

MYTHS AND  
MISCONCEPTIONS  
AROUND ABORTION  
IN INDIA

## ABOUT THE YP FOUNDATION

The YP Foundation (TYPF) is a youth development organisation that facilitates young people's feminist and rights-based leadership on issues of health equity, gender justice, sexuality rights, and social justice. TYPF ensures that young people have the information, capacity, and opportunities to inform and lead the development and implementation of programmes and policies that impact their lives and are recognised as skilled and aware leaders of social change.

TYPF's Safe Abortion for Everyone programme advocates for comprehensive abortion services in India by generating evidence through research and encouraging youth-led advocacy through our multilingual online courses and fellowships

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Produced by The YP Foundation with support from the Safe Abortion Action Fund



Published in August 2022

## INTRODUCTION

Fifty years into enacting the Medical Termination of Pregnancy Act of 1971, abortion continues to be a contested topic in India. The several myths and misconception around abortion reinforce the stigma that further poses a barrier for pregnant persons in accessing safe and comprehensive abortion services. While there are no exclusive studies conducted on such myths and misconceptions, however, research on abortion providers, unmarried and married abortion seekers in urban and rural spaces have documented statements reflecting them. This document consolidates such statements, and also provides scientific responses against them.

## METHODOLOGY

The compilation is from a selected list of published researches and reports on abortion and maternal health in India. To streamline the articles, web-searches on PubMed, Medline and Google Scholar were done. Using the keywords, “abortion myths”, & “India”, 2 articles were shown on PubMed, 26 on Google Scholar, and zero on Medline. The keywords, “abortion misconception” & “India” resulted in 8 articles on PubMed, 3 on Google Scholar, and zero on Medline. The results on the web-searches showed the evident literature gap and the lacking terminology of ‘abortion myths’ and ‘abortion misconception’ in the studies conducted in India. This was further challenging to find materials for this review. The articles were further extracted from the Annotated Bibliography on ‘Maternal Health and Abortion in India, 2000–2014’ published by Achutha Menon Centre for Health Science Studies and Sree Chitra Tirunal Institute for Medical Sciences & Technology, Kerala, India\*. The annotated bibliography has 151 abstracts reviewed from various studies on reproductive and maternal health. The list of studies from web-search and from the Annotated Bibliography was further refined based on the review of the abstracts and relevance to this review.

Finally, 29 articles were considered for the review and are cited in the References. The myths and misconceptions statements that emerged from the review are categorized under the themes of ‘Medical Procedures and Public Health’, ‘Legal’, and ‘Gender and Social Norms’. These ‘Myths’ in the first column are addressed with ‘Facts’ in the second column, followed by ‘Demographics’ that indicates where/who they came from. The ‘Additional Information’ section under each category are certain important inferences that came out during the review process of the articles.

\* Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST). Studies on Maternal Health and abortion in India:2000–2014. An Annotated Bibliography. Trivandrum, Achutha Menon Centre for Health Sciences and Studies, SCTIMIST, 2015.

# MEDICAL PROCEDURES AND PUBLIC HEALTH



## MEDICAL PROCEDURES AND PUBLIC HEALTH



MULTIPLE  
ABORTIONS  
ARE RISKY

MYTH

There is no evidence that having more than one abortion in a lifetime causes any ill effects on health or on future pregnancies. If done with safe methods and settings by a qualified service provider, there is no increased risk for multiple abortions.

Lack of, or inability to access contraception, surviving abuse and violence, and health complications, are some of the reasons why people undergo repeated abortions.

FACT



### DEMOGRAPHICS

- MTP providers (ObGyns+ MBBS degrees) from rural Jharkand (Bokaro).<sup>4</sup>
- MTP providers (qualified +unqualified RMPs) from Maharashtra.<sup>5</sup>

# MEDICAL PROCEDURES AND PUBLIC HEALTH

MYTH	FACTS	DEMOGRAPHICS
Misoprostol intake can be done anytime after Mifepristone intake	<p>The recommended dosage for less than 12 weeks the pregnancy is Mifepristone 200 mg orally, followed 1-2 days later by Misoprostol 800 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue)</p> <p>World Health Organization, 2019. Medical management of abortion. World Health Organization.</p>	<p>MTP providers (ObGyns—both degree and diploma + MBBS) from Bihar (Patna, Muzaffarpur, Bhagalpur, Nawada) and Maharashtra (Aurangabad, Wardha, Satara, Thane, Mumbai)<sup>1</sup></p> <p>Pharmacists from Bihar, Jharkhand<sup>2</sup> and Delhi<sup>3</sup></p>
MA pills do not have a fixed dosage	<p>The recommended dosage for less than 12 weeks the pregnancy is Mifepristone 200 mg orally followed 1-2 days later by Misoprostol 800 mcg vaginally, buccally (inside the cheek) or sublingually (under the tongue)</p> <p>World Health Organization, 2019. Medical management of abortion. World Health Organization.</p>	<p>MTP providers (ObGyns—both degree and diploma + MBBS) from Bihar (Patna, Muzaffarpur, Bhagalpur, Nawada) and Maharashtra (Aurangabad, Wardha, Satara, Thane, Mumbai)<sup>1</sup></p> <p>Pharmacists from Bihar, Jharkhand<sup>2</sup> and Delhi<sup>3</sup></p>
Performing abortion in second trimester is risky	<p>Abortions are safer when performed as early as possible. However, with advances in medical technology, second-trimester abortions are safe when performed by trained providers with appropriate recommended methods under safe conditions.</p>	<p>MTP providers (ObGyns+ MBBS degrees) from rural Jharkhand (Bokaro)<sup>4</sup></p> <p>MTP providers (qualified +unqualified RMPs) from Maharashtra<sup>5</sup></p>
Home remedies such as eating raw papaya, sesame seeds and jaggery, insertion of a stick that had been dipped in the latex into the uterus are methods of abortion	<p>These methods are not medically approved and are unsafe to practice.</p> <p>Abortion seekers are forced to opt for such methods due to a lack of access to modern methods under safe conditions.</p> <p>These methods could induce serious health complications including death.</p>	<p>MTP providers (unqualified herbal) from rural Jharkhand (Bokaro)<sup>4</sup></p> <p>Young married women from rural Tamil Nadu (Vellore)<sup>6</sup></p> <p>Married women from Maharashtra, Gujarat, Andhra Pradesh, and Tamil Nadu<sup>8</sup></p> <p>Women from rural and suburban slums of Maharashtra (Pune<sup>9</sup> and Mumbai<sup>10</sup> respectively)</p> <p>Married women who have undergone abortion from rural Tamil Nadu (Dharampuri)<sup>11</sup></p>

<p>Abortion is more dangerous and difficult than natural delivery</p>	<p>On the contrary, safe abortion is less risky than childbirth. The 2018 National Academies of Sciences conducted a study on different mortality rates in the US for abortions at different gestations and childbirth. It states that the “risk of death subsequent to legal abortion (0.7 per 100,000) is a small fraction of that for childbirth (8.8 per 100,000).</p> <p>Abortion-related mortality is also lower than that for colonoscopies (2.9 per 100,000), plastic surgery (0.8 to 1.7 per 100,000), dental procedures (0.0 to 1.7 per 100,000), and adult tonsillectomies (2.9 to 6.3 per 100,000).” You can read the full study here.</p>	<p>Women from rural Maharashtra (Pune)<sup>9</sup></p>
<p>Abortion if done in first pregnancy can affect future fertility</p>	<p>There is no relation between safe abortion and fertility. If performed under safe conditions, abortions are very safe and do not have any long-term consequences including on fertility.</p> <p>However, if performed under unsafe conditions, abortion can lead to morbidity and mortality including reproductive tract infections that can affect future fertility.</p>	<p>Women from rural Maharashtra (Pune)<sup>9</sup></p> <p>MTP providers (qualified +unqualified RMPs) from two districts of Maharashtra<sup>5</sup></p> <p>Survivors of rape who sought abortion<sup>12</sup></p>
<p>Circulation of MA pills in the market has increased sex-selective abortion</p>	<p>Sex-determination is possible through USG and not in the first trimester while MA pills are prescribed legally for induced abortions in the first trimester, and under medical supervision, in certain cases, multiple dosages are prescribed to induce abortion in the second trimester.</p> <p>However, focusing solely on the circulation of the MA pills fails to address the issue of sex-selective abortion effectively and curtails access to abortion services. There are multiple factors contributing to increasing sex-selective abortion such as the poor implementation of the PCPNDT Act, medical providers who perform sex determination against the law, and societal pressures related to gender, leading to son preference and daughter aversion.</p>	<p>Pharmacists from Bihar,<sup>13</sup> Maharashtra,<sup>13</sup> Rajasthan,<sup>13</sup> and Uttar Pradesh<sup>13 28</sup></p>

## ADDITIONAL INFORMATION

- While unqualified MTP providers certainly know they are not technically recognised as healthcare providers, they are unaware that abortion service provision is linked to criminal offence<sup>4</sup>
- Women from rural areas of Tamil Nadu (Vellore) preferred to visit unqualified MTP providers as they could have abortions quickly and go home. Women also visited these providers to obtain remedies for simple ailments; hence, their neighbours would not suspect that they had gone for an abortion. These providers used D&C for terminating pregnancies.<sup>6</sup>
- Young unmarried women from Bihar and Jharkhand took a longer time in recognising their pregnancy in comparison to the married women. This thereby delays them in accessing abortion services<sup>14</sup>

# LEGAL





## LEGAL

## MYTH

TERMINATION OF  
PREGNANCY IS  
ILLEGAL

## FACT

Historically, under the Indian Penal Code, Section 312 to 316 that dealt with 'voluntary miscarriages' (current day meaning induced abortion), criminalised abortion. The Medical Termination of Pregnancy Act, enacted in 1971 was an exception for existing laws and allowed abortions under certain conditions and time frames. The PCPNDT Act, enacted in 1994 criminalizes sex determination, but not abortion.

According to the MTP (Amendment) Act 2021, for abortions up to 20 weeks, one doctor's approval is needed, for 20-24 weeks of the gestation period, sanction by two medical practitioners is necessary, thereby making abortion a legalised process. However, sex-selective abortion does not come under the exception provided under the MTP Act. This conflation of the MTP and PCPNDT Act often poses a barrier for abortion seekers accessing the services.

## DEMOGRAPHICS

- Women who had undergone abortion from Jharkhand (Bokaro)<sup>4</sup> and Maharashtra<sup>15</sup>
- Women from rural Maharashtra (Pune)<sup>9</sup>
- Married women from rural Bihar,<sup>16</sup> Jharkhand,<sup>16</sup> and Tamil Nadu (Vellore)<sup>6</sup>
- Pharmacists from Bihar, Maharashtra, Rajasthan and Uttar Pradesh<sup>13</sup>

# LEGAL

MYTH	FACTS	DEMOGRAPHICS
<p>MA service provision is allowed beyond 7 weeks of gestation in India</p>	<p>MTP Act amendment of 2002 allows till 7 weeks while MoHFW guidelines of 2010 allow till 9 weeks. The WHO recommends medical abortion for pregnancies less than 12 weeks.</p>	<p>MTP providers (ObGyns—both degree and diploma + MBBS) from Bihar (Patna, Muzaffarpur, Bhagalpur, Nawada) and Maharashtra (Aurangabad, Wardha, Satara, Thane, Mumbai)<sup>1</sup></p>
<p>Abortion cannot be done without the consent/ no-objection certificate from spouse or family members.</p>	<p>Under MTP Act 1971, the consent of the husband or family members is not required. The consent of only the abortion seeker is needed. In the case of a minor or a mentally disabled person, the consent of their guardian in writing is required.</p> <p>Regardless of what is in the law, evidence shows that consent of spouse/partner or in case of unmarried women, that of parents is asked even if they are adults. This is a violation of the law and of their reproductive rights.</p>	<p>Married women from Maharashtra,<sup>8</sup> Gujarat,<sup>8</sup> Andhra Pradesh,<sup>8</sup> Tamil Nadu<sup>8</sup> and Madhya Pradesh<sup>29</sup></p> <p>Women from rural Maharashtra (Pune)<sup>9</sup></p> <p>Survivors of rape who sought abortion<sup>12</sup></p> <p>Married women (15–39 years of age) with at least one child from Madhya Pradesh<sup>18</sup></p> <p>Married women from rural Tamil Nadu (Vellore)<sup>6</sup> and West Bengal (South 24-Parganas)<sup>22</sup></p> <p>Young women abortion seekers from Bihar and Jharkhand<sup>14</sup></p> <p>MTP Providers from Gujarat,<sup>19</sup> Tamil Nadu<sup>20</sup> and Madhya Pradesh<sup>21</sup></p> <p>Medical students of govt. and private medical colleges of Maharashtra<sup>23</sup></p>
<p>Abortion can be offered only if the seeker agrees to contraception or sterilisation</p>	<p>MTP Act does not mention such conditions for abortion seekers. Contraception is provided only if the woman consents to it. Such conditionality is often practiced and is a violation of reproductive rights.</p>	<p>Survivors of rape who sought abortion<sup>12</sup></p> <p>Married women from rural Tamil (Vellore)<sup>6</sup></p> <p>Women from suburban slum of Maharashtra (Mumbai)<sup>10</sup></p>

A doctor's prescription is not required to purchase MA pills

MA pills are Schedule-H drugs, which means they can only be dispensed with a Registered Medical Practitioner's (RMP) prescription. An RMP can legally prescribe MA pills for pregnancies leading up to seven weeks based on MTP Amendment 2002, and in 2003 by a further amendment, allowed certified abortion providers to prescribe abortion drugs outside of a registered facility as long as emergency facilities were available to them.

Survivors of rape who sought abortion<sup>9</sup>

Pharmacists from Delhi,<sup>3</sup> Maharashtra,<sup>13</sup> Rajasthan,<sup>13</sup> Uttar Pradesh,<sup>13</sup> Bihar,<sup>2,13</sup> Jharkhand<sup>2,13</sup>

Young women abortion seekers from Bihar and Jharkhand<sup>14</sup>

According to the MTP Act, a Registered Medical Practitioner is Registered medical practitioner is defined as a "medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956, (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics".

Married women from rural Tamil Nadu (Vellore)<sup>6</sup>

Women from suburban slum Maharashtra (Mumbai)<sup>10</sup>

Married women who had undergone abortion from rural Maharashtra<sup>15</sup>

Unqualified local practitioners or Community Health Workers can give medical prescription or perform abortion.

Only an RMP can legally perform an abortion.

Women abortion seekers from Rajasthan(Udaipur)<sup>24</sup>

Abortion is for married women

Under MTP Act, women can terminate pregnancy up to 24 weeks regardless of their marital status.

Married women from Maharashtra, Gujarat, Andhra Pradesh, and Tamil Nadu<sup>8</sup>

MTP providers (qualified + unqualified RMPs) from two districts of Maharashtra<sup>5</sup>

Young women abortion seekers from Bihar and Jharkhand<sup>14</sup>

Married women who had undergone abortion from rural Maharashtra<sup>15</sup>

Public information campaigns on abortion designed for the people of Rajasthan from the year 1997-2002.<sup>17</sup>

MTP Providers from Gujarat,<sup>19</sup> Tamil Nadu<sup>20</sup> and Madhya Pradesh<sup>21</sup>

Medical students of govt. and private medical colleges of Maharashtra<sup>23</sup>

Legal Professionals (law students, practising lawyers, judges and magistrates)<sup>25</sup>


## ADDITIONAL INFORMATION

- Awareness of the PCPNDT Act was far greater among women and service providers, than about the details of the MTP Act.<sup>7,17</sup>

# GENDER ROLES AND SOCIAL NORMS




## GENDER ROLES AND SOCIAL NORMS



ABORTION IS A 'SIN', ESPECIALLY IF IT IS THE FIRST PREGNANCY OR PERFORMED AFTER CERTAIN GESTATIONAL PERIOD

MYTH



Considering abortion as 'sin' is rooted in religious and cultural norms that assign childrearing as 'sacred' and an important part of 'motherhood'.

FACT

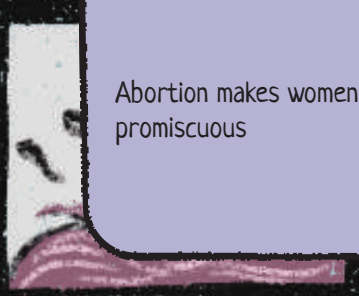
### DEMOGRAPHICS

- Community Health Workers from Rajasthan (Udaipur)<sup>24</sup>
- Young unmarried abortion seekers from Kerala (Trivandrum)<sup>25</sup>
- Legal Professionals (law students, practicing lawyers, judges, and magistrates)<sup>25</sup>

# GENDER ROLES AND SOCIAL NORMS



MYTH	FACTS	DEMOGRAPHICS
<p>Abortion is murder</p> <p>Superstitions on childbearing and abortion</p> <p>“... child born from a third pregnancy would not survive (three being an unlucky number) and therefore women becoming pregnant for the third time were forced to terminate the pregnancy. Sometimes if the pregnancy coincided with some accident to the breadwinner or the head of the family, it was perceived as an ill omen and the woman would be compelled to terminate that pregnancy.”</p>	<p>While meant to condemn sex-selective abortion, the use of words such as kanya bhrunhatya (murder of the female fetus in the womb) and garbhasthya shishu ka (murder of the infant in the womb), implicitly equates all abortions with murder and creates confusion about the legal status of abortion.</p> <p>A rights-based messaging, along the lines of human rights and ethical discourse is needed to address such disapproving perspectives on abortion.</p> <p>There has been no scientific evidence of such claims. Therefore, pushing the pregnant person for abortion takes away their reproductive agency and rights.</p>	<p>Public information campaigns on abortion designed for the people of Rajasthan from the year 1997-2002.<sup>17</sup></p> <p>Married women from rural West Bengal (South 24- Parganas)<sup>22</sup></p>
<p>Abortions out of wedlock is considered immoral.</p>	<p>The socio-cultural norms on sexuality dictates a patriarchal understanding of sex outside the realm of marriage as immoral. Such practices control women’s sexuality and limit their reproductive and sexual autonomy.</p> <p>The law under MTP Act, however, permits women to terminate pregnancies up-to 24 weeks regardless of their marital status.</p>	<p>Married women from Maharashtra, Gujarat, Andhra Pradesh, and Tamil Nadu<sup>8</sup></p> <p>MTP providers (qualified +unqualified RMPs) from two districts of Maharashtra<sup>5</sup></p> <p>Young women abortion seekers from Bihar and Jharkhand<sup>14</sup></p> <p>Married women who had undergone abortion from rural Maharashtra<sup>15</sup></p> <p>Public information campaigns on abortion designed for the people of Rajasthan from the year 1997-2002.<sup>17</sup></p> <p>MTP Providers from Gujarat,<sup>19</sup> Tamil Nadu<sup>20</sup> and Madhya Pradesh<sup>21</sup></p> <p>Medical students of govt. and private medical colleges of Maharashtra<sup>23</sup></p> <p>Legal Professionals (law students, practising lawyers, judges and magistrates)<sup>25</sup></p>



Abortion makes women promiscuous

There is no correlation between abortion and promiscuity; rather such statements are made to shame abortion seekers, and to control their sexuality.

Women from rural Maharashtra (Pune)<sup>9</sup>

## ADDITIONAL INFORMATION

- It is worth taking note of the fact that the woman seeking an abortion was held responsible for being in that situation by more women providers than men (more than half as compared to only about one third), more urban than rural providers (45 percent vs 32 percent) and more private providers than public providers (44 percent vs 20 percent)<sup>5</sup>
- Women prefer uncertified medical providers or private facilities over government hospitals to maintain their privacy due to social stigma on abortion. They fear their confidentiality might get breached if they consult in government facilities, which are nearby and are affordable in comparison to private facilities.<sup>4, 8, 11, 12, 20, 22, 26, 27</sup>

## RECOMMENDATIONS

Inadequate spaces to access rights-based and non-judgemental information on abortion have sustained several myths and misconception. These misconceptions permeate all demographics including frontline workers and healthcare providers that stems from misinformed knowledge of the legalities, and religious and social understanding of abortion. This enables gatekeeping of access to affordable safe abortion services, especially for those belonging to the marginalised communities. Furthermore, this secondary research reflects the gap in the current abortion discourse and the need for an inclusive and intersectional perspective. There are limited studies conducted on abortion access that examine the intersection of gender, caste, age, disability, location and almost nil for queer and trans\* communities. Through this document, we also aim to generate dialogue and invite researchers, community practitioners, and legal & healthcare professionals to expand literature and advocacy to address myths and misconceptions, and thereby stigma on abortion to make safe abortion accessible to everyone.

How this resource can relate to

### RESEARCHERS

- This secondary research reveal the dearth of academic literature with a specific focus to understand the myths and misconceptions related to abortion even within abortion-focused research. To cover this literature gap, researchers can integrate this aspect into their research conceptualisation.
- Myths and misconceptions are often influenced by a myriad of socio-cultural factors and practices. Given the rich socio-cultural diversity of the country, the myths and misconceptions are also bound to vary. This secondary research depicts the paucity of data from a large number of states and UTs of the country as well as from marginalised social groups, thus likely to miss a range of myths and misconceptions which needs to be addressed. To have a more comprehensive evidence base, researchers can focus on the under-represented geographies and/or social groups as their study location and study population.
- The research team for this resource tried to review all published literature to the best of our knowledge and listed in the references. However, if there isare any other relevant published or unpublished literature, we request researchers to share the same with us at [safe@theypfoundation.org](mailto:safe@theypfoundation.org) so that they can also be featured on the [SAFE Resource Hub](#), which is a platform for all your abortion related information needs created by The YP Foundation.



## COMMUNITY PRACTITIONERS

- While through anecdotes and work engagements it might be evident to community practitioners that there are myths and misconceptions around abortion, this resource has attempted to compile those in a scientific manner along with facts to demystify them. Thus, community practitioners can use it in discussions/sessions related to abortion or even broader SRHR/women's rights/women's health issues.
- We would be interested in collating other myths and misconceptions pertinent to abortion that one might encounter while working at a community level so that they can also be highlighted and demystified. Thus, we request community practitioners to share such information with us at [safe@theypfoundation.org](mailto:safe@theypfoundation.org) in the language of your preference.
- Build collective and gradual movement for abortion as a reproductive health rights issue and conduct community campaigns, collective meetings to demystify abortion and promoting safe abortion seeking.

## FACULTY AND ADMINISTRATORS AT HEALTH AND LEGAL SYSTEMS

The issue of abortion service provision is situated at the intersection of health and law alongside the socio-cultural aspects. Thus, apart from wider community awareness of the issue, it is of critical importance that health and legal practitioners have a comprehensive factual and rights-based understanding of abortion. This secondary research (and anecdotes) establishes that both students and practitioners of health and law-related disciplines harbour significant myths and misconceptions around abortion. Evidence shows that both in-training education and in-service education are essential to ensure a thorough impact on knowledge levels, attitudes and practice. Thus, request to:

- Health-related/Law related course faculty to integrate abortion as an important topic in the course curriculum and encourage students to take up abortion as a topic for research/field/project work
- Administrators of health and legal systems/institutions to conduct periodic training sessions on abortion which covers health, legal and socio-cultural aspects from an intersectional feminist, and rights-based approach.

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