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Medical abortion through telehealth in India: a critical perspective

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Abstract: *The COVID-19 pandemic and nationwide lockdowns have significantly impacted access to abortions for millions of people in India. One of the proposed solutions to address the inaccessibility of abortion services is the use of teleconsultation or "telemedicine" where pregnant persons consult with Registered Medical Practitioners (RMPs) over voice or video calls. The RMPs then prescribe the necessary medication electronically. However, telehealth services bring their own set of social and legal challenges. Although they can allow for greater access to medical abortions, especially in situations where pregnant persons are unable to opt for in-person medical care, it is important to note that telemedicine is not a one-stop solution for lack of access to timely, affordable abortions. This is particularly due to the structural barriers of caste, class, religion, gender, and disability that impede access to healthcare services. In this article, we examine the need for telehealth services in India as a means of increasing access to medical abortion services and the structural barriers that prevent it from being an effective and equitable solution for all.* DOI: 10.1080/26410397.2022.2107090

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Introduction

From 21st April to 21st May 2020, the L.V. Prasad Eye Institute in Hyderabad used teleconsultations for children with ophthalmological conditions. Dr Kekunnaya, Head of the Child Sight Institute, stated that telehealth services offered "the means to reach out to these children in remote areas" and noted that it was a question of health equity.[1] Dr Kekunnaya also stated, however, that certain conditions always require in-person consultations and that video calls often could not be conducted due to connectivity issues. His takeaway from the teleconsultation approach, therefore, was that it is a valuable tool to reach out to remote areas, but it has its limitations.[1]

The COVID-19 pandemic had a severe impact on access to all kinds of healthcare services across South Asia, including abortion. From March to April 2020, as many countries entered lockdowns to curb the spread of COVID-19, access to contraceptives and abortions was greatly reduced.[2] In India alone, the nationwide lockdown and consequent restrictions on mobility, as well as shortage of non-COVID healthcare centres, has led to a worst-case scenario of an estimated 1.04 million unsafe abortions.[3] Losing access to timely abortion services results in delayed abortion or compels pregnant persons to carry unwanted pregnancies to term – a violation of their rights to bodily and decisional autonomy.[4] In India, even though an estimated 81% of abortions conducted annually are medical abortions either in or outside medical facilities,[5] pressure to address gender determination practices has led to

crackdowns in several states on abortion service providers as well as pharmacists selling medical abortion pills.[6]

In addition to these barriers to accessing safe abortions, access to medical abortion has also been drastically impacted by the COVID-19 pandemic and nationwide lockdowns, with approximately 1.85 million pregnant persons losing access to medical abortion services in India alone.[7] One of the proposed solutions to address this issue in India is the use of telehealth services where pregnant persons consult with Registered Medical Practitioners (RMPs) over voice or video calls and the RMPs prescribe the necessary medication electronically. In India, the Telemedicine Practice Guidelines introduced in March 2020,[8] allowing for a number of healthcare services to be delivered through telemedicine, do not take into account the possibility of medical abortions guided through telemedicine.

The legal framework around abortions in India, even prior to the COVID-19 pandemic, is complex and regulated by multiple laws, which complicates access to abortions, particularly for marginalised persons, including adolescents, Dalit, Adivasi and Bahujan persons, persons with disabilities and transgender and gender-variant persons. It is important to understand this interplay of different laws to be able to explore and recommend avenues for the effective implementation of telehealth initiatives across the country.

The Medical Termination of Pregnancy Act, 1971 (amended by the MTP Amendment Act, 2021) currently governs abortions in India.[9] In certain circumstances a pregnant person may undergo an abortion until 20 weeks of gestation on the recommendation of one RMP, and for specified categories of women up till 24 weeks of gestation on the recommendation of two RMPs. As per the latest MTP (Amendment) Rules, 2021 these specified categories of women include survivors of sexual assault or rape or incest; minors; those whose marital status has changed during pregnancy; those living with physical disabilities or mental illness; cases of fetal malformation with substantial risk of the fetus being incompatible with life or of a physical or mental anomaly if a child is born; and on humanitarian grounds or during disaster or emergency situations. When pregnant persons are unable to access safe abortion services within the gestational limit imposed by law, they are left with no choice but to carry the pregnancy to term against their will, or to resort to unsafe back alley abortion methods,[5] which impinges upon their reproductive and bodily autonomy, and poses a threat to their health, safety, and lives.

Restricted mobility both within and across states during the COVID-19 lockdowns, as well as breakages in medical supply chains and the inter-state movement of drugs, and the lack of clarity on the availability of abortion services severely hindered access to safe abortion services.[10–11] However, while telehealth would be a welcome move in increasing access to abortion, we must acknowledge that it brings with it its own set of social and legal challenges. Significantly, infrastructure required to set up teleconsultation services across India currently does not exist.

According to a recent study,[12] internet penetration in India in 2021 is still only approximately 45% and is plagued with a lack of network connectivity. Further, even when infrastructure is available, its unequal distribution can severely affect health outcomes for specific groups. For instance, Indian men are 33% more likely on average than women to own a phone,[13] which has clear implications for access to timely and confidential telehealth services, especially for women experiencing intimate partner violence and/or reproductive coercion.[10]

There are structural challenges with the healthcare system in India including caste, class, religion, gender, disability, language, education, age, and geographical location, as well as a lack of adequate budgeting, insufficient infrastructure, and unreliable electricity supply and internet connectivity in many parts of the country. Resultantly, telehealth remains a largely urban-centric solution and does little to provide access to abortion services to *all* persons.

In this article, we examine the need for telehealth services in India – as a means of increasing access to medical abortion services – and the structural barriers that prevent it from being an effective and equitable solution for all. In part one, we examine the legal framework for abortion in India, focusing on rules and regulations surrounding medical abortion, and barriers to accessing the same. We focus in part two on the COVID-19 pandemic and national lockdown in India, wherein the Central Government issued the Telemedicine Practice Guidelines, 2020. Although abortion was categorised as an essential service during the lockdown, there were several barriers

to accessing medical abortion pills during these times. In part three, we examine the barriers in accessing medical abortion in India in the context of telehealth. We critically examine challenges pertaining to infrastructure, budget, and funding for telehealth, the roles played by caste and class discrimination in the delivery of healthcare services, as well as other important socio-economic factors that ultimately designate telehealth as an urban-centric solution which, on its own, is unlikely to improve abortion access or outcomes for poor, rural, and marginalised persons.

Legal framework for abortion in India

In India, abortion is criminalised for both the person who seeks abortion and the person who performs it, i.e. the healthcare provider, under Section 312 of the Indian Penal Code (IPC), 1860. The MTP Act is an exception to the criminalisation of abortion under the IPC, allowing for certain pregnancies to be terminated by RMPs.[14] Prior to the 2021 amendment, the MTP Act allowed termination of a pregnancy only up to 20 weeks in cases of rape or incest, risk of injury to physical/mental health, risk to the life of the pregnant woman, and diagnosis of fetal anomalies.[15] For married women, pregnancies resulting from contraceptive failure were considered to cause mental anguish and therefore could be terminated. As stated in the introduction, the recently introduced MTP Amendment Act raised the upper gestational limit to a 24-week period for terminating pregnancies, in certain cases. The Act now also requires the opinion of doctors/medical boards to terminate pregnancies beyond 24 weeks in cases of fetal anomalies. Despite these proposed changes, the amended MTP Act is still inadequate for the realisation of the reproductive rights of pregnant persons in the country.[16] It is still highly doctor-centric in nature, relying on medical opinions to grant or refuse permission for abortions, without placing primacy on the reproductive and decisional autonomy of the pregnant person.

Medical abortions are allowed to be performed through a combination of mifepristone and misoprostol pills, or through prescription (by RMPs) of higher dosages of misoprostol alone when mifepristone is unavailable or unaffordable.[17] In India, amendments to the rules and regulations governing the MTP Act in 2002 allowed for medical abortions, approving the combined mifepristone-misoprostol regimen for early termination of pregnancies (up to 7 weeks). The Rules were amended again in 2003 to specify that medical abortions could be provided by certified providers in their clinics, on the condition that there was access to a registered and approved facility for back-up and that the clinic displayed a certificate of approval from the site's owner. The latest amendment to the MTP Rules in 2021 has retained all previous provisions while extending the gestational age to 9 weeks to obtain a medically managed abortion.

A Guttmacher study in 2015 estimated that 81% of abortions annually in India are medical abortions.[5] However, nationwide alarm ensued when the 2011 census results in India revealed the most skewed child sex ratio to date, and policymakers and medical professionals were pressured to address gender determination practices, wherein prenatal gender determination is undertaken to terminate "female" fetuses. This led to crackdowns on abortion service providers as well as pharmacists selling medical abortion (MA) pills in several states.[18]

Access to MA pills has been difficult in various parts of India due to different laws holding the field. Approvals and documentary requirements for MA pills are governed by the Drugs and Cosmetics Act, Rules, and Regulations.[19] The constant changes in regulations and reporting requirements coupled with threats from local Drug Inspection Authorities have dissuaded chemists from stocking and selling MA pills.[20] In a recent study conducted in India between January and March 2020, the Foundation for Reproductive Health Services India (FRHSI) found that there was an abysmal shortage of MA pills among chemists in five out of six states surveyed.[21] According to this study, "79 per cent of chemists no longer stock MA drugs to avoid legal issues and excessive documentation requirements".[21] Moreover, a recent IDF study found that of the total 1.85 million abortions likely to be compromised due to the pandemic, nearly 80% can be attributed to decreased sales of MA drugs from chemists.[22]

In addition to these barriers to safe abortions, access to medical abortion has also been drastically impacted by the COVID-19 pandemic and nationwide lockdowns.[23] One of the proposed solutions to address this issue in India is the use of telemedicine services where pregnant persons consult with RMPs over voice or video calls and the RMPs prescribe the necessary medication electronically.[10] The World Health Organization (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 continuing education of healthcare providers, all in the interests of advancing the health of individuals and their communities.[24]

Some scholars suggest that such telehealth services are critical not only in the event of public health emergencies such as the COVID-19 pandemic, but also for persons with disabilities who may have mobility challenges or those in rural areas with limited access to health facilities.[25] The next section covers the use of telehealth services for medical abortion and the legal framework for it in India.

Telehealth and medical abortion

Healthcare delivery systems across the world have seen various technological innovations to ensure equitable access, comprehensive delivery, and quality of care. Proper use of technology has been beneficial for patients as well and providers, especially in primary health care settings.[26] Dissemination of quick information, mapping, and monitoring of public health data, self-management of diseases, self-administration are some of the uses of digital healthcare systems.[26] At the forefront of these efforts lies telehealth, the modern use of which is either done through an internet connection (broadband or cellular), a voice VOIP call, or other communication services such as text message or chats.

In March 2020, Fundacion Oriéntame – an organisation founded in Colombia in 1977 to ensure all women had access to health care including reproductive health services[27] – began offering abortion services through telehealth.[28] Oriéntame had been developing a virtual programme to offer abortion services through teleconsultations several months prior to the COVID-19 outbreak, and the lockdown in the country pushed the organisation to launch it.[28] The conversations that pregnant women have with Oriéntame staff are not restricted to discussing abortions; staff provide guidance on obtaining contraceptives, as well as other information on sexual and reproductive health. According to Paula Avila-Guillen, head of the Latin American initiatives programme at the Women's Equality Center based out of the United States,

[The doctors at Oriéntame] are really breaking some of the biggest barriers in terms of access. In a country like Colombia where there are so many rural areas, it is very hard for women to actually go to the clinic.[28]

However, Avil-Guillen also notes, paradoxically, that living in rural areas may mean women have poorer access to the internet and smartphones and thus to these telemedicine services.

Telehealth-related services started in India as early as 2001 in a limited capacity.[29] The primary aim was to fill the gaps in a country where the demand for faster and better health was rapidly increasing. There are many factors which have contributed to the recent popularity of telehealth in India and in other countries as a major contributor of health delivery. Irrespective of its drawbacks, it is widely accepted that telehealth has the potential to cross geographical barriers, cut costs, save time, ensure privacy, and ensure quality of care for the patients.[30] In the case of sexual and reproductive health, specifically abortion, telehealth can be extremely useful in forming linkages between policies and delivery of services in a timely and effective manner.[10] The challenges posed by the COVID-19 pandemic and further restrictions initiated by lack of physical movement, have paved the way for a more inclusive, effective, and affordable telehealth service model which focuses on abortion as an essential service,[10] provided that the socio-cultural realities of the country and the existing barriers around abortion are kept in mind while formulating policies around it.

On 25th March 2020, India entered a nationwide lockdown with strict restrictions on movement of people and vehicles. The International Planned Parenthood Federation reported that globally over 5000 clinics offering sexual and reproductive health services had closed due to the pandemic.[31] The largest number of closures were in the South Asia region, with nearly 2000 clinics and service outlets shutting down.[31] A report by Marie Stopes International states that in India in 2020, 1.3 million "fewer women received services between January and June than in the same period last year".[32] The same day that lockdown was announced, the Ministry of Health and Family Welfare in India issued the Telemedicine Practice Guidelines, which allow for

several healthcare services to be delivered through telemedicine.

It is important to note here that until these Guidelines were issued, the legality of the use of teleconsultation in the field of medicine was unclear. These Guidelines brought detailed clarity on that aspect and set out a protocol for telemedicine using different methods of teleconsultation, both visual and audio. Subsequently, on 13th April 2020, the government declared abortion as an essential service during the COVID-19 lockdown.[33] Nevertheless, the legal framework for abortion in India does not explicitly allow for medical abortions via teleconsultation. For example, there are several ambiguities, including the fact that medical abortion pills were not included in the list of approved drugs in the Guidelines. Although the Guidelines state that, "digital health is a critical enabler for the overall transformation of the health system"[34] it failed to allow or operationalise access to MA pills and other related abortion services during the lockdown. Lists O, A, and B of the Guidelines which specify the approved medicines that may be prescribed via teleconsultation do not mention the MA pill, but do not explicitly prohibit it. The only drugs the Guidelines refer to include: "OTC medicines, ointments, ear drops, eye drops; refill medicines for diseases such as hypertension, diabetes, and asthma; or add-on medicines for existing conditions".

According to Sections 3 & 4 of the MTP Act, only a Registered Medical Practitioner (RMP) can carry out an abortion service and only in a registered place. Further, if the abortion is to take place within 9 weeks (as per Rule 4A (1)(a) of the MTP Rules 2021) of gestational age, an RMP is qualified to prescribe mifepristone with misoprostol to the patient only at the registered clinic as per Explanation to Rule 5 of the MTP Rules, 2003. The Central Drugs Standard Control Organisation (CDCSO) also approved the use of MA Pills for the medical termination of pregnancy up to 63 days or 9 weeks of gestation based on the first day of the last menstrual period on 16th December 2008.[35] According to the *Comprehensive Abortion Care: Training and Service Delivery Guidelines* published by the National Health Mission in 2018,[36] the second pill (misoprostol) can safely be taken by the pregnant person at home, at the discretion of the RMP. Despite the recent clarification, contradictory policies in the past have created significant confusion amongst RMPs. Hence, many RMPs believe that the administration of the first pill (mifepristone) should still be in the hospital and that the actual termination eventually happens at home, and thus there is some ambiguity on whether a pregnant person could self-administer both MA pills at home, if obtained through a teleconsulting prescription. Arguably, since the first pill (mifepristone) is to be taken orally, it is possible to allow for this also to happen at home after the patient is given detailed instructions by their medical practitioner. According to the 2018 Comprehensive Abortion Care Guidelines, private sector facilities including outdoor facilities (clinics) can prescribe MA pills. However, it is pertinent to note that Section 4 of the MTP Act still only allows for pregnancies to be terminated at a government hospital, or at a place approved by the government. Hence, it is necessary that Section 4 be interpreted broadly in line with these Guidelines.

Further, the National Human Rights Commission (NHRC) in October 2020 issued an *Advisory on Rights of Women* highlighting the importance of continuing to provide abortion services:[37]

The lockdown has had an unprecedented impact on women's ability to access safe abortion services. Such a situation has left pregnant women with very few choices such as, continuation of pregnancy even though it may be unplanned or unintended; attempting an unsafe abortion; or waiting until the relaxation of the lockdown restrictions to probably undergo a second-trimester abortion in a health facility.

The NHRC also recommended that medical abortion pills should be made available at chemists at all times and that private sector health facilities should not deny abortion services. A study by researchers from the Guttmacher Institute, International Institute for Population Sciences and the Population Council found that in 2015, nearly half of all pregnancies in India were unintended, with an unintended pregnancy rate of 70 per 1000 women aged 15–49 years of age, and abortions accounting for one-third of all pregnancies.[5]

The World Health Organization's guidelines on abortion have recognised that self-assessment and self-management of medical abortion can be empowering for pregnant persons, suggesting that if patients have adequate information and access to telehealth providers, they can safely manage medical abortion in their first trimester even in "low literacy, low-resource"

environments.[38] Although India released its Telemedicine Practice Guidelines only in 2020, studies from Australia, Canada, the Netherlands, and the United States have shown that medical abortion through telemedicine seems to have been "highly acceptable to pregnant people and providers, with safety and efficacy similar to in-person provision", for years now.[39] Patients who have used telehealth solutions for abortion have reported advantages like "decreased travel, reduced cost, and time",[40] and did not feel judged for their choices.[41]

Several countries such as England, France, New Zealand, Northern Ireland (in some circumstances), Pakistan, Scotland,[10] South Africa, and Wales started to allow at-home abortions with guidance from telemedicine professionals to ensure access to abortions and/or post-abortion care.[42–48] The UK, for instance, has allowed abortion services via telemedicine, with telephone or video call consultations, and abortion pills to be used under the supervision of the provider.[49] Marie Stopes UK offers telephone screening consultations to clients and, "the choice of booking an in-person or telehealth appointment for medical abortion", for which MA pills can be sent to them by post or picked up from the clinic.[50]

A study carried out in India, China, and Cuba on the safety, efficiency, and acceptability of medical abortions surveyed 1373 women who were given the choice between surgical or medical abortions, and their health outcomes.[51] Its findings were that in all the countries, more medical than surgical abortion patients indicated they would opt again for the same procedure, with similar health outcomes between surgical and medical abortion cases.[51] Medical abortions were deemed to be "safe, efficacious, and acceptable in developing countries".[51] These findings have been mirrored across the world. A study in Ireland and Northern Ireland found that at-home medical abortions with pills sent in the mail, done under the remote supervision of a provider, appeared to be just as safe as those done at a clinic, with 95% of the women in the study reporting successfully terminating their pregnancy.[51] In Tunisia, Blum *et al*. found that medical abortions conducted at home were safe and effective, with young and single women preferring self-management rather than clinic abortions.[52] Further, Ipas in Pakistan provides free consultations for those needing self-managed abortion or post-abortion support, with the help of public and private sector health professionals.[10] Thus, telehealth for abortion can be a safe, effective option for both providers and clients – especially when it helps reduce the burden on pregnant persons, many of whom may have other responsibilities and/or may be unable to access in-person care.

Studies from across the world pre-pandemic have proved the efficacy of abortion carried out through mobile phones and internet access.[53] As a response to laws and policies preventing access to abortion services, many independent web-based organisations such as "Women on Web" and "Women Help Women" (about 26 across the world) have been providing services such as delivery of MA Pills, information and knowledge creation and access to a physician.[54] Despite the existence of sufficient evidence from across the world proving the effectiveness of telehealth as a viable substitute for in-person visits to healthcare workers, there continue to be legal ambiguities. Studies have also proved the efficacy of the method and the high rate of acceptability by pregnant persons.[10] Highlighting its importance during and after the pandemic, a recent study has gone to the extent of calling teleconsultation and the digital divide a "social determinant of health during the COVID-19 Pandemic".[55]

Any transformation in telehealth must keep abortion in mind as one of its services, while also ensuring that no one is left behind in the effort. Arguably, telehealth would allow for greater access to medical abortions; however, the infrastructure required to set up teleconsultation services across India does not currently exist. A 2020 report by the Telecom Regulatory Authority of India stated that there are only 33 rural internet subscribers per 100 population.[56] In spite of having 560 million users and being the second largest online market after China, the internet penetration rate in India is less than 50%, which means about half of the country's citizens would not be able to avail themselves of digital health services, if it were to be implemented on a national scale.[57] In the following section, we examine the structural barriers that impede access to healthcare services in India and argue that telehealth does little to alleviate these problems. We find that the structural, institutional, and social issues around abortions, medical abortions, and telehealth characterise telehealth services for abortions as a largely urban-centric solution, thus neglecting marginalised and rural persons. We discuss this in the next section.

Telehealth: an urban-centric solution

India has a plethora of barriers that affect access to healthcare services, as well as telehealth for medical abortions. One of the biggest hurdles is that people's health outcomes exhibit a "social gradient",[58] with studies highlighting lower levels of utilisation of health services among Dalit persons in India.[59] In the context of telehealth, low socio-economic status is associated with a relatively lower ability of adults to use technology autonomously, as greater education and income are important factors in determining freedom to use the Internet where and when people want.[60] This in turn affects timely help-seeking behaviour and the delivery of treatment.[61] Initiatives such as eSanjeevani, a virtual outpatient (OPD) platform that aimed to offer free telehealth consultations,[62] have been shown to exclude Dalit persons, instead "augmenting mostly the welfare of the already dominant and well-to-do castes in the region".[62] Age is another crucial factor associated with the inequality around telehealth.[60,63] Additionally, telehealth may not be accessible to persons with disabilities,[64] as "hearing and vision impairment may affect treatment delivery via telehealth technology".[65] Such discrimination is compounded by language barriers that are encountered in the face of predominantly English information.[66] Several Indian start-ups have launched healthcare apps that provide tele-consultation, but very few of them support local languages, thereby confining their reach to English speakers and excluding all others.[67]

The lack of requisite infrastructure, including internet facilities, smartphones, and computers, hinders effective provision of such services to those residing in rural areas of India. It is not merely the availability of internet connectivity that matters for access but its quality and speed as well. For instance, the conditional and restricted access to 2G internet in Kashmir is insufficient for the purposes of digital health care. Similarly, there are issues of accessibility in north-eastern states of India where only 35% of people have internet access.[68] RMPs who conduct teleconsultations must be technologically savvy to the extent that they are acquainted with how to operate video chatting apps[69] and must also be able to communicate effectively through digital means, with good "web-side" manners – of which there is a deficit in India.[70] Further, lack of medical dispensaries impedes the benefits of teleconsultations, as even though doctors issue prescriptions, the non-availability of such medication in remote areas is a big issue.[71] Telehealth could also create barriers to minors accessing abortion care, since legal reporting requirements under the Protection of Children from Sexual Offences Act, 2012 may complicate or deny them the care they need.[71]

The other significant challenge with teleconsultation frameworks is with regard to the privacy of patient data. Recently, a German security firm, Greenbone Networks, reported several health data breaches and leaks in India[70] in their February 2020 report, outlining leaks of patient data "including X-ray images, names, ailments, treating physicians, which pointed to gaps in the confidentiality and data protection system".[70,72] In another instance, Religare Health Insurance found private data of over 5 million of its users and employees leaked on the dark web.[73] Use of third-party apps to transmit personal information, which would be a part of telehealth initiatives, could have serious implications for patients in case there were leaks, as abortions are still highly stigmatised in India. Finally, a lack of budgetary allocation to digital health care and telehealth will negatively impact the infrastructure needed to improve access to such initiatives, especially in rural areas and for those unable to access in-person services.[74]

Conclusion

A review of the legal framework around abortion and telehealth in India, especially in the context of the COVID-19 pandemic, shows that while teleconsultations and telehealth can be used to improve access to healthcare services for persons who are unable to avail themselves of in-person consultations, the primary beneficiaries of such digital initiatives will be urban, middle or upper class, dominant castes and privileged persons for a few medical conditions. In spite of the conditional legalisation of abortion in India through the MTP Act, 1971 (amended in 2021) and the issuance of the Telemedicine Practice Guidelines 2020, abortion access still remains a highly contentious and stigmatised issue in society. There are a plethora of studies from across the world that attest to the safety and desirability of at-home medical abortions achieved through teleconsultation. However, infrastructure challenges,

lack of internet, electricity, and of course, societal stigma still act as significant barriers to providing (and availing of) medical abortions through teleconsultation. Therefore, while digitising healthcare is important, it is imperative that the Government invest in increasing the healthcare budget, infrastructure, training, and awareness-building to ensure that existing inequities in the Indian healthcare system are addressed, before undertaking more tech-driven initiatives that may be inaccessible to a large proportion of people.

The limitations of India's healthcare infrastructure in general and digital health infrastructure in particular raise the likelihood of discrimination in the course of use; data disclosed during teleconsultation that hypothetically may be used to concentrate unfairly on a certain person could produce a misleading perception of the existence of or transmission of a disease. Telehealth is not without potential but it is important to be cognisant of how a policy mechanism that aims at boosting the efficacy of the healthcare sector of a nation is likely to disproportionately benefit only a particular section of the society and boost discrimination towards other, marginalised communities. This is particularly true for medical abortion since the existing policy barriers, or the lack of rights-based policies, have the potential to exacerbate the gaps in access to services. Further, lack of an inclusive infrastructure can severely affect the delivery of quality care to those seeking information or services around medical abortion. Finally, telehealth adds a disproportionate burden on the person seeking health services and is not appropriate for all health conditions. Thus, any future policy in this area ought to keep these existing barriers in mind.

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Résumé

La pandémie de COVID-19 et les confinements dans l'ensemble du pays ont eu de profondes répercussions sur l'accès à l'avortement de millions de personnes en Inde. L'une des solutions proposées pour remédier à l'inaccessibilité des services d'avortement est le recours à la télémédecine ou aux téléconsultations pendant lesquelles les personnes enceintes consultent des médecins agréés avec des appels audio ou vidéo. Le médecin prescrit ensuite les médicaments nécessaires par voie électronique. Néanmoins, les services de télésanté comportent leurs propres ensembles de problèmes sociaux et juridiques. Même s'ils

Resumen

Para millones de personas en India, la pandemia de COVID-19 y los cierres a nivel nacional han tenido un impacto significativo en el acceso al aborto. Una de las soluciones propuestas para abordar la inaccesibilidad de los servicios de aborto es el uso de la teleconsulta o "telemedicina", donde las personas embarazadas consultan con médicos titulados por audio o videollamadas. Los médicos recetan los medicamentos necesarios electrónicamente. Sin embargo, los servicios de telesalud traen sus propios retos sociales y jurídicos. Aunque la telemedicina puede facilitar mayor acceso al aborto con medicamentos,

permettent d'élargir l'accès aux avortements médicamenteux, spécialement dans des situations où les personnes enceintes ne sont pas en mesure d'opter pour des soins médicaux en présentiel, il est important de noter qu'il ne s'agit pas d'une solution unique pour régler le manque d'accès à des avortements ponctuels et d'un prix abordable. C'est dû en particulier aux obstacles de caste, de classe, de religion, de genre et de handicap qui entravent l'accès aux services de santé. Dans cet article, nous examinons le besoin de services de télésanté en Inde comme moyen d'élargir l'accès aux services d'avortement médicamenteux et les barrières structurelles qui les empêchent d'être une solution efficace et équitable pour tous.

especialmente en situaciones donde las personas embarazadas no pueden optar por recibir atención médica presencial, es importante señalar que no es una solución de un solo punto de contacto por falta de acceso a servicios de aborto oportunos y asequibles. Esto se debe en particular a las barreras estructurales de casta, clase, religión, género y discapacidad que impiden el acceso a los servicios de salud. En este artículo examinamos la necesidad de servicios de telesalud en India como un medio de ampliar el acceso a los servicios de aborto con medicamentos y las barreras estructurales que impiden que sea una solución eficaz y equitativa para todas las personas.