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Gender, Reproductive Health, and Abortion in Contemporary India

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Abstract

In India, abortion is a major public health, social, and gender problem that is intimately related to women's health, reproductive rights, and general well-being. The Medical Termination of Pregnancy (MTP) Act provides a legal framework, but access to safe and reasonably priced abortion procedures is still inconsistent among social classes and geographical areas. This study looks at how abortion affects gender health and wellbeing in India, emphasizing aspects related to physical, psychological, social, and reproductive health. It investigates how abortion-related experiences and results are impacted by variables such gender inequity, low knowledge, societal stigma, poor healthcare infrastructure, and socioeconomic inequities. According to the study, having access to safe abortion services improves women's health by lowering maternal mortality, stopping unsafe abortion practices, and increasing reproductive autonomy. However, many women—especially those from underprivileged communities—are frequently forced to seek risky procedures due to obstacles to accessing healthcare, which can lead to major health issues and psychological suffering. The wider effects of abortion on gender health, such as women's empowerment, ability to make decisions, level of education, and involvement in the economy, are also covered in this study. The study highlights the necessity of bolstering reproductive healthcare services, advocating gender-sensitive legislation, raising knowledge of legal rights, and tackling the social stigma associated with abortion. It is based on secondary data and current literature. Improving gender health outcomes and accomplishing more general objectives of gender equality and sustainable development in India depend on ensuring fair access to safe abortion services.

Keywords: Abortion, Gender Health, Women's Health, Reproductive Rights, MTP Act, Gender Equality, Wellness, India.

Introduction

The research that is being presented falls within the field of sociology of gender and health. The study of women's health, including abortion, falls within the category of gender and health in sociology. An abortion is a medical or surgical treatment used to purposefully terminate a pregnancy before the embryo or baby is born. It is sometimes referred to as a pregnancy termination. Either medication or surgery are used to terminate the pregnancy. Unsafe abortion complications are a significant public health concern for women in poor nations. Abortion is permitted in India for a variety of societal and medical reasons. Officially, minors require their father's or husband's consent before receiving safe abortion services from qualified medical professionals at facilities that have been registered. (Menon, N. 1995).

In reality, women are denied access to safe abortion services due to a number of factors, including restricted access to licensed abortion providers, the risk of forced contraceptive acceptance, the expense of obtaining a legal abortion, the stigma attached to induced abortion, and a lack of knowledge about the procedure's legality. Because of this, women frequently turn to unskilled covert practitioners working in hazardous environments. The

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consequences of abortions performed under such circumstances range from life threatening to chronic reproductive tract morbidity such as infections, chronic disability and infertility. For every 100,000 live births in India, an estimated 453 women pass away from maternal causes each year (UNFPA 1997). (Ghose, A., Inamdar, P., & Bagchi, P. 2022).

The wide variety across states is hidden by this statistic. Although state and national estimates are not exact, they can show certain patterns. In 1992, there were around 738 and 711 maternal fatalities per 100,000 births in Orissa and Madhya Pradesh, respectively. Kerala has a very low ratio of 87 maternal deaths per 100,000 births among the big states. It is estimated that unsafe abortions account for 15% of maternal mortality in India on average. Under what circumstances are these abortions performed? What effects do these unintended pregnancies have? In both rich and developing nations, women, couples, and communities depend on this reproductive health service. (Tomar, P., Tripathi, N., & Pathak, P. K. 2026).

Induced abortion is a crucial component of women's reproductive health care when faced with unwanted pregnancies, particularly in situations where women lack access to adequate family planning. Women's health depends on the availability and safety of abortion services, and one element in that process is to create a favourable legal environment. (Patra, A. 2024). Since 1971, abortion has been permitted in India, the world's second most populous nation, for a variety of reasons. Approximately 26% (328 million) of India's more than 1.2 billion inhabitants are women of reproductive age (15–49). Data from the 2012 Sample Registration System indicates that Indian women give birth to an average of 2.4 children over their lives. Six: The total fertility rate, a crucial measure of reproductive health, has decreased from 3.6 in 1991. Compared to their rural counterparts (2.6), urban women have fewer children (1.8). The social, demographic, and economic variety of India's states as well as the disparities in access to healthcare services across the nation are reflected in the broad variations in reproductive outcomes. (Visaria, L., Kalyanwala, S., & Ramachandran, V. 2026).

Literature review

Educate men and women of reproductive age about the risks associated with unsafe abortion practices and the availability of safe abortion services. Pregnant women, mothers-in-law, and husbands frequently make household decisions. Campaigns that raise awareness of the risks associated with unsafe abortion services as well as the availability of safe abortion facilities and procedures might focus on all of these issues. Both women seeking abortions and those who choose the providers of abortion care must prioritize safe abortion services.

A key element of any awareness-raising effort is the stage of gestation at which a woman can safely terminate a child. When a problem is initially identified, the care a woman receives is critical. The female head of family usually takes care of the lady first in her own home. When it comes to deciding whether or not to seek care, women with problems typically have a supporting role. Verifiable statistics on the incidence of abortion has been found to be lacking in India. Abortion and unsafe abortion rates vary greatly. Acceptable methods for gathering data on abortion incidence are labour-intensive, include a variety of data collection techniques, and require the construction of questionnaires that take into account local cultural norms.

The book "The Ethics of Abortion: Woman's Rights, Human Life, and the Question of Justice" was written by Christopher Kaczor. The Ethics of Abortion is the book's central theme. A thorough investigation was conducted

in Meghalaya for Detal Navin's book, "Improving Comprehensive Abortion Care Services in Meghalaya." (Jacob, A. 1974). The lady may see a competent allopathic physician, a skilled midwife, a variety of community-level practitioners, or a traditional birth attendant if such treatment is deemed required. In rural communities, there is a common lack of knowledge regarding the kinds of treatments and the providers that women accuse of providing abortion services. This service delivery gap has to be better identified and addressed if women who need emergency treatment after an abortion complication are not getting it from the health care system (Potts et al. 1998; Johnston et al. 2001).

In most nations, including India, the third crucial component of abortion care connecting women to other reproductive health services is hampered by a lack of knowledge and suitable facilities. (Patel, T. 2018). Numerous studies carried out in Uttar Pradesh have shown that medical professionals are not concerned about post abortion reproductive health care, such as screening for and treating STDs and RTIs, because they are unaware of the risk that STDs or RTIs could contribute to the spread of HIV or morbidity like secondary infertility. (Bandewar 2000; Mathai 1999) Improve the facilities that now provide abortion services. In order to guarantee that safe abortion service providers are present at their locations during clinic hours, that fees do not surpass a predetermined threshold, and that patients receive high-quality care from the moment they enter the clinic through the provision of services and contraceptive counselling, monitoring of these providers may be required. Monitoring services might be offered by both public and private medical officials.

Objectives of the research

1. To understand the socio-ethical condition of pregnancy termination. .
2. To study about the interrelationship between the woman and their family members.
3. Raising Awareness of welfare Action Plan regarding to woman health.

Discussion and data analysis

The Medical Termination of Pregnancy Act In order to control and provide access to safe abortion, the Indian Parliament approved the Medical Termination of Pregnancy (MTP) Act in 1971.2 As of this writing, this law allows only licensed allopathic physicians at approved abortion facilities to perform abortions in order to save a woman's life or to maintain her physical or mental health; it also permits abortions in situations involving rape, incest, economic or social necessity, fatal impairment, or the failure of a married woman's or her husband's contraceptive method. (Chattopadhyay, S. 1974).

The lady's husband or other family members do not need to provide their approval for the abortion, but if the woman is under the age of 18 or mentally ill, a guardian's consent is needed. The statute permits the termination of an unwanted pregnancy up to 20 weeks of gestation; however, a second doctor's consent is needed if the pregnancy is more than twelve weeks. The Medical Termination of Pregnancy Act of 1971 significantly expanded the list of conditions under which abortion is permitted in India. By passing this Act, the government hoped to lower the number of illegal abortions and the ensuing morbidity and death rates among mothers. (Dalvie, S., Barua, A., & Apte, H. 2015).

However, due to the obstacles to legal abortion, most women seeking abortions continue to seek services from uncertified providers thirty years after the historic legislation was passed. While some unlicensed practitioners provide safe treatments, many perform unsafe abortions that lead to complications or even death. Women who have less access to services, such as teenagers and low-income rural women, are more likely to have unsafe abortions and have complications. According to studies, the woman performing the abortion typically chooses a certain physician with the help of her spouse or other family members. (Jain, D. 2024).

Although the exact number of abortions performed in India is unclear, the most often used estimate is that over 6.7 million abortions occur there each year. Only around one million of these are carried out lawfully, according to official data. Both medical professionals and non-medical professionals carry out the remaining abortions. Given that abortion is permitted for a wide range of reasons and accessible in both the public and private health sectors, unsafe abortion rates are quite high in India. Abortion services are currently not sufficiently decentralized, and true decentralization of legal services would require legislative reform. To reduce morbidity and mortality from unsafe abortion in this context, several broad activities require strengthening: decreasing unwanted pregnancies; increasing access to safe abortion services; and increasing the quality of abortion care, including post abortion care. (Patel, K., & More, V. 2025).

Ratios of MTPs, Government Approved MTP Facilities and Population by State

State	No. of MTPs (1993–94)	No. of Approved Facilities	Population (1996)	MTP Facility Ratio	MTP Population Ratio	Population per Facility
Andhra Pradesh	13,719	373	72,155,000	37	0.19	193,445
Assam	21,372	100	24,726,000	214	0.86	247,260
Bihar	11,060	209	93,005,000	53	0.12	445,000
Gujarat	10,263	700	45,548,000	15	0.23	65,069
Haryana	22,438	228	18,553,000	98	1.21	81,373
Karnataka	9,077	471	49,344,000	19	0.18	104,764
Kerala	34,433	559	30,965,000	62	1.11	55,394
Madhya Pradesh	33,086	295	74,185,000	112	0.45	251,475
Maharashtra	97,079	1,775	86,587,000	55	1.12	48,781
Odisha	19,510	169	34,440,000	115	0.57	203,787
Punjab	19,436	242	22,367,000	80	0.87	92,426
Rajasthan	29,023	316	49,724,000	92	0.58	157,354
Tamil Nadu	42,364	623	59,452,000	68	0.71	95,429
Uttar Pradesh	12,103	425	156,692,000	29	0.08	368,687
West Bengal	64,273	452	74,601,000	142	0.86	165,047
India	609,915	9,271	934,218,000	63	0.65	100,768

Source: Compiled from research data on abortion practices in India.

Amendments to the MTP Act :

Since 1971, the Indian government has implemented policies aimed at increasing the number of legal abortion providers in order to provide access to safe and legal abortion services. Prior to 2000, there was little real abortion provision in lower-level public facilities (such basic health centres), even if it was allowed in the public sector. The National Population Policy formally suggested in 2000 that abortion be made available in all public institutions, including primary health centres, up to eight weeks of gestation.21. Ten years later, community health centres are still the principal providers of abortions up to eight weeks of gestation, and lower-level service is still difficult since most primary health clinics lack qualified abortion physicians on staff.

Proposed 2014 Amendment to the MTP Act

A change to the MTP Act, which was formally suggested by the Ministries of Health and Law in 2014 and is currently awaiting approval by Parliament, has been discussed for a number of years by government officials, advocacy groups, and segments of the Indian medical community. The 2014 draft amendment proposes expanding access to legal abortion to nurses, auxiliary nurses, midwives, and practitioners trained in the Indian System of Medicine with recognized qualifications in Ayurveda, Unani, Siddha, or homeopathy. It also increases the gestational age and permits abortion at a woman's request up to 12 weeks.

Medical Termination of pregnancy act (2020)

The Rajya Sabha passed Medical Termination of Pregnancy (amendment) Bill,2020. The bill was passed in the Lok Sabha in March 2020.

The Bill seeks to amend the Medical Termination of Pregnancy Act (1971).

Provisions: Termination as a result of contraceptive method or device failure:

- According to the Act, a married woman may end a pregnancy up to 20 weeks if a contraceptive technique or device fails. For this reason, the Bill permits single women to also end a pregnancy.
- One certified medical professional's opinion is required for pregnancy termination up to 20 weeks of gestation, rather than two or more.
- Gestation is the period of foetal development between 20 and 24 weeks of gestation, according to the opinions of two licensed medical professionals.
- If there are significant fatal abnormalities, the state-level medical board's opinion is required before a pregnancy can be ended after 24 weeks. A medical board must be established by each state government.
- A gynaecologist, a paediatrician, a radiologist or sonologist, and any additional number of members that the state government may specify will make up these Medical Boards.
- Upper Gestation Limit for Special Categories: It raises the upper gestation limit from 20 to 24 weeks for certain groups of women, which will be specified in the MTP Rules' amendments. These groups would include rape survivors, incest victims, and other vulnerable women, such as minors or women with disabilities.
- Confidentiality Unless authorized by a current legislation, the "name and other particulars of a woman whose pregnancy has been terminated shall not be revealed."

Contemporary debate on MTP in India: -There has been a debate which has been raised in India now a days that is-

- Time limit should be increase above from 24 weeks in rarest cases such as rape victims, so that justice could meets to the victim.
- Abortion laws should be delinked from criminal laws. It should be treated as health care problem.
- MTP and POCSO acts are linked, it shouldn't because it is fearful issue so that victims are choose to unsafe abortion.

As in 2022 Supreme court given a judgement on MTP, add article 21 with MTP as they have right to dignity, privacy and body autonomy. Decisional authority only will have to be pregnant lady. SC also said POCSO and MTP should be treated equally.

Difference between MTP Act 1971 and MTP Amendment Act 2021

Basis of Difference	MTP Act, 1971	MTP Amendment Act, 2021
Full Name	Medical Termination of Pregnancy Act, 1971	Medical Termination of Pregnancy (Amendment) Act, 2021
Objective	To legalize abortion under certain conditions	To expand safe and legal access to abortion services for women
Maximum Gestation Limit	Up to 20 weeks	Up to 24 weeks for certain categories of women
Opinion of Doctors	1 doctor up to 12 weeks; 2 doctors for 12–20 weeks	1 doctor up to 20 weeks; 2 doctors for 20–24 weeks
Eligible Women for 20–24 Weeks	Not specifically mentioned	Includes rape survivors, minors, differently-abled women, victims of incest, etc.
Unmarried Women	Mainly focused on married women	Includes unmarried women also
Contraceptive Failure Clause	Applicable only to married women and husbands	Applicable to any woman and her partner
Privacy and Confidentiality	No strong confidentiality provision	Identity and details of woman kept confidential
Medical Board Provision	No Medical Board provision	State-level Medical Board for foetal abnormality cases
Termination Beyond 24 Weeks	Generally, not allowed	Allowed in special foetal abnormality cases
Women's Reproductive Rights	Limited recognition	Greater emphasis on dignity and autonomy
Focus	Population control and maternal health	Women-centric healthcare and reproductive justice
Legal Protection for Doctors	Basic legal protection	Expanded legal clarity and protection

Use of Technology	Based on older medical standards	Updated according to modern medical practices

Conclusion: Compared to the MTP Act of 1971, the MTP Amendment Act of 2021 is more inclusive and progressive. It increases access to safe abortion services, guarantees anonymity, and broadens women's reproductive rights.

Abortion, contraception and gender. The availability and usage of contraceptives, as well as the social, cultural, family, and gender dynamics around whether and when contraception is appropriate, all influence the necessity for abortion in India. In fact, the majority of unwanted pregnancies that were ended by abortion happened during times when women were not using any kind of contraception, according to qualitative studies carried out as part of the Abortion Assessment Project in several states in 2002; very few were reportedly caused by contraceptive failure.

Abortion among unmarried adolescents- Being pregnant or giving birth outside of marriage is highly stigmatized in India, particularly in youth. Nearly all (92%) of the 549 unmarried teenagers who had abortions in Bihar and Jharkhand during 2007 and 2008 done so because they were single or did not want to raise a kid by themselves. A sizable minority of respondents (18%) stated that the pregnancy was the consequence of nonconsensual sex, which was typically carried out by neighbours (6%) or family members (9%). In-depth interviews conducted in Maharashtra between 1996 and 1998 yielded similar results. Most of the 16 unmarried teenagers who had abortions stated that their pregnancy was the consequence of having nonconsensual intercourse with a family member or their job (Patel, T. 2018).

Son preference and sex-selective abortions. Son preference is influenced by a variety of social, cultural, and economic factors, such as patrilineal kinship and inheritance customs, a patrilocal marriage system, the belief that sons will assist with farming or a family business and provide security for their parents in old age, and religious customs requiring sons to perform last rites for their parents.68, 77, 78 Daughters, on the other hand, often pay dowries and other marriage-related expenses, depart after marriage, and seldom help their elderly parents. (Gangoli, G. 1998).

Conclusion

Thirty years after the indications for legal abortion were significantly liberalized in India, this review of the literature demonstrates that morbidity and death from unsafe abortion continue to be a major issue for Indian women. According to research findings, unsafe abortions are widespread, with teenagers and single women particularly at risk for morbidity and death. Additionally, research indicates that the needs of Indian women, especially those living in rural areas, are not being met by the present legal abortion services for a variety of reasons. A substantial sample of licensed providers and registered institutions in four states have been thoroughly examined, and methods for enhancing services have been found in those four state studies. Additionally, methods for enhancing clinical care have been found via facility-based research on abortion provision.

The demands of women at the community level have been documented in several qualitative studies. The literature review is used to inform policy review suggestions. Members of the Ministry of Health and Family Welfare, public and private abortion providers, and important non-governmental groups must work together to revise any policy. This study of the literature demonstrates how much is known about the availability of safe and unsafe abortion services in India, as well as the need to enhance safe abortion and contraception options in order to better serve the needs of women who become pregnant unintentionally. However, much more research must be done before initiatives to guarantee low-income Indian women have easy access to safe abortion services are put into place. The cost in terms of women's health and lives emphasizes the need to efficiently and effectively pursue efforts to make abortion safer and more accessible for Indian women.

Suggestions

- Raise Awareness of Legal Abortion Rights: Run campaigns to raise awareness of women's reproductive rights and the Medical Termination of Pregnancy (MTP) Act. Distribute information via educational institutions, healthcare facilities, and online resources.
- Improve Access to Safe Abortion Services: Increase the number of safe and reasonably priced abortion clinics, particularly in underserved and rural regions. Make sure government health facilities are staffed by qualified medical personnel.
- Lessen Social Stigma: To lessen stigma and prejudice in society, encourage candid conversations about abortion and reproductive health. Promote neighborhood-based initiatives that assist women in making reproductive decisions.
- Enhance Reproductive Health Education: Include reproductive health awareness and thorough sex education in school curricula. Inform men and women about safe abortion procedures, family planning, and contraception.
- Strengthen Counseling and Mental Health Support: To address emotional and psychological issues, offer counseling services before to and following abortion. Create support networks for women dealing with issues related to their reproductive health.
- Boost Family Planning Services: Make current contraceptive techniques and family planning information more widely available. Encourage people to make educated decisions about their reproductive health.
- Address Gender Inequality: Put laws into place that give women more control over their reproductive choices. Promote male involvement and shared accountability in areas pertaining to reproductive health.
- Enhance Data Gathering and Research: Regularly study women's experiences, healthcare access, and abortion trends. Create evidence-based policy based on trustworthy regional and national data.
- Ensure Confidentiality and Privacy: Healthcare institutions should maintain strict confidentiality to encourage women to seek safe medical services without fear of social repercussions.

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