

The case for the use of telehealth for abortion in India

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ABSTRACT: *India has the world's fastest growing outbreak of COVID-19. With limited mobility, increased reports of intimate partner violence, changes in living patterns of migrants, delays in accessing contraception and safe abortion care, and potential changes to decisions about parenting, there may be an increased need for abortion services in India due to the pandemic. The use of technology for providing abortion information and services has been well documented in global literature. The safety of abortion provision using telehealth has been established in several contexts including the United States and Australia. The importance of hotlines and other support systems that use technology to provide information and support to clients through their abortion is also highlighted in the literature. Several countries, such as the United Kingdom, France, New Zealand, and Pakistan are now allowing the use of technology for abortion/post-abortion care in light of the pandemic; however, India's telemedicine guidelines do not include abortion. In a country where the majority of abortions take place outside the health system, allowing the use of telemedicine for abortion can help bring legality to users, and expand access to those facing additional barriers in accessing the care they deserve. We outline models for telemedicine provision of abortion in India and discuss the regulatory changes required to make telehealth for abortion a reality in India.* DOI: 10.1080/26410397.2021.1920566

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India has the world's fastest growing outbreak of COVID-19,¹ with more than 22.6 million cases, as of 10 May 2021.² Given the impact of COVID-19 on the healthcare infrastructure in India, some of the authors of this commentary had recommended the use of telemedicine for provision of safe abortion in India to meet the potentially increased demand for abortion during and post-pandemic.³ In this commentary, we discuss in detail the potential for the use of telehealth technologies in changing the safe abortion access landscape for all pregnant persons in India and discuss various models of safe abortion provision using technology.

The critical need for increased access to safe abortion access in India

Of the 15.6 million induced abortions in India in 2015, 81% of abortions took place using medical

abortion and 73% of all abortions were medical abortions outside of facility settings. Only 9% of medical abortions took place in a facility (7% in public and 2% in private facilities).^{4*} With limited mobility, increased reports of intimate partner violence, changes in living patterns of

*Although the proportion of post-abortion clients treated for incomplete use of medical abortion is high, many of the clients may not have needed additional treatment to complete their abortion; rather this indicates the need for abortion seekers to get reliable information for the safe use of medical abortion pills. The Medical Termination of Pregnancy (MTP) Act (1971) and the subsequent rules in 2003 permit medical abortion up to seven weeks' gestation, and allow certified abortion providers to prescribe medical abortion pills even outside of a registered facility (as long as there is access to the registered facility that can provide emergency care). The Drugs Controller General of India (DCGI) then approved combipack (200 mg mifepristone and 800 mcg misoprostol) up to 9 weeks in 2008.

migrants, delays in accessing contraception and safe abortion care, and potential changes to decisions about parenting, there is an increased need for safe abortion services in India due to the pandemic.⁵

The updated operational guidance from the WHO for maintaining essential health services in the COVID-19 context recommends minimising facility visits and provider-client contacts through the use of telemedicine for abortion to the full extent allowed by law and urges stakeholders to consider expanding telemedicine mechanisms for medication delivery in contexts where it is effective.⁶ As a result of the pandemic, several countries including England,⁷ France,⁸ New Zealand,⁹ Northern Ireland (in some circumstances),¹⁰ Pakistan,¹¹ Scotland,¹² and Wales¹³ now permit at-home abortions with guidance from a medical professional over the internet or phone to ensure access to safe, legal abortion, and/or post-abortion care. The Telemedicine Practice Guidelines for India published on 25th March 2020¹⁴ do not specifically include abortion services and the authors believe that this is a missed opportunity for ensuring access to safe abortion during COVID-19 and expanding access post-pandemic.

The use of telehealth[†] for abortion

The use of technology for counselling, assessing medical eligibility for abortion, prescribing medical abortion, provision of information and support during abortion, and following up post-abortion, is not new. Studies using data from Australia, Canada, the Netherlands, and the United States show that the provision of medical abortion through telemedicine seems to be highly acceptable to pregnant people and providers, with safety and efficacy similar to in-person provision.¹⁵ Studies also show that clients using telehealth reported decreased travel, reduced cost, and time,^{16–18} and did not feel judged for their choices.¹⁹ Additionally, providers have expressed that using telehealth for abortion provides them flexibility with their schedule and location.¹⁷ Thus, telehealth for abortion can be a safe, effective option acceptable to providers and to clients – especially when it helps reduce the burden on pregnant people, many of whom may have

caregiving responsibilities and/or may have to lose wages to travel for in-person care.

Models for the use of telehealth for safe abortion

Several models for various components of telemedicine abortion provision exist in practice. In a site-to-site model, the client receives care at a clinic and the provider is located in a remote location. Another clinical staff member who does not provide abortion care may be present in the clinic to facilitate the client's visit. In the direct-to-client model, the client is at home (or another convenient location) when receiving care. Telehealth technologies that have been used in these models include videoconferencing, telephone calls, and text and internet-based messaging.²⁰ Below, we outline some examples of telehealth models for abortion provision – specifically counselling, eligibility assessment, medication acquisition, and support.

In the United Kingdom (UK), as a response to COVID-19, a direct-to-client model for abortion care has been approved for eligible clients up to 10 weeks, where both pills can be taken at home, without having to present at a clinic. Marie Stopes UK offers clients an initial telephone screening consultation and, if eligible, clients are offered the choice of booking an in-person or telehealth appointment for a medical abortion service. Following the remote consultation and assessment, medical abortion drugs are either sent to them by post or can be picked up by clients from the clinic.²¹

In Pakistan, Ipas has implemented a direct-to-client model that provides free consultations for those needing medical abortion, self-managed abortion support, or post-abortion contraception with public and private sector health professionals. Lady health workers are involved in reaching out to their communities to create awareness about the telehealth model.¹¹

Direct-to-client telehealth models are also utilised outside the formal health care setting. Globally, several models that have harnessed technology to provide information and support to abortion seekers exist. Several safe abortion hotlines have been providing information and support to abortion seekers for decades. The support from the hotlines has the potential not just to reduce harm, especially in restrictive settings, but also to increase the quality of abortion care

[†]In this article, we use telehealth and telemedicine interchangeably.

experienced. For instance, in Indonesia, where legal provision of induced abortion is permitted only in cases of life endangerment or rape, abortion incidence is estimated to be nearly 2 million each year, with most occurring outside of facilities. Abortion seekers can email or call Samsara, a hotline that provides information about medical abortion and how to follow WHO-recommended protocols. Hotline counsellors are engaged with clients to the extent desired by the client.²² In India, several platforms, such as Hidden Pockets, Love Matters, Nurse Nisa, Ask Nivi, Women First Digital, and Haiyya provide information on abortion legality, access, and referrals via online platforms and social media. Thus, models that provide information on how to access abortion in India already exist. The authors believe that the pandemic provides an opportunity to expand to a full-fledged telemedicine medical abortion service delivery model that can be integrated within existing health and support systems to expand choice and access and improve quality.

Is India equipped for a technology revolution in abortion?

India is one of the biggest and rapidly growing markets for digital consumers, with 560 million internet subscribers in 2018. A study estimated that if telemedicine replaced 30–40% of in-person outpatient consultations, India could save up to US\$10 billion and improve care, especially for those in remote and low-resource settings. As of 2018, more than 110,000 villages have already been equipped with broadband connectivity and 92.7% of villages have mobile services.²³

Since the beginning of the pandemic, several technological platforms have seen a rise in the number of unique users and consultations across different fields of health.²⁴ Telemedicine is already being used for non-urgent gynaecological and obstetric consultations, thereby providing appropriate care and counselling and reducing in-person consultations and follow-up appointments during the pandemic.²⁵

It is evident that many reproductive health users are already looking to digital media for information and referrals, and providers are also becoming familiar with and open to using technology for providing different types of health care (as evidenced by the number of doctors signing up for different platforms),²⁴ including sexual and reproductive health care. Given that clients

and providers are already engaging with using technology, we believe that the time is ripe for integrating abortion services in India within telemedicine in India – from counselling, eligibility assessment, and medication acquisition, to information and support provision and follow-up.

What could an integrated telehealth model in India look like?

Based on existing models of care, a system of remote care could look like the following:

Abortion seekers could speak with a registered medical provider (RMP) who could assess eligibility for medical abortion. The RMP could be located physically in a clinic or taking the call virtually through the internet or phone. The eligibility assessment could include pregnancy confirmation (a positive urine pregnancy test or an assessment of pregnancy signs and symptoms) and dating (relatively certain estimate of the first day of their last menstrual period), as well as assessing for risk factors for ectopic pregnancy.^{26,27} For those deemed eligible for medical abortion, prescriptions can be provided as outlined in the Telemedicine Practice Guidelines. Clients can then procure the medications from a nearby local pharmacy or e-pharmacy.

If a list of RMPs willing to provide remote care can be collated, abortion seekers could reach out to hotlines and online platforms to find their nearest provider. Hotlines and online platforms could counsel abortion seekers and assist them with finding an RMP who is able to provide remote support. Hotlines and online sources could also provide further information on what to expect during the process, how to manage side effects, symptoms, and signs of possible complications, provide support during the abortion process, and carry out follow-up assessments. If clients require additional clinical support, they could help direct them to the nearest facility for care. Thus, various models of telehealth could work hand-in-hand to support abortion clients in a manner similar to that for other healthcare services.

Currently, the telemedicine practice guidelines outline a number of situations for which telemedicine can be used; it should be expanded to include first-trimester medical abortion as well. This will allow abortion via telemedicine to serve as a legitimate alternative means of service provision for safe and effective care, increase choice to access

care that could be less stigmatising and more confidential, and expand access to those who may be unable to seek care otherwise, while bringing abortion provision via telemedicine into the regulatory framework governing other medical services currently permitted by the guidelines. Allowing telehealth provision of abortion can also improve accountability to the health system and clients through the maintenance of electronic health records and prescriptions at a secure location. The mechanisms of accountability and grievance redressal that are applied to other procedures permitted via telemedicine by the guidelines provided by the Government of India (such as requiring providers to abide by principles of medical ethics; regulations from the Indian Medical Council; using telemedicine platforms that can maintain the confidentiality of clients; taking measures to protect privacy and confidentiality of clients; not coercing clients to receive care via telemedicine when they may express a preference for in-person care; and maintaining documentation of consultations) could apply to safe abortion provision via telemedicine. By testing, piloting, documenting, reviewing, and scaling up abortion protocols, similar to other procedures permitted via telemedicine, increased access as a result of using telehealth models can be balanced with efficiency in service provision, and lessons learnt in accountability and data maintenance can be shared across different services. It would also be useful to gather lessons learnt from telemedicine provision of abortion in other contexts around the world.^{28–30}

Barriers to and challenges with telehealth technologies

Telehealth for abortion is in no way the silver bullet. Indian men are 33 percentage points more likely to own a phone than women, on average,³¹ which has clear implications for access. Furthermore, those experiencing intimate partner violence and/or reproductive coercion may seek additional confidentiality in their care process, and this could be challenging if they are unable to access telemedicine services from a convenient location, or if they are dependent on their partner to access technology. Telehealth could also create additional barriers to minors accessing abortion care, since legal reporting requirements[‡] may delay/complicate the care they need. Telemedicine for abortion can also leave behind those

without reliable internet/phone lines and/or access to electricity or mobile phones, or those with low digital literacy. Those unable to reach an RMP for a consultation in a site-to-site model or in the case of needing additional medical care may also not benefit from telehealth.

Evidence from literature in India suggests nurses, allopathic and ayurvedic physicians are all able to effectively assess medical eligibility and assess completion of abortion.^{32,33} Hence, the MTP Act needs to be amended to include the cadre of health workers who can provide abortions, which could dramatically increase access to safe abortion, especially in rural areas. In addition, there is over-regulation of medical abortion pills by drug control authorities, which is resulting in the non-availability of abortion pills in many states. Some pharmacists also do not stock abortion pills due to misinformation about legality and/or beliefs that they are harmful to users.^{34,35} To ensure availability of telehealth for abortion, access to abortion pills should also be unencumbered. Law and policy should change to allow the provision of medical abortion by suitably trained community health workers such as Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), and at the public health sub-centre level. Telemedicine abortion providers should be allowed to dispatch drugs directly to clients, which would entail a broader interpretation of the Drugs and Cosmetics Act. Additionally, studies have shown that abortion providers may not provide services up to the legal limit, may refuse services due to experiences with corruption and intimidation from government officials monitoring the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (2003), and/or due to judgmental attitudes or poor understanding of the law.^{36–38} It is crucial that law and policy enable RMPs to offer stigma-free care to the full extent legally permitted, without fear.

In order for telehealth to be a reality legally, several policy and programming changes would be necessary. The MTP Act already permits the use of medical abortion pills in any place where

[‡]Current requirements per the Protection of Children from Sexual Offences Act (POSCO) 2012 require mandatory reporting of any sexual activity below the age of 18. Although set up to protect minors, this may deter adolescents from seeking abortion care.

the RMP is present (unlike surgical abortion where it would need to be an approved facility). A minor amendment can enable virtual consultations also to be permitted for medical abortion provision. There is a need to update policies and guidance around medical abortion provision. The MTP Act (which allows the use of medical abortion drugs only up to seven weeks of gestation) and DCGI guidelines (which allow the use of the medical abortion combipack up to nine weeks) should be updated so that they are in line with WHO-recommended evidence-based guidelines and centering the needs of clients.³⁹ The MTP Act, DCGI guidelines, and Comprehensive Abortion Care guidelines should be updated to permit the provision of medical abortion through prescriptions generated after a teleconsultation visit with an RMP (clarifying the registration process to approve a remote provider) and allow medications to be taken at home to ensure that the entire process can be safely managed at the client's place of choosing. Thirdly, the telemedicine guidelines should be updated to explicitly include medical abortion as a service that is permitted.

Additionally, providers (RMPs, community health workers like ANMs and ASHAs, and pharmacists) should also be trained in the remote provision of medical abortion, including legality, supporting clients with procuring pills, and advising them on how to take the pills, how to manage side effects, and signs of possible complications. These efforts to expand medical abortion services may face opposition from the anti-choice movement, and/or those who conflate abortion access with sex-selection, similar to barriers that the overall safe abortion movement faces. Civil society, clinicians, community health workers, policy makers, and researchers should work collaboratively to use evidence to inform policy-making, keeping the safety and health of the pregnant persons as a priority.

Conclusion

Expanding telehealth to include information, support, and services around medical abortion can be a safe and revolutionary way to expand access to safe, legal abortion. Although according to WHO guidance, abortions in the first trimester can be safely self-managed as long as there is access to information and support, and to a facility in case of complications,⁴⁰ in Indian law, abortions

outside of health facilities without prescription from an RMP are currently illegal.

Offering abortion through telehealth can provide clients a legal, safe, and supported experience: expanding the use of telemedicine for abortion can provide legal protection to those self-managing without a prescription, without having to meet physically with an RMP. Given the need for medical abortion in India and the already existing self-use in large numbers, the openness of clients and providers alike to use technology for health, and the established safety of abortion via telemedicine from global models, it is clear that there is appetite for abortion provision using telemedicine. Public sector provision of abortion has several challenges – lack of trained staff, equipment and supplies, and non-judgmental care up to the legally permitted extent, to name a few.³⁸ Telemedicine for abortion can not only help address gaps in the public sector provision of safe abortion but can also serve as a viable choice even when quality services are available since it would reduce the burden on the health infrastructure by reducing in-person visits and enhancing privacy and confidentiality needs of clients. By expanding telemedicine to include medical abortion, India can forge the way ahead for safe abortion access not just during the pandemic, but also creating an opportunity for long-lasting impact.

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References

1. COVID-19 in India: the dangers of false optimism. The Lancet. 2020;396(10255):867. doi:10.1016/S0140-6736(20)32001-8.
2. India: WHO Coronavirus Disease (COVID-19) Dashboard [Internet]. Geneva: WHO. Available from: <https://covid19.who.int/region/searo/country/in>
3. Chandrasekaran S, Diamond-Smith N, Srinivasan K, et al. Preparing for an increased need for abortion access in India during and after COVID-19: challenges and strategies. Stud Fam Plann. 2020;51(4):377–383. doi:10.1111/sifp.12139.
4. Singh S, Shekhar C, Acharya R, et al. The incidence of abortion and unintended pregnancy in India, 2015. Lancet Glob Health. 2018;6(1):e111–e120. doi:10.1016/S2214-109X(17)30453-9.
5. Preparing for an increased need for abortion access in India during and after COVID-19: challenges and strategies – Chandrasekaran – studies in family planning – Wiley Online Library [cited 2020 Nov 15]. Available from: <https://onlinelibrary.wiley.com/doi/full/10.1111/sifp.12139?af=R>
6. Maintaining essential health services: operational guidance for the COVID-19 context interim guidance [cited 2020 Nov 15]. Available from: <https://www.who.int/publications/item/WHO-2019-nCoV-essential-health-services-2020.1>
7. Temporary approval of home use for both stages of early medical abortion. GOV.UK [cited 2020 Nov 15]. Available from: <https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion-2>
8. FRANCE – early abortion via telemedicine permitted as of 10 April 2020. International Campaign for Women’s Right to Safe Abortion (SAWR) [cited 2020 Nov 13]. Available from: <https://www.safeabortionwomensright.org/news/france-early-abortion-via-telemedicine-permitted-as-of-10-april-2020/>
9. Abortion services available by phone for some New Zealanders during lockdown. RNZ. Published April 7, 2020 [cited 2020 Nov 15]. Available from: <https://www.rnz.co.nz/news/national/413671/abortion-services-available-by-phone-for-some-new-zealanders-during-lockdown>
10. Abortion Pill Treatment at Home | BPAS [cited 2020 Nov 15]. Available from: <https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/>
11. Telehealth initiative answers ‘the need of the hour’ in Pakistan. Ipas [cited 2020 Nov 13]. Available from: <https://www.ipas.org/news/telehealth-initiative-answers-the-need-of-the-hour-in-pakistan/>
12. Abortion: Covid-19: Approval for Mifepristone to be taken at home and other contingency measures. 10.
13. Temporary approval of home use for both stages of early medical abortion. GOV.WALES [cited 2020 Nov 15]. Available from: <https://gov.wales/temporary-approval-home-use-both-stages-early-medical-abortion>
14. Telemedicine Practice Guidelines. Published online 2020. Available from: <https://www.mohfw.gov.in/pdf/Telemedicine.pdf>
15. Endler M, Lavelanet A, Cleeve A, et al. Telemedicine for medical abortion: a systematic review. Bjog. 2019;126(9):1094–1102. doi:10.1111/1471-0528.15684.
16. Grindlay K, Lane K, Grossman D. Women’s and providers’ experiences with medical abortion provided through telemedicine: a qualitative study. Womens Health Issues Off Publ Jacobs Inst Womens Health. 2013;23(2):e117–e122. doi:10.1016/j.whi.2012.12.002.
17. Grindlay K, Grossman D. Telemedicine provision of medical abortion in Alaska: through the provider’s lens. J Telemed Telecare. 2017;23(7):680–685. doi:10.1177/1357633X16659166.
18. Ehrenreich K, Kaller S, Raifman S, et al. Women’s experiences using telemedicine to attend abortion information visits in Utah: A qualitative study. Womens Health Issues. 2019;29(5):407–413. doi:10.1016/j.whi.2019.04.009.
19. Ireland S, Belton S, Doran F. ‘I didn’t feel judged’: exploring women’s access to telemedicine abortion in rural Australia. J Prim Health Care. 2020;12(1):49–56. doi:10.1071/HC19050.
20. Improving access to abortion via Telehealth. Guttmacher Institute. Published May 7, 2019 [cited 2020 Nov 15]. Available from: <https://www.guttmacher.org/gpr/2019/05/improving-access-abortion-telehealth>
21. Home abortion pills at Marie Stopes UK [cited 2020 Nov 13]. Available from: <https://www.mariestopes.org.uk/abortion-services/online-medical-abortion/>
22. Gerdts C, Hudaya I. Quality of care in a safe-abortion hotline in Indonesia: beyond harm reduction. Am J Public Health. 2016;106(11):2071–2075. doi:10.2105/AJPH.2016.303446.
23. Digital India. Published online March 2019. <https://www.mckinsey.com/~/media/McKinsey/Business%20Functions/McKinsey%20Digital/Our%20Insights/Digital%20India%20Technology%20to%20transform%20a%20connected%20nation/MGI-Digital-India-Report-April-2019.pdf>
24. India’s e-health regulations are a rare COVID policy success. Nikkei Asia [cited 2020 Nov 13]. Available from: <https://asia.nikkei.com/Spotlight/Comment/India-s-e-health-regulations-are-a-rare-COVID-policy-success>
25. Bindra V. Telemedicine for women’s health during COVID-19 pandemic in India: A short commentary and important practice points for obstetricians and gynaecologists. J

- Obstet Gynaecol India. 2020;16:1–4. Published Online July. doi:10.1007/s13224-020-01346-0.
26. Coronavirus (COVID-19) infection and abortion care: information for healthcare professionals [cited 2021 Jan 28]. Available from: <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf>
 27. Guidance for providers offering misoprostol-alone for abortion amidst COVID-19 [cited 2021 Jan 28]. Available from: https://gynuity.org/assets/resources/MA-Covid-English-Print_200730_203759.pdf
 28. Hyland P, Raymond EG, Chong E. A direct-to-patient telemedicine abortion service in Australia: retrospective analysis of the first 18 months. *Aust N Z J Obstet Gynaecol.* 2018;58(3):335–340. doi:10.1111/ajo.12800.
 29. King M. The first-year anniversary of the application of telemedicine to early medical abortions in UK. *Journal of Medical Ethics blog.* Published April 4, 2021. Accessed April 8, 2021. <https://blogs.bmj.com/medical-ethics/2021/04/04/the-first-year-anniversary-of-the-application-of-telemedicine-to-early-medical-abortions-in-uk/>.
 30. Enabling abortion services during COVID-19. IPPF South Asia Region. Published December 24, 2020 [cited 2021 Apr 8]. Available from: <https://www.ippfsar.org/resource/enabling-abortion-services-during-covid-19>
 31. Barboni G, Field E, Pande R, et al. A tough call: understanding barriers to and impacts of women’s mobile phone adoption in India. Published online October 2018. https://epod.cid.harvard.edu/sites/default/files/2018-10/A_Tough_Call.pdf.
 32. Warriner IK, Wang D, Huong NM, et al. Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *The Lancet.* 2011;377(9772):1155–1161. doi:10.1016/S0140-6736(10)62229-5.
 33. Jejeebhoy S, Kalyanwala S, Mundle S, et al. Feasibility of expanding the medication abortion provider base in India to include ayurvedic physicians and nurses. *Int Perspect Sex Reprod Health.* 2012;38(3):133–142.
 34. Chandrashekar V, Vajpeyi A, Sharma K. Availability of medical abortion drugs in the markets of four Indian states, 2018. Published online 2019. Available from: <https://pratiyacampan.org/wp-content/uploads/2019/09/availability-of-medical-abortion-drugs-in-the-markets-of-four-indian-states-2018.pdf>.
 35. Chandrashekar V, Choudhuri D, Vajpeyi A. Availability of medical abortion drugs in the markets of six Indian states. Published online 2020. Available from: <https://pratiyacampan.org/wp-content/uploads/2020/08/frhs-india-report-on-availability-of-medical-abortion-drugs-in-the-markets-of-six-indian-states-document.pdf>.
 36. Potdar P, Barua A, Dalvie S, et al. “If a woman has even one daughter, I refuse to perform the abortion”: Sex determination and safe abortion in India. *Reprod Health Matters.* 2015;23(45):114–125. doi:10.1016/j.rhm.2015.06.003.
 37. Hirve SS. Abortion Law, policy and services in India: a critical review. *Reprod Health Matters.* 2004;12(sup24):114–121. doi:10.1016/S0968-8080(04)24017-4.
 38. Abortion and unintended pregnancy in six Indian states: findings and implications for policies and programs. Guttmacher Institute. Published October 9, 2018 [cited 2020 Nov 13]. Available from: <https://www.guttmacher.org/report/abortion-unintended-pregnancy-six-states-india>
 39. Civil society recommendations on making the Medical Termination of Pregnancy (Amendment) Bill 2020 a Rights Based Legislation. Published online March 10, 2020. Available from: <https://pratiyacampan.org/wp-content/uploads/2020/04/civil-society-recommendations-on-making-the-mtp-amendment-bill-2020-a-rights-based-legislation.pdf>
 40. WHO | Health worker roles in providing safe abortion care and post-abortion contraception. WHO [cited 2020 Nov 15 2020]. Available from: http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/

Résumé

L’Inde enregistre le rythme le plus rapide de propagation du COVID-19 au monde. Avec une mobilité limitée, des signalements accrus de violences du partenaire intime, des changements des modes de vie des migrants, des retards dans l’accès à la contraception et à un avortement sûr, ainsi que des changements potentiels des décisions relatives au rôle de parent, il est possible que l’Inde connaisse un besoin accru de services d’avortement du fait de la pandémie. L’utilisation de la technologie pour fournir des

Resumen

India tiene el brote de COVID-19 de más rápido crecimiento del mundo. Con movilidad limitada, crecientes informes de violencia de pareja, cambios en patrones de vida de migrantes, retrasos para acceder a los servicios de anticoncepción y de aborto seguro y posibles cambios a las decisiones sobre la crianza de los hijos, podría haber mayor necesidad de servicios de aborto en India debido a la pandemia. El uso de tecnología para proporcionar información y servicios de aborto está bien documentado en la literatura mundial.

informations et services d'avortement a été bien documentée dans les publications internationales. La sûreté de la pratique de l'avortement par le biais de la télésanté a été établie dans plusieurs contextes, notamment les États-Unis d'Amérique et l'Australie. Les publications mettent aussi en lumière l'importance de lignes d'assistance téléphonique et d'autres systèmes d'appui qui ont recours à la technologie pour fournir des informations et un soutien aux clientes tout au long de leur avortement. Compte tenu de la pandémie, plusieurs pays comme le Royaume-Uni, la France, la Nouvelle-Zélande et le Pakistan autorisent désormais l'utilisation de la technologie pour l'avortement/les soins après avortement; néanmoins, les directives de l'Inde sur la télémédecine n'incluent pas l'avortement. Dans un pays où la majorité des avortements se déroulent hors du système de santé, permettre l'utilisation de la télémédecine pour l'avortement peut aider à conférer une certaine légalité aux utilisatrices et élargir l'accès de celles qui rencontrent des obstacles supplémentaires pour obtenir les soins dont elles ont besoin. Nous décrivons brièvement des modèles de pratique de l'avortement avec la télémédecine en Inde et analysons les modifications de la réglementation exigées en vue de faire la télésanté pour l'avortement une réalité en Inde.

La seguridad de la prestación de servicios de aborto vía telesalud se ha establecido en varios contextos, incluidos Estados Unidos y Australia. La importancia de líneas de atención telefónica y otros sistemas de apoyo que utilizan tecnología para proporcionar información y apoyo a usuarias a lo largo del proceso de aborto también se destaca en la literatura. Varios países, entre ellos el Reino Unido, Francia, Nueva Zelanda y Pakistán, ahora permiten el uso de tecnología para proporcionar servicios de aborto/atención postaborto en vista de la pandemia; sin embargo, las directrices de India sobre la telemedicina no incluyen el aborto. En un país donde la mayoría de los abortos ocurren fuera del sistema de salud, permitir el uso de telemedicina para el aborto podría ayudar a llevar legalidad a las usuarias y ampliar el acceso a las personas que enfrentan barreras adicionales para acceder a los servicios que merecen. Presentamos los modelos de prestación de servicios de aborto vía telemedicina en India y discutimos los cambios normativos necesarios para que la telesalud para el aborto sea una realidad en India.