed to constitute a grave injury to the pregnant woman's mental health.

3. Under Section 3 (2B), the twenty-week or twenty-four-week restriction may be removed in circumstances when the pregnancy lasts more than 24 weeks if the Medical Board determines that a termination is required because of serious fatal abnormalities. A board made up of a gynecologist, pediatrician, radiologist, sonologist, and other professionals would be established by each state government for this purpose.

---

[6] Ambika Gupta, 'A Critical Analysis of the Shortcomings under the MTP (amendment) Act,2021' (2021) 1(8) Vishwakarma University Law Journal <https://vulj.vupune.ac.in/archives/8.pdf> accessed 09 February 2025
[7] *Ibid*
[8] *Ibid*
[9] The Medical Termination of Pregnancy (Amendment) Act 2021
[10] The Medical Termination of Pregnancy Act 1971, s 3

4. Section 5A provides for women's privacy, stating that no RMP shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act except to a person authorized by any law for the time being in force.[11]

GAPS AND CHALLENGES IN THE AMENDED LAW

In India, the Medical Termination of Pregnancy (Amendment) Act, 2021, was a step in the right direction. Nevertheless, there are still a number of implementation gaps and difficulties in spite of the legal gains. Legal restrictions, accessibility problems, and social stigma are the main causes of these difficulties, which prevent many women from having access to safe and affordable abortions.

Constitutional Hurdles: Women's Autonomy and State Control in India's Abortion Policies: The MTP Act of 1971 allows for abortion on medical grounds and in circumstances when a woman's life or physical or mental health is in jeopardy, as well as on humanitarian grounds when the pregnancy is the result of sex offences such as rape or intercourse with a lunatic woman.[12] The pregnant woman seeking an abortion will have to explain herself. This situation exhibits that abortion remains tied to the state-sanctioned conditions and not the rights of the woman.[13] In Suchita Srivastava v Chandigarh Administration,[14] a bench of three judges adjudged that a woman's right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution. Reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. In K.S. Puttaswamy (Retd.) v UOI,[15] Justice Chandrachud observed that reproductive choice is a personal liberty guaranteed under Article 21 of the Indian Constitution. Clearly, despite strong jurisprudence on reproductive rights and women's privacy, there is no fundamental transfer of authority from the doctor to the woman seeking an abortion. Because the legislation does not protect women's legal abortion rights, it is mostly used to regulate doctors and abortion centres. As a result, abortion is still associated with state-mandated criteria rather than a woman's rights.

---

[11] The Medical Termination of Pregnancy Act 1971, s 5A
[12] *ABC v State of Maharashtra through Rajapur Police Station and Anr* (2021) SCC OnLine Bom 419
[13] Gupta (n 6)
[14] *Suchita Srivastava v Chandigarh Admn.* (2009) 9 SCC 1
[15] *KS Puttaswamy (Retd.) v Union of India* (2017) 10 SCC 1

MTP ACT: Intersection with other Laws: No statute can be studied in isolation.[16] The MTP Act, 1971, as well as the Pre-Conception and Pre-Natal-Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (henceforth referred to as the PCPNDT Act, 1994), the Protection of Children from Sexual Offences Act, 2012 (henceforth referred to as the POCSO Act, 2012), and the Bhartiya Nyaya Sanhita, 2023 (henceforth referred to as the BNS, 2023) are intertwined in a quadrix.[17]

1. Given the extensive use of sex determination tests and female fetus abortion, the PCPNDT Act aims to prevent female feticide. In our patriarchal society, new reproductive techniques that were developed to detect issues in the embryo have been misused to determine the child's gender. Therefore, the PCPNDT Act effectively outlawed abortion for female children. The MTP Act of 1971 and the PCPNDT Act of 1994, when taken together, present an intriguing contrast: although women's autonomy over their bodies is part of the right to an abortion, it should be illegal for them to abort female fetuses.[18]

2. In India, induced abortion services are governed under the MTP Act. It outlines precisely who, where, and when an abortion can be performed. The POCSO Act of 2012 was passed by the Indian government to prevent and address child sexual abuse. The POCSO Act requires medical professionals to report sexual abuse of children, whereas the MTP Act allows certified physicians to end pregnancies resulting from rape. This is where the two Acts cross.

3. The intersection of the MTP Act and the POCSO Act may result in delays, ambiguity, or even denial of access for young girls seeking abortions. When an adolescent girl is raped and seeks medical assistance to terminate her pregnancy, the doctors are legally obligated to notify the juvenile police unit or police authorities of the incident. Some families use dangerous or illegal abortion methods instead of seeking medical guidance because they are afraid of societal disapproval, putting the unborn child's life in jeopardy.[19]

---

[16] Richard H. Fallon Jr, 'The Meaning of Legal "Meaning" and Its Implications for Theories of Legal Interpretation' (2015) 82(3) The University of Chicago Law Review <https://www.jstor.org/stable/43575199> accessed 11 February 2025
[17] Gupta (n 6)
[18] *Rekha Sengar v State of M.P.* (2021) 3 SCC 729
[19] *Ibid*

The relationship between the MTP Act and BNS was explained by Justice RM Sahai and Justice BL Hansaria in Jacob George (Dr) v State of Kerala[20] as follows: *"After the enactment of the MTP Act 1971, the provisions of the Penal Code relating to miscarriage have become subservient to this Act because of the non-obstante clause in section 3, which permits abortion/miscarriage by a registered practitioner under certain circumstances."*

The Medical Board Will Only Make Decisions About Termination In Certain Circumstances:[21] The MTP (Amendment) Act, 2021 was passed to alleviate the backlog of cases that were submitted as Writ petitions before the Hon'ble Supreme Court and numerous High Courts, asking for authorization to end pregnancies beyond twenty weeks in situations of rape-related pregnancies or fetus abnormalities. Consequently, the window for pregnancy abortions has been extended beyond twenty-four weeks, but only in cases where a Medical Board has found a serious fetus anomaly. It's crucial to remember that this kind of legislation implies that the process for terminating rape-related pregnancies that have progressed over the 24-week mark is the same: a Writ Petition is the exclusive way to get clearance.[22]

ACCESSIBILITY ISSUES IN RURAL AND MARGINALIZED COMMUNITIES

Although access is theoretically increased by the legislative framework, service availability is still a major obstacle. Only registered medical practitioners (RMPs) are permitted to perform abortions under the MTP Act, but there is a serious scarcity of these specialists, especially in rural areas. Dalit, Adivasi, and economically disadvantaged women, who frequently have to travel great distances, are further restricted in their access by the need for specialised facilities.[23] Abortions are more frequently performed in private hospitals, although these facilities are frequently prohibitively costly for low-income women. Despite providing supposedly free services, government hospitals are frequently overworked, poorly equipped, and challenging to get to.

Stigma and Social Barriers:[24] Social stigma is still a significant impediment even in cases where access to legal and medical care is available. Many doctors and hospitals refuse to

[20] *Jacob George (Dr) v State of Kerala* (1994) 3 SCC 430
[21] Kaur (n 1)
[22] Gupta (n 6)
[23] Freedy Andrés Barrios Arroyave et al., 'A Systematic Bibliographical Review: Barriers and Facilitators for Access to Legal Abortion in Low and Middle-Income Countries' (2018) 8(5) Open Journal of Preventive Medicine <https://www.scirp.org/journal/paperinformation?paperid=84591> accessed 13 February 2025
[24] *Ibid*

deliver abortions owing to personal, religious, or moral objections. Women seeking abortions, especially unmarried women, often encounter censure, harassment, and coercion. Married women often seek spouse or family consent because of societal standards, even if it is not legally required. Due to fear of shame or legal barriers, many women opt for risky, illegal abortions. Unsafe abortion remains a primary cause of maternal mortality in India, particularly in rural areas where access to legal abortion is limited.

THE ROLE OF TELEMEDICINE IN ABORTION ACCESS

"Consumers are not only becoming aware of telemedicine but starting to demand access to it. It is becoming a part of the standard of care that should be made available throughout the country."[25]

- Jonathan D. Linkous CEO of the American Telemedicine Association.

A game-changing tool for increasing access to healthcare, especially for reproductive health treatments, is telemedicine. Access to abortion care in India could be improved by incorporating telemedicine, particularly for women living in rural and underdeveloped areas. Legal, moral, and regulatory issues still exist, nevertheless.

Meaning of Telemedicine: Telemedicine/telehealth can be understood as the delivery of healthcare services by healthcare professionals using information and communication technologies for the exchange of valid information for the diagnosis, treatment, and prevention of disease and injuries, as well as continuing education of healthcare providers and research and evaluation, all in the interests of advancing health.[26]

The World Health Organisation (WHO) defines Telemedicine as, 'The delivery of healthcare services, where distance is a critical factor, by all healthcare professionals using information and communication technologies, for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the

[25] Jonathan D. Linkous, 'Survey: Consumers want telemedicine, but where and how to get it isn't always clear' (*MobiHealthNews*, 04 October 2016) <https://www.mobihealthnews.com/content/survey-consumers-want-telemedicine-where-and-how-get-it-isnt-always-clear> accessed 13 February 2025
[26] *Ibid*

continuing education of healthcare providers, all in the interests of advancing the health of individuals and their communities.'[27]

Origin and Growth of Telemedicine: Telemedicine's origins can be traced back to centuries ago when epidemic information was broadcast across Europe through bonfires and heliographs.[28] In the early 1900s, radio was used for casualties and medical reinforcement. Since the 1990s, private organisations and companies have shown interest in developing telemedicine. The introduction of the internet transformed telemedicine by facilitating click-to-consult teleconsultations. To enhance the provision of healthcare, the Indian Ministry of Communications and Information Technology launched the Development of Telemedicine Technology initiative in 1999.

More than 75 telemedicine nodal centres have been developed nationwide by the Indian Space Research Organisation (ISRO) and the Department of Information Technology. One of the first states to use the telemedicine paradigm was West Bengal. To serve the northeastern states, the Department of Space, ISRO, and the North Eastern Council (NEC) established the North Eastern Space Applications Centre (NESAC) in 2000. In isolated locations, the NESAC also set up Village Resource Centres.

A network-enabled hospital information system was successfully introduced in 2001 as part of the Kerala Oncology Network (ONCONET Kerala) Telemedicine Project. Access to digital healthcare has increased thanks to initiatives like eSanjeevani and the National Telemedicine Network (NTN). Telemedicine became a vital tool for providing healthcare, particularly reproductive and abortion services, as a result of the pandemic's acceleration of its use.

Telemedicine Guidelines 2020:[29] The Board of Governors of the Medical Council of India (MCI) has developed guidelines to address the lack of legislation and ethical telemedicine practice in India. The guidelines identify video, audio, and text communication methods and outline conditions for practitioners to use them. They aim to provide practical advice for doctors to use telemedicine in their normal practice, ensuring effective and safe medical care based on current information, resources, and patient needs.

---

[27] 'Global Observatory for eHealth' (*WHO)* <https://www.who.int/observatories/global-observatory-for-ehealth> accessed 13 February 2025
[28] Supreet, *Law relating to Health Care and Technology* (1st edn, Bookwards 2021)
[29] Telemedicine Guidelines 2020

The guidelines also require Registered Medical Practitioners (RMPs) to complete online training sessions within three years. Individuals registered in the State Medical Register or Indian Medical Register are competent to perform telemedicine but must complete an online course within three years, adhering to ethical principles and standards. The Central Government may announce drugs for teleconsultation, including those for common diseases or during public health crises. These drugs are classified into List A, List B, and Prohibited list. RMP must provide patients with signed prescriptions, which must adhere to the code of conduct and not violate the Drugs and Cosmetics Act, of 1940. Prescriptions sent directly to a pharmacy require express agreement and should only be issued to the patient's preferred pharmacy.

The code of conduct and data protection requirements for teleconsultation providers will apply, requiring confidentiality of patient information, proper platform use, patient records, reasonable fees, and receipts/invoices for telemedicine consultations, treating them as in-person consultations.

Telemedicine in Abortion Care: In response to the impact of the COVID-19 pandemic on access to abortion in India, teleconsultation or telemedicine has been suggested. Through voice or video consultations, registered medical practitioners can prescribe electronic medications to expectant moms. However, telemedicine faces societal and legal challenges, including systemic restrictions based on gender, caste, class, religion, or disability. Abortion was deemed a necessary service by the Indian government on April 13, 2020, during the COVID-19 shutdown. However, medical abortions performed using teleconsultation are not specifically permitted by India's abortion laws.

The Telemedicine Practice Guidelines, published by the Ministry of Health and Family Welfare, offer a methodology for telemedicine utilising several teleconsultation techniques, including audio and visual.[30] Medical abortions performed using teleconsultation are not specifically permitted by India's Legal Framework for Abortion. The Guidelines' list of permitted medications has several ambiguities, one of which is the inclusion of medical abortion pills.

[30] *Ibid*

In its October 2020 Advisory on Rights of Women, the National Human Rights Commission (NHRC) emphasised the significance of maintaining access to abortion services. Pregnant women have been forced to choose between waiting for the lockdown restrictions to be lifted, trying a risky abortion, or continuing their pregnancy. The NHRC advised that private health facilities should not refuse abortion services and that medical abortion pills should always be accessible.[31]

POTENTIAL BENEFITS OF TELEMEDICINE IN ABORTION CARE

Increased Accessibility: Women in underserved and rural areas can obtain safe abortion treatments because of telemedicine. It lessens the need for travel, which is especially advantageous for women with limited mobility or financial resources.

Confidentiality and Decreased Stigma: The fear of being judged or criticised, which can be a major deterrent to seeking care, is lessened when healthcare is available discreetly and from home. The privacy offered by telemedicine is crucial for delicate health issues, such as reproductive health, since it enables women to receive the assistance they require without fear of exposure or societal shame. Telemedicine offers a more private and secure option in conservative cultures were going to a clinic could draw unwelcome attention. In addition to protecting privacy, it empowers women by allowing them to make healthcare decisions without worrying about prejudice or injury.

Cost Effectiveness: By lowering the frequency of in-person visits, telemedicine can greatly reduce the burden on healthcare systems and alleviate clinic overcrowding. Healthcare professionals may handle more patients in less time via virtual consultations, which improves system efficiency overall. It also saves money on time and transportation expenses. Patients don't have to go far, which is particularly advantageous for those who live in remote or underdeveloped locations. Additionally, it eases the strain on patients by allowing them to get care in the convenience and affordability of their own homes.

Improved Safety: During a medical abortion, telemedicine guarantees ongoing medical care, which is essential for patient safety and comfort. The danger of complications can be reduced with the right advice from medical experts. A medical abortion frequently includes follow-

[31] Sruthi Chandrasekaran et al., 'The case for the use of telehealth for abortion in India' (2021) 29(2) Sexual and Reproductive Health Matters <https://www.jstor.org/stable/48714669> accessed 14 February 2025

up visits to monitor the procedure, make sure the abortion is complete, and quickly handle any possible problems. In the absence of telemedicine, some women may have to handle the process by themselves or without expert assistance, which raises the possibility of risky treatments. Healthcare professionals can identify issues early, provide guidance, and provide patients with the support they need during the process by providing virtual follow-up care.

CHALLENGES TO TELEMEDICINE IN ABORTION CARE

Legal Restrictions: Online consultation may not always guarantee accurate verification of pregnancy duration, and the MTP Act restricts abortion to certain weeks. Furthermore, it is essential to make sure that only licensed professionals provide abortion drugs to avoid abuse.

Unequal Digital Access: Telemedicine's spread is constrained by rural areas' continued struggles with digital literacy and internet connectivity. Communication between patients and healthcare practitioners might be hampered by sluggish or unreliable video consultations caused by poor internet access. Furthermore, rural communities might not know how to use telemedicine systems efficiently if they lack a solid understanding of technology.

Strengthening E-Pharmacy Regulations: To guarantee the safe and responsible distribution of pharmaceuticals, including abortion pills, online pharmacies must be regulated. Online pharmacies can make healthcare more accessible, but purchasing medications without the right medical supervision carries hazards. In particular, abortion pills should only be taken under a doctor's supervision to guarantee the procedure is safe and to offer the required assistance in the event of difficulties. Without supervision, there's also a chance that dangerous or fake medications could be sold, which could be extremely dangerous for your health.

Training and Certification of Providers: Healthcare providers who offer tele-abortion services must get specific training in both digital counselling and the legal framework surrounding abortion since regional laws might differ greatly. Because distant consultations necessitate distinct communication strategies to guarantee empathy, clarity, and privacy while preserving the patient's comfort and trust, training in digital counselling is essential.

COMPARATIVE ANALYSIS: LESSONS FROM GLOBAL PRACTICES

Canada - Fully Legalized Telly Abortion: In Canada, abortion is no longer illegal. It's medical care. It is financed by the government. Who is qualified to offer care in your region and where you live determines access. Abortion is a regular, popular, and safe procedure.[32] There is Advance Provision and Menstrual Regulation in Canada. People have abortion pills on hand in case they need them, according to advance provision. For this to happen, a doctor would have to be open to prescribing pharmacological abortion to a non-pregnant patient. To guarantee that the medication is appropriate, the doctor would probably need to perform a screening beforehand.

As an alternative, advance provision can entail the individual getting the tablets online while not pregnant, which entails the logistical and legal issues already mentioned.[33] Menstrual regulation, or MR, is the practice of taking misoprostol and mifepristone following a missing period without being aware of the possibility of pregnancy. In this context, the phrase missed-period pills (abbreviated MPP) may also be employed.

According to a 2020 study, more than 40% of the 678 respondents said they would be considering missed-period medications. The study concluded that before taking medications that could disrupt a pregnancy, some people with missed periods do not want pregnancy confirmation. Therefore, making missed-period pills available in the US would increase the range of reproductive services available and maybe enhance patient-centred care delivery. In Canada, this would probably be the case.[34] However, it is illegal to sell either mifepristone or mifegymiso, the Canadian trade name for the combination medication containing mifepristone and misoprostol, to anybody without a prescription.[35]

The UK's Pills by Post Program: As a stopgap measure during the COVID-19 pandemic, the UK launched the Pills by Post scheme in March 2020 to guarantee ongoing access to early medical abortion services. Mifepristone and misoprostol, the drugs used in abortions, were

[32] 'Accessing Abortion in Canada Pamphlet by Wellness Within' (*Action Canada for sexual health and rights*, 14 September 2022) <https://www.actioncanadashr.org/resources/factsheets-guidelines/2022-09-14-accessing-abortion-canada-pamphlet-wellness-within> accessed 14 February 2025
[33] *Ibid*
[34] *Ibid*
[35] Julianne Stevenson and Jennifer Taylor, *Self-Managed Abortion in Canada* (2022)

mailed to eligible women up to 10 weeks pregnant as part of this program, allowing them to do the procedure at home without going to a clinic.

The initiative sought to solve obstacles to in-person medical care during lockdowns and lower the likelihood of COVID-19 transmission.[36] The program was originally scheduled to end, but it was extended and declared permanent in England and Wales in March 2022 after receiving parliamentary approval. Data showing the efficacy and safety of telemedicine abortions, together with the enhanced accessibility they offered, played a role in this choice.[37] To integrate telemedicine into its healthcare system, especially for reproductive services, India might learn from the UK's experience.

Australia - Nationwide Tele-Abortion Services: People can end early pregnancies (up to 9 weeks gestation) from the comfort of their homes with Australia's nationwide tele-abortion facilities, which offer safe and private medical abortion care via telehealth. This method entails phone or video consultations with medical specialists, after which the patient receives the required prescription drugs at their home. Among the leading suppliers of these services are Clinic 66 and Marie Stopes International (MSI) Australia. Comprehensive tele-abortion services from MSI Australia include medicine delivery, follow-up care, and two clinical consultations.

Clinic 66 provides telemedicine medical abortion services through its platform, Abortion Online. Over the last ten years, Australia's tele-abortion paradigm has changed. Women can now get medical abortions without going to a clinic thanks to a nationwide direct-to-patient telemedicine service that was introduced by the Tabbot Foundation in 2015. This program was a major step towards making abortion services more widely available nationwide.[38] With the exception of South Australia, tele-abortion services are well-established and readily available in Australia as of February 2025.

These services offer a dependable choice for early pregnancy termination and have been incorporated into the healthcare system. Usually, the procedure entails remote initial and

[36] *Ibid*
[37] Denis Campbell, 'MPs vote to continue abortion 'pills by post' scheme in England' *The Guardian* (30 March 2022) <https://www.theguardian.com/world/2022/mar/30/mps-vote-to-continue-abortion-pills-by-post-scheme-in-england> accessed 15 February 2025
[38] Paul Hyland et al., 'A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months' (2018) 58(3) The Australian & New Zealand Journal of Obstetrics & Gynecology <https://doi.org/10.1111/ajo.12800> accessed 15 February 2025

follow-up consultations as well as direct patient medication delivery. For people looking for abortion services, this approach guarantees privacy and ease.[39] India can improve its reproductive healthcare services by learning a lot from Australia's tele-abortion framework.

The lack of access to abortion services in rural and isolated locations is one issue that may be resolved in India by putting in place a comparable telemedicine strategy. India might increase the availability of medical abortion services by utilising telemedicine, guaranteeing that women, irrespective of their location, have access to safe and lawful options. But it's important to consider India's particular structural problems, such as differences in healthcare infrastructure, internet availability, and sociocultural aspects. These obstacles would need to be removed to adapt the tele-abortion model to the Indian setting and guarantee fair and efficient service provision.[40]

WHAT INDIA CAN LEARN?

To provide safe, easily accessible, and private reproductive healthcare, India can learn a lot from other countries' experiences incorporating telemedicine into abortion services. The viability and efficacy of telemedicine-based abortion services have been demonstrated by the successful implementation of laws in nations like the United Kingdom, Canada, and Australia.

The regulatory latitude that permits medical professionals to give remote medical abortion consultations is among the most important lessons learnt. The government of the United Kingdom implemented a regulation during the COVID-19 epidemic that permits women to obtain medical abortion pills using telemedicine, eliminating the need for in-person appointments.

According to studies, this strategy increased accessibility, decreased wait times, and preserved patient safety; as a result, the UK made telemedicine for early abortion a permanent policy in 2022. Likewise, Canada has a well-established abortion telemedicine system. Since 2017, the nation has allowed mifepristone to be administered through telehealth, increasing availability, particularly for women living in rural and isolated

[39] *Ibid*
[40] Dipika Jain et al., 'Medical abortion through telehealth in India: a critical perspective' (2022) 29(2) Sexual and Reproductive Health Matters <https://doi.org/10.1080/26410397.2022.2107090> accessed 15 February 2025

locations. According to research, Canadian telemedicine abortion procedures are as safe, successful, and fraught with few difficulties as in-person care.

These international examples highlight the necessity for India to:

Update Legal Barriers: India's existing legal system does not specifically allow telemedicine for abortion. Access might be significantly improved, particularly in underserved areas, by implementing a clear policy that permits teleconsultations and at-home medical abortion.

Ensure Digital Healthcare Infrastructure: To make tele-abortion a reality, especially for women in rural and tribal regions, telehealth platforms must be strengthened and internet connectivity must be widely available.

Educate Medical Professionals: Abortion care has been successfully incorporated into primary healthcare in nations like Canada, where telemedicine-based services are provided by qualified general practitioners. India might follow suit to lessen its reliance on specialised gynaecologists, who are frequently hard to find in rural areas.

Address Stigma and False Information: Abortion is still very stigmatised in many regions of India. Public awareness initiatives that are based on evidence-based outreach initiatives in the UK and Canada may be able to debunk myths and promote reasoned decision-making.

SUGGESTIONS

Lower mortality rates and safe abortion services must be given top priority if women's sexual and reproductive health is to improve in India. It’s taboo to talk about abortion, and because many women are unaware that there are legal abortion options available, they think it's illegal. Enhancing understanding of abortion occurrences, educating women about the law and their rights, enhancing abortion services, and offering top-notch facilities are some suggestions for ensuring safe abortion.

Many women in remote regions experience difficulties in accessing licensed facilities or lack access to qualified providers. More skilled professionals should be trained, and comprehensive MTP training programs for post-abortion care and contraception advice should be offered. The prevalence of unintended pregnancies and unsafe abortions among teenagers is rising; thus, adolescent reproductive health services need to be. Since the Medical

Termination Act does not take rights-based methods into account, the gestation time for termination should be extended by a maximum of 24 weeks.

Given that the majority of women consult their spouses when making decisions about reproductive health, men must be included in reproductive health education. Men should be educated about the value of safe abortion, the repercussions of unsafe abortion, the warning signals of problems following an abortion, and how to get involved in campaigns that support small families and the use of contraceptives.

In India, community-based providers and other organisations can be crucial in guaranteeing women's reproductive rights. This multi-sectoral strategy can assist in addressing these challenges as the government decentralises health services and panchayats become involved in the healthcare system.

CONCLUSION

Given that women are in charge of their destiny and that birth happens in their bodies, reproductive autonomy is essential to their welfare. While it is acknowledged that these rights are unalienable and constitute a component of human rights, moral restraints frequently prohibit women from freely expressing their bodily autonomy. Although new methods have been developed in India to provide access to safe abortions, the majority of abortions take place outside of medical institutions, endangering the lives of expectant mothers.

Safe and medical abortion is further impeded by the patriarchal society and the stigma associated with women, especially single women. Women are constantly subjugated by males and are unable to act independently. Constitutional principles testify to the fragility and destabilising nature of the social order, which is composed of overlapping systems. Unsafe abortions have an adverse effect on a woman's sexual and reproductive health, leading to medical issues as well as mental and emotional distress.

Women's human and fundamental rights are violated when they are denied access to safe abortion. Teenagers frequently turn to unmarried women for abortions, particularly those who fall pregnant outside of a medical facility. In cases when they are unable to connect with family members and need more care, post-abortion facilities, and medical assistance should

receive more attention. To sum up, reproductive autonomy is essential to women's welfare, and its absence endangers the lives of expectant mothers improving access to safe abortion and removing the stigma attached to women's reproductive autonomy are key to resolving these problems.