Abortion, contraception, pregnancy—how women's bodies became a battlezone

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Outside, the mid-morning heat is stifling. It's not humid like the bustling metropolises of Mumbai or Kolkata; here in New Delhi it's a dry heat, the type of heat that exhausts you, made worse by a thick layer of dust which sticks to your face and stings your eyes.

On the maternity ward inside the hospital at Jamia Hamdard University all the metal gurneys are taken, some with sheets, some without.

Many women are curled up on their sides, their arms embracing the tiny babies they've recently given life to. Their mothers and mothers-in-law crowd the otherwise sparse room with laughs of joy and excitement.

A few women, however, are not here to give birth. Vidya, aged 18, is one of them. (Vidya's name has been changed to protect her identity.) She arrived at the hospital yesterday with her mother. She's two months pregnant, and unmarried – a huge taboo in India.

India legalised abortion in 1971 when it passed the Medical Termination of Pregnancy (MTP) Act, but an abortion can't be performed solely on the woman's request. The procedure is allowed if her physical or mental health is under threat or the child that would be born would have "such physical or mental abnormalities as to be seriously handicapped".

The provision includes women under 18, as long as they have their guardian's consent, and women made pregnant by rape. A woman doesn't need the consent of her husband and can legally terminate at up to 20

weeks' gestation.

One clause, however, is specifically reserved for married women: abortion because of contraceptive failure.

But in many cases like Vidya's, nurses and doctors ignore this and perform the procedure anyway, knowing full well that if it doesn't happen here, it'll happen elsewhere and perhaps unsafely. They ignore the absence of Vidya's bindi – the red dot typically worn by married Hindu women on their forehead – and that of the vermilion mark in the parting of her hair which would illustrate her lifelong commitment to her husband.

Vidya, dressed in an oversize dark blue jumper, hangs her head. Her scruffy hair covers her eyes and she occasionally clutches her stomach. "We do not agree with continuing with this pregnancy," her mother says. I ask Vidya whether she will continue seeing her boyfriend, who, like her, is in XI standard – the second-to-last year of school.

Her mother interjects: "I will talk to him and his family also and after some time, after he completes his study, she will agree to do the marriage," she says.

Vidya isn't given a chance to respond.

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In 1973, two years after India legalised abortion, the US Supreme Court handed down a landmark decision that recognised for the first time that the constitutional right to privacy "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy".

The decision came after 'Jane Roe' – an unmarried woman who wanted

to safely and legally end her pregnancy in Texas – challenged the state law that made it a crime to perform an abortion unless a woman's life was at stake.

The court struck down the Texas law and set a legal precedent around the country, leading more than 30 other states to overturn their abortion bans. The decision made abortion not only profoundly safer but far more accessible to millions of women around the US.

"America's movement for choice has been such a powerful leader globally in terms of access to abortion and contraception," says Sarah Hodges, a historian at the University of Warwick, UK.

But 44 years on, abortion remains one of the US's most controversial and polarising issues, with people pitted against one another as either 'pro-choice' or 'pro-life'. Today, many argue that women's sexual and reproductive rights are under renewed attack, fuelled by religion and the conservative right wing.

Upon taking office in January 2017, President Donald Trump moved quickly to reinstate and expand the Mexico City Policy, also known as the global gag rule, which prohibits federal funding for overseas NGOs that provide abortion services or information about abortion. The order has also extended to stopping US funding for organisations that offer abortion counselling or advocate for abortion rights in other countries.

Not long afterwards, the US cut its funding for the United Nations Population Fund – the UN agency that deals with family planning and reproductive health – claiming that its operations violate the gag rule.

And in mid-April, in a sign that curbs on reproductive rights weren't just going to affect those overseas, Trump signed legislation to allow states to deny certain federal funding to Planned Parenthood, an organisation that

provides reproductive healthcare, including abortion, in the US and globally.

In fact, as of 1 August 2017, 53 state-level abortion restrictions have been enacted in the US, according to the Guttmacher Institute, a research and policy centre in Washington that supports abortion rights. More than 300 have been enacted since 2011.

Elizabeth Nash, senior state issues manager at Guttmacher, says the goal of implementing more restrictions – which are concentrated in the southern and Midwestern states – is to completely rid states of abortion providers. "Many legislators are motivated by wanting to eliminate access to abortion entirely," she says. "If they could they would pass abortion bans but they can't.

"Instead they adopt smaller restrictions which make it difficult, if not impossible, for a woman to get to a clinic and for clinics to keep their doors open."

One of the most controversial new restrictions requires abortion providers in Texas to bury or cremate aborted fetal tissue so that it has a "dignified disposition", rather than disposing of it as medical waste.

The idea, Nash argues, is to get the public to view the tissue as "more valuable". She believes the law, which came into effect on 1 September, will have a big impact on providers, who will have to arrange funeral homes for the tissue. But in a state like Texas, which is strongly anti-abortion, she fears clinics will face insurmountable challenges in finding funeral homes that agree to be associated with abortion.

As the US continues to clamp down on abortion, India is working – albeit slowly – to extend women's access to it. Amendments to the 1971 MTP Act that are waiting to be tabled in Parliament include allowing

women to abort at up to 24 weeks, and replacing the term "married women" with "all women" in the contraceptive failure clause.

"Unlike America, the MTP Act is liberal. We didn't even have to fight a battle," says Poonam Muttreja, executive director of the Population Foundation of India, a national NGO that advocates for gender-sensitive health policies. "I think we were very fortunate to have it so easily."

But while the policy may look good on paper, the reality for many women is different. Most abortions in India – two-thirds, according to a 2008 government estimate – are carried out by "unauthorized, often unskilled providers".

Knowing this, it's not surprising that unsafe abortions are a big problem: they are responsible for 9 per cent of all maternal deaths in India. So why do women take the risk?

Millions face structural, institutional and cultural barriers to using accredited abortion services – things like stigma, not knowing the law, expense, fears about confidentiality, and lack of access to healthcare institutions. Such barriers disproportionately affect poorer women, who often live in remote, rural areas.

Another major barrier is a woman's lack of agency, explains Muttreja, who says that almost half of women seeking an abortion don't tell their husbands. This, she says, often leads them to risk their lives in back alleyways with uncertified providers or quacks, or take over-the-counter abortion pills with little guidance.

"I believe for every woman who dies there's 20 women who live life dying through serious morbidities because of how these abortions are done," she says at her office in New Delhi. "They don't want their husbands to know they're getting an abortion because often abortion is a

proxy for contraception. Women are not expected to use contraceptives [but] abortion would be a much worse offence.

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The rains have arrived in the north-eastern Indian state of Manipur and so the mosquitoes have too. Electric green rice paddies, wild hills and low-lying grey clouds surround Imphal, the state's capital city.

By Indian standards it doesn't really feel like a city – under 300,000 people live here and there are fewer than three million in the entire state, which, like the other seven states of the north-east, are separated from the mainland by Bangladesh. Manipur feels isolated and is reminiscent of parts of neighbouring Myanmar and nearby Nepal – from the locals' strong Mongolian facial features to the steaming chicken momos on the side of the road.

At the Regional Institute of Medical Sciences – a government hospital in central Imphal – a dozen makeshift tents line the corridors, housing crowds of people who have travelled from all across the state and are waiting to see a doctor.

Inside the bustling maternity ward, women's cries from the labour room mingle with babies' screams as they're welcomed into the world.

Sanathoi, aged 21, has a round face and glowing skin. She wears sparkly blue earrings and has her long black hair tied back with a white scarf. She holds her newborn son tightly in her arms as her husband, mother and mother-in-law crowd around, offering her sips of orange juice and salted crisps.

Two days ago she travelled 17 kilometres from her village to give birth to her first child. She decided not to follow the example of her mother

(who gave birth to all her children at home), preferring an institutional birth, like more and more Indian women.

Eighteen months ago Sanathoi married a daily labourer from a nearby village. She proudly tells me it was a "love" marriage. They met during Thabal Chongba – a popular Manipuri folk dance that's part of Yaoshang, a five-day festival held in March every year. It's the most important festival in the state and often the only opportunity for young men and women to mingle.

Over the last decade, according to the National Family Health Survey, the unmet need for family planning across India has stagnated at around 13 per cent: almost one in seven married women aged 15–49 don't want to get pregnant at the moment but are not using contraception. Use of modern contraceptive methods (such as the pill, condoms, IUDs and sterilisation) has also held steady, at a little under 50 per cent.

In contrast, in Manipur the unmet need has almost doubled, from 16 per cent in 2005 to 30 per cent in 2015. And use of modern contraceptives has almost halved, from 24 per cent to 13 per cent. The reasons for this change are unclear, but one of the results, experts suggest, is a rise in the number of women relying on abortion for birth control. "If you don't give family planning then abortion will increase," says Nabakanta Sharma, a gynaecologist and obstetrician in Imphal. "It's happening in Manipur."

Sanathoi says her baby was unplanned; she doesn't know how to prevent pregnancy. "I don't plan to use family planning. I don't know of any methods," she says. "I think I'll be pressured to have another baby. I can't even think about it."

While Accredited Social Health Activists – a type of community health workers – are meant to be present in every village across the country to

advise on family planning, Sanathoi says no one has visited her village to educate her about contraception. Her mother, Manitombi, now 46, married when she was 12; she had her first child at 15 and went on to have another nine in quick succession. "During my time it was normal to have 10 to 12 children," Manitombi says. "I didn't know about having less children."

I ask Manitombi if she wants her daughter to have more children, like she did. She chuckles. "I wish Sanathoi will have lots of kids – I want her to have spacing in between births but I don't know any methods."

Sanathoi shrugs her shoulders at her mother's comments. It seems like her fate has already been sealed.

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One day in 2000 in Renee Bracey Sherman's Illinois school, her golf teacher dressed up in surgeon's scrubs, held a condom in his hand and waved it around the classroom full of teenagers.

"If a surgeon was wearing all this to protect himself from a person with HIV but he's only coming at you with this, don't you see a problem with that?" he asked the class, to impress upon them the fallibility of contraception and thus the importance of abstinence. Believing his point had not quite been made, he clicked through a series of slides that depicted sexually transmitted infections – the type of images that would make any teenager shiver.

This was the kind of sex education Renee received.

A year after finishing high school, she was working a retail job while studying at Northeastern Illinois University. She'd been with her boyfriend for the past three years and was on the oral contraceptive pill,

choosing to rely on friends' advice about sex.

The pill cost her $120 every three months but one month she was short on cash. Her next pay date was only a week away, so why bother her parents? And anyway, she thought, a friend had told her that the pill builds up in your system and actually makes it hard to get pregnant even if you miss a few days.

So she missed a week. And then she missed a period.

"As my case shows, if you're misinformed you end up not knowing how your body works and having an unintended pregnancy," she says from Washington, where the now 31-year-old works as a reproductive justice activist and board member at NARAL Pro-Choice America, an organisation working to expand access to abortion.

Her boyfriend suggested she keep the baby and give it to his auntie to look after. That wasn't an option for Renee. The other possibility involved maxing out the credit card her parents had given her – strictly for emergencies – when she was 17. She'd never used it before but it had a $500 limit – just the amount she needed to pay for the procedure. And this, she thought, was an emergency.

Renee was relieved and, to this day, believes her decision to have an abortion was one of the best she's ever made. She was able to finish her studies, keep her job and ultimately choose the path she wanted for herself.

But she's concerned other women will face the same financial difficulties she did when paying for contraception. She's worried about the Trump administration's plan to overhaul the Affordable Care Act's birth control mandate, which requires nearly all employers to offer health insurance that covers access to a wide range of contraceptives.

According to a draft proposal obtained by Vox in May, and confirmed by a report in the Wall Street Journal in August, the Trump administration is preparing to overhaul the mandate and allow any employer to seek a moral or religious exemption from the requirement. That could mean that millions of women who currently receive contraception for free would have to start paying for it. For many who already struggle to pay for rent and food, birth control is something they may have to give up.

Not everyone sees this as a concern. Donna J Harrison, executive director of the American Association of Pro-Life Obstetricians and Gynaecologists, applauds the likely change.

Such moves also stoke the flames of debate around the question: if women have reduced access to contraception, will abortion rates increase?

Many public-health experts argue that as contraceptive use increases, abortions decrease; after all, both offer means of achieving fertility control. Others, however, say that the increased use of contraception leads to higher abortion rates. (There's no science to back this claim.)

For Cicely Marston, associate professor of social science at the London School of Hygiene and Tropical Medicine, it's very simple: "If you are really genuinely anti-abortion then it makes sense to increase access to contraception to as many people as possible."

Not everyone who has an abortion feels the relief Renee experienced. When 16-year-old Georgette Forney saw the fetus she had had aborted carried away in a stainless steel container, she didn't know that it would take almost two decades before she found closure. This came when she held a memorial service for Elizabeth, the name she gave to her baby.

"It was healing," she says from her home in Pennsylvania. "It was a profound way to attack all the pain and take authority over it and own it." It was also the beginning of her work for a ministry dedicated to ending abortion and her search for more women to speak out about regretting their abortions.

To that end, Forney believes abstinence is the only method to prevent unwanted pregnancy; she doesn't believe in birth control. "I want abortion to really become unthinkable and unnecessary," she says.

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The things that stop women accessing family planning in India are well documented. But as well as the economic, political and infrastructural obstacles, there's another kind – the kind that spreads via word of mouth.

Data from India's latest National Family Health Survey shows that just 1.5 per cent of married women of reproductive age use IUDs – less than a quarter of the equivalent figure in the US.

Experts blame the unpopularity of IUDs in India on myths surrounding their use. These include the belief that an IUD "can go to your brain and make you crazy" or that it "can go to your neck and you can choke and die", says peer educator Ankita Rawat, who works with young people in New Delhi to improve access to contraception.

I ask Poonam Muttreja if she's ever come across such rumours. She wobbles her head as if she's heard it all before. "The fact people are full of myths and misconceptions irritates the hell out of me," she says. "They are plucked from the sky."

Nine years ago, when she was 28, Geeta Devi was sterilised at the nearest hospital to her village, about 25 km away. She'd had two sons

and, on the advice of the local health worker, it was "time". She wasn't driven by the financial incentive ($20 for undergoing the procedure) but rather by her husband's unwillingness to go for what she called the "chop" (a vasectomy), because of the time off he'd need from his work as a labourer. The operation, he said, would make him weak, meaning he couldn't tend to the fields. And time off work could be detrimental to the family's income.

At her mud-brick home in Sampla, a village in Rohtak district in the northern Indian state of Haryana, she wishes men would overcome their fear of vasectomy-induced weakness. "They insist that we get sterilised but men should come forward and take responsibility."

Many men also believe that sterilisation will reduce their libidos and make sex less pleasurable. (There's no science to back this claim.)

The government recognises the need to get the onus for family planning off of women – especially in the absence of a wide range of contraceptive options – and increase the popularity of male sterilisation. In its National Health Policy, the government sets an aim of increasing male sterilisation at least six-fold. But how it will reach this goal remains to be seen.

"Men do not take responsibility for family planning – they think it's the business of women," Muttreja says. "Family planning is not a women's issue, it's a people's issue. [Men] have to take… more responsibility than women because they have all the agency." Women, she argues, lack the authority or opportunity to make decisions about childbearing, let alone asking their husbands to get sterilised.

"Women can't negotiate contraception. It's something they have to keep to themselves because often even if a woman suggests her husband to wear a condom, she's seen as promiscuous," she says.

Sarah Hodges agrees. "No one opts in for sterilisation. These are women who don't have choice over most things in their life."

In 2000, the US Food and Drug Administration (FDA) approved the drugs misoprostol and mifepristone to end pregnancy within the first ten weeks – also known as medical abortion. Many people thought that the reproductive revolution had finally arrived.

It was believed that the drugs, which have been shown to be highly effective and safe, would dramatically increase women's access to abortion. But the excitement was premature. The approval of the pills came with tight restrictions on how they can be distributed – only in clinics, medical offices and hospitals, and only by or under the supervision of a doctor certified to prescribe them, and only to patients who have signed an FDA-approved patient agreement. Those restrictions, the FDA says, are to ensure the safe use of mifepristone.

After the FDA restrictions came state restrictions. In Arkansas, for example, a law was implemented in 2015 requiring providers to counsel patients that medical abortion may be reversed if a woman is given a high dose of progesterone after taking the pills. (There's no science to back this claim.)

As restrictions on abortion increase, it's no surprise that women are trying to find their own answers. In fact, Google data shows a surge in searches for the topic of self-induced abortion in the US in 2011 – the same year that marked a steep increase in anti-abortion legislation on a state level.

Increasingly, women are turning to the internet to procure the pills, like they are in many other parts of the world where abortion is illegal or highly restricted.

"How can it be that in a country like Ethiopia, which has poor health infrastructure, you can buy the pills for $5 and just use them?" says Elisa Wells, who in 2014, along with two colleagues, began the Plan C campaign, a website dedicated to giving American women reliable information about medical abortion. "The idea that women have better access to abortion there than women in the US is crazy," she says.

Wells believes the online revolution could "upend" the system and break down barriers for women. "No longer do you have to find a clinic near you, which is disruptive to your normal life, or far away… you could just get it online and do it from the convenience of your home. You no longer have to walk through the gauntlet of protestors, who are so stigmatising – there's no need for women to be subjected to that."

Donna Harrison, from the American Association of Pro-Life Obstetricians and Gynaecologists, is firmly against women obtaining abortion pills online – or at all. She says it's far more dangerous than surgical abortion, despite studies showing that both procedures, if done correctly, are incredibly safe.

For women looking to procure the pills online, the main concerns – aside for deciphering which websites are fakes – are legal. "We have seen in recent years women who've been arrested and sometimes convicted for seeking abortions outside the legal system," says Elizabeth Nash from the Guttmacher Institute.

"We have to ensure that women can do this safely without the threat of legal prosecution. Ultimately what would be wonderful is if women could access healthcare when they need and not have to use a clandestine process."

Two years after FDA approval in the US, India followed suit, allowing registered medical practitioners to provide medical abortion at up to

seven weeks, in accredited facilities. In 2003 it extended the law to allow these providers to prescribe the drugs in other settings, meaning that women could get the pills over the counter with a prescription. The idea was to deter women from seeking unsafe abortions and ultimately reduce the harm and deaths that these can cause.

But again, the law may say one thing but it plays out differently on the ground. Research shows that over 70 per cent of sales of these drugs take place without prescription, and pharmacists often fail to explain to women how to take the pills or offer traditional medicine instead.

"Traditional or alternative drugs… often lead to complications or incomplete abortion. Often the clients are so poor that they can't afford the combination of drugs and they don't want to go to the hospital even if it's free," says Rajib Acharya, statistician and demographer at the Population Council in India, a research organisation focused on health issues.

And there remain other major barriers to the uptake of medical abortion, including cost, ignorance and stigma.

At the end of the day many women, Muttreja believes, will still seek out the quack down the road because they fear being seen at the pharmacy. "Do women actually have the courage to go to a pharmacy which is always [run by] a man and ask them to give her medical abortion tablets?" she asks.

Despite their vast physical distance apart and differences in language, culture and so much more, women like Sanathoi and Renee are both part of the story of the monumental challenges women face today: how to manage their bodies in a world where their sexual and reproductive health and rights are increasingly under attack.

Back in New Delhi, Vidya's mother is slouched by her bed on a stool, sweat dripping down her forehead. Intermittent power cuts temporarily stop the rotting fans and make the already unbearable heat even worse.

"She has brought great shame on the family," she says, shaking her head as the nurse stands by. Vidya has heard it all before; she doesn't contradict her mother. In fact, she barely flinches. "Yes, I plan for marriage at the end of the year," Vidya says, staring into the distance. Silently, she is wheeled off for the procedure.