

**MANY A SLIP BETWEEN THE CUP AND THE LIP:
UNIVERSAL ACCESS TO SAFE
ABORTION SERVICES IN INDIA**

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MANY A SLIP BETWEEN THE CUP AND THE LIP: UNIVERSAL ACCESS TO SAFE ABORTION SERVICES IN INDIA

1. Introduction

Safe abortion services remain a distant dream for the large majority of the world's women at the finish of a decade of the 21st century. Worldwide, 210 million women become pregnant every year, of which about 42 million unplanned or unwanted pregnancies are terminated voluntarily. Nearly half of all induced abortions (20 million) are unsafe (1). Ninety five percent of unsafe abortions occur in developing countries. Five million women - or 1 in 4 who have an unsafe abortion are likely to suffer severe complications. Almost 70,000 women die from these complications every year (1).

The much acclaimed Programme of Action of the International Conference on Population and Development (ICPD) in 1994 put reproductive rights, reproductive health firmly on the global agenda, and highlighted gender equality as a necessary condition for achieving these. However, it took a rather ambiguous stance on abortion. On one hand, it acknowledged unsafe abortion as a major public health concern, and on the other, contented itself with a demand for health services to address "**complications arising from abortion**". In other words, women would be left to their own devices to terminate a pregnancy, and health services would step in then to save the woman from morbidity or mortality that could result.

In its much debated paragraph 8.25, the document on the Conference's Programme of Action states:

'In no case should abortion be promoted as a method of family planning. All government and relevant intergovernmental and non-governmental organizations are urged to strengthen the commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislation process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortion' (2).

(1) The World Health Organization defines **unsafe abortion** as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

India is among the small number of countries, where induced abortion is legal for a wide range of indications. More than three decades after the Medical Termination of Pregnancy Act (1971), eight per cent of all maternal deaths in India are from abortions (3). This paper examines the barriers to accessing safe abortion that Indian women continue to contend with, including an unfavourable policy environment amidst growing concerns about sex-selective abortion of the female foetus. The paper concludes with a plea for safeguarding women's access to safe abortion services as an important public health and women's rights intervention.

2. Abortion in India: An overview

Legislation on induced abortion in India

In most countries of the world, legislation to decriminalise and liberalise abortion services was won after a long-drawn struggle by the women's movement and civil society actors. India is an exception. Its Medical Termination of Pregnancy (MTP) Act of 1971 was enacted through action by medical professionals, supported by state machinery concerned with rapid population growth.

The MTP Act permits a "trained" provider within an approved health facility to terminate a pregnancy if one or more of the following indications exists:

- ▶ the pregnancy poses risks to the mother's life or can cause serious damage to her physical and mental health
- ▶ there is substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities
- ▶ the pregnancy was caused by rape
- ▶ the pregnancy was caused by failure of contraception in a married woman or her husband

The Act allows termination of pregnancy (abortion) up to 20 weeks, but requires the opinion of two registered medical practitioners for termination of pregnancy between 12 and 20 weeks. The consent of the women is needed for carrying out the procedure. If the women is below 18 years or is mentally ill, then the procedure may be carried out with the consent of a guardian (4).

The MTP Act of 1971 was amended in 2002. Through the amendment, responsibility for approval of MTP facilities was shifted from the state to the district level, and District Level Committees (DLCs) were formed. This was intended to minimise delays in approval of service delivery points. The amendment also permits provision of medical abortion² services. An authorised abortion provider can now provide medical abortion services even in his/her own clinic, provided s/he has access to a health facility for emergency care and/or surgical abortion in case of incomplete or failed abortion.

(2) Medical abortion is the termination of pregnancy through the use of a drug or a combination of drugs without use of surgical intervention. The most commonly used combination of drugs for medical abortion is mifepristone, given first, and misoprostol, a prostaglandin drug, given 36-48 hours later.

Incidence of abortion

About 7.1 million abortions were estimated to take place every year in India in 1996-97, of which 6.7 million were unreported (5). In the late 1990s, 17 out of every 1000 pregnancies in India ended in an abortion according to National Family Health Survey-2 (6). However, studies from individual states have reported much higher rates of abortion: 45.4 per 1000 pregnancy outcomes in Maharashtra (7), 67 per 1000 pregnancy outcomes in Tamil Nadu (8). Similar findings are also reported from a study in Madhya Pradesh (9). The actual ratios may be even higher. Mishra and Dileep (2003) have estimated the induced abortion ratio using NFHS-2 data to be 189 per 1000 live births, more than 10 times that reported by the survey (10). These seems more likely to be accurate in the light of global estimates.

The proportion of pregnancies that end in an induced abortion worldwide is reported to be 20 % or 200/1000: 280/1000 in developed countries and 190/1000 in developing countries (11).

Profile of abortion seekers

The majority of abortion seekers are married women in the age group 20-29 years (12). Women are far less likely to terminate their first or second pregnancies as compared to pregnancies of order three and above (6). Educated, urban women from higher income groups have much higher abortion ratios than less educated, rural women from low-income groups (5-7, 13). The reason seemed to be poor geographic access to government facilities and inability to pay for private facilities. A study from Maharashtra reported that women from dalit and adivasi communities had lower ratios of abortion, presumably for reasons of poor access (7).

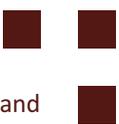
Reasons for seeking abortion

Many of the factors leading to unwanted pregnancies are a result of gender-power inequalities between women and men. These include women's poor negotiating powers around their sexual and reproductive lives, non-consensual sex, poor access to contraceptives, and women's lack of awareness of matters related to sexuality and reproduction.

For example, one-fourth of 34 unmarried abortion seekers in a Trivandrum study reported that the pregnancy was a result of coercive sex. A vast majority of them did not know enough about contraceptive methods and did not use any method; and 92% did not associate their missed menstrual period with a potential pregnancy. One young unmarried woman in a study from Trivandrum thought that "one or two sexual contacts will not lead to pregnancy" (14).

Married women forced into an unwanted pregnancy feel that they have no option but to terminate it.

My husband is a drunkard and does not bring home any money. He just loves to sleep with me. After I conceive, he ignores me or physically abuses me. He will pretend to be concentrating on some work. When the child is born he will deny paternity to the child by saying that he is not the 'real' father of the child. Since I have experienced all these twice, I decided to go for an abortion. There is no other way I could have handled the situation. In any case when children are born, I have to provide them with food while he goes around disclaiming his fatherhood. [35-year old married woman, Tamil Nadu] (15).



Unmet need for contraception among Indian women was about 13% in 2005-06 (NFHS-3), and unmet need for spacing was as high as 25% and 15% for women aged 15-19 years and 20-24 years respectively (16). A large number of studies confirm that between 70-88% of women seek an abortion because they do not want any more children, or would like to delay the birth of the next child (5, 7, 8, 13-14, 17-19).

Non-use of contraception rather than contraceptive failure underlies many unplanned pregnancies. Several qualitative studies report that women believed abortion to be a safer option than IUDs and other spacing methods (5). In a 2007 study from Delhi, almost half of all abortion seekers (47.5%) had never used any method of contraception. Of those who had used a method of contraception, only 18% had used an effective method such as oral contraceptive pills; 45% had used either withdrawal or periodic abstinence and 36.8% had used condoms (18). The vast majority of abortions (70-95%) take place within 12 weeks of pregnancy (7, 12, 17, 20-23).

The other reasons usually cited, although by a relatively small proportions of women, are economic difficulties, contraceptive failure, concerns about the mother's health and congenital anomalies.

Pregnancy in single women is socially censured, and therefore almost always terminated unless access to abortion is unavailable for some reason (14). In a Manipur study, unwed mothers belonging to 15-24 age group constituted the majority of those seeking termination of their first pregnancy (13).

3. Barriers to accessing safe abortion services

There is a large unmet need for safe abortion services

Only about half the women who desire to terminate a pregnancy may actually succeed in having an induced abortion, whether in a safe and legal facility or elsewhere. A study from rural Madhya Pradesh found that 40% of women interviewed had ever wanted to terminate a pregnancy but only 23% succeeded in doing so (9). The lower abortion ratios for rural areas may also be an indication of the huge gap between demand and availability or access to (safe or any) abortion services.

Many reasons underlie women's unmet need for safe abortion. These may be grouped under three major factors: (a) Poverty and gender-inequality; (b) Unresponsive health system and (c) Unfavourable policy environment.

Gender inequality and poverty

It is in the context of abortion decisions that one becomes acutely aware of the power differentials between women and men in matters related to sexuality and reproduction. Many of the reasons for unsafe abortion, like those for unwanted pregnancy, are again gender-related, and include women's own lack of information, decision-making power, and/or financial resources.

Lack of information

It appears that the legality of abortion in India is a well-kept secret, especially from women who need



to use the services. There are only marginal differences across states Irrespective of the level of female literacy and coverage by health care facilities. Two studies from rural Maharashtra conducted in the late 1990s reported that only 18% and 30% of women respectively knew that abortion was legal. Even fewer knew correctly the eligibility criteria and gestation period up to which a pregnancy may be terminated (20, 24). A 2000 study from Tamil Nadu reported that 84% assumed that abortion was illegal in India (25). In 2002 study covering rural Madhya Pradesh, only 9% of the women knew that abortion was legal and could state the gestation period during which pregnancy could be legally terminated. Almost half of the sample (49%) believed that abortion was illegal, 36% did not know about the legal status, and 6% did not know the gestation period for pregnancy termination, although they knew that abortion was legal (9).

Even when women know about the legal status of abortion, they may not be able to easily find out where services are available. A study in six states in the early 2000s noted that almost no facilities, including those certified, displayed the availability of abortion services or their MTP registration (26).

Lack of decision-making power

Almost all women have to negotiate the termination of a pregnancy with their husbands or partners. This often delays the termination of pregnancy into the second trimester. One study found that in 56% of the second trimester abortions, the delay was because of having to seek the husband or partner's consent. Husbands often decided on the course of action. In one instance, the husband bought a tablet from the medical store, but the tablet did not work. He then did not have time to accompany his wife to the hospital, delaying the abortion. In another instance, a husband coerced his wife, already admitted in a hospital for abortion, to seek discharge (14).

A higher proportion of teenage married women (almost 25%) did not have a say in matters related to seeking an abortion as compared to their older counterparts (11%), in a study from Maharashtra (20).

"I wanted to keep it, but he said, 'Why are you so eager to keep it? It must be someone else's. If it is mine you will do as I say.' After that what could I do?" [19 years old, 9th std. educated]

Unmarried women are especially disadvantaged in terms of decision-making, because of the stigma attached to pregnancy outside marriage, and the fear of being severely punished if they disclosed their pregnancy (14). Some may be in denial, while others conceal their pregnancies till they can no longer be hidden (26). Second trimester abortions are far more frequent among unmarried than in married women. In a study from rural Maharashtra, 72% of unmarried women sought abortion in the second trimester as against 26% of all women (7). In a Chandigarh study, 60% of abortions in unmarried women took place in the second trimester as against only 7% in married women (27).

Lack of financial resources

Lack of financial resources is frequently mentioned by women as a major barrier to accessing safe abortion services. This may be surprising, given that safe abortion services are supposed to be provided free of cost in government health facilities. Studies conducted during the period 1995-

2002, among women who used public sector facilities, indicate that average spending ranges from Rs.135 to Rs. 873 across different settings (28). Costs of abortion are much higher in the private sector. In Maharashtra (2001-02), the median costs were Rs. 173.70 in a public facility as compared to Rs.1293.60 in a private facility (7).

Costs of abortion increase with period of gestation. One study reports the cost of second trimester abortion to be at least four-times that of first trimester abortion, both in the public and in the private sector (20). Another study reports a 20% increase for 8-12 weeks gestation and 40% increase for pregnancies of 12-20 weeks as compared to pregnancies below 8 weeks (7).

There may also be a cost disparity by marital status, with single women having to pay more. For example, a clinic in Delhi reportedly charged Rs. 400-Rs 600 for abortions if the woman was married, and Rs. 1200 if she was not (28).

Women with least decision-making power, including single women, and those without ready access to money to have an abortion may thus find themselves having to have a second trimester abortion, usually involving a riskier procedure than first trimester abortions, and having to pay more for it.

Those who cannot afford the cost of a private sector facility and do not have a public facility within a reasonable distance, are forced to seek the services of unqualified providers at considerable risk to their lives and wellbeing. In a rural Tamil Nadu district with a wide network of abortion service providers, 12 of 97 abortion seekers included in a study used unqualified and unsafe providers. Eight went to M___, who had only secondary level education and had learned to perform Dilatation and Curettage as assistant to a medical doctor, because she charged only Rs 200-300. This was despite her poor track record, of three deaths and numerous instances of serious post-abortion complications during the five years preceding the study. Four of the poorest women went to a traditional abortionist who used even less safer methods (22).

Unresponsive health system

An abortion by a trained professional under safe conditions is one of the safest procedures. However, when women cross the many gender and poverty related hurdles and choose to terminate an unplanned or unwanted pregnancy, other barriers have to be overcome: for example, poor availability and access to appropriate services; negative provider attitudes and poor quality of care which make abortion unsafe even within a certified health facility.

Poor availability

Overall, there are estimated to be about 4 abortion facilities per 100,000 populations, of which only one is a public sector facility, and the remaining 3 are private facilities. Also, abortion services in the public sector were usually available only in taluka and district hospitals and not at the level of the Primary Health Centre (PHC) (26). Both public and private sector abortion facilities are disproportionately concentrated in urban areas: towns and metropolitan cities. In a Maharashtra study, the mean distance to an induced abortion facility in its rural sample was 24.9 kms for public

and 19.4 kms for private facilities. In its urban sample, the mean distance to an induced abortion facility, public or private, was about 5-6 kms while in Mumbai, the mean distances to a public and private abortion service facility were only 1.5 kms and 1.9 kms respectively. Because they were unable to reach an abortion facility earlier, second trimester abortion was three times more common among rural as compared to urban women, and in Mumbai, only 3.5% of all abortions took place after 12 weeks of gestation (7).

For those already facing a delay in pregnancy termination because of poor service availability, more trouble is in store. A large number of facilities do not provide second trimester abortions. According to the Abortion Assessment Project - India's study in six states, 7 out of 10 abortion facilities (public and private taken together) offered only first trimester abortion services (26).

There are a number of legal barriers that come in the way of increasing the number of abortion facilities and providers. According to the MTP Act, all government facilities are permitted to provide abortion services. However, private facilities desiring to do so, need to have their eligibility certified by a District Level MTP Committee. They are required to install equipment and supplies for general anaesthesia and abdominal surgery, guarantee that a trained provider as anaesthetist is available, and subject themselves to site inspection and sequential recommendation by district and state MTP authorities. Much of these requirements are not necessary if abortion methods/techniques other than Dilatation and Curettage (D&C) are used (e.g. Manual Vacuum Aspiration, medical abortion using Mifepristone and Misoprostol) (30).

In the face of poor access to formal providers, women have to depend mainly on informal providers who use unsafe and invasive methods (22). Informal providers include not only traditional female herbal practitioners but also Auxiliary Nurse Midwives (ANM), unqualified Rural Medical Practitioners (RMP) and chemists (31). In Madhya Pradesh, while 77% of urban women respondents in a study terminated their pregnancy using a medical procedure, only 44% of rural women did so. Fifty six per cent (56%) of rural women in the study had their pregnancies terminated by some dubious and potentially unsafe method (9).

Mausi (the dai) inserted a herbal piece (in the cervix) and she prepared a tonic with another herb and made P_ drink it. After one hour pain started. Her back and hands and legs became strained. P_ took a second dose of herbal tonic before the evening meal. After the second dose, watery discharge started from the vagina at midnight, and there was also blood. Then severe pain started in hands, legs, back, lower abdomen. The pain increased. During the rest of the night the products were expelled, bit by bit, and the process continued throughout the night and next morning. The last products and placenta came out around twelve noon the next day. Afterwards, P_ had intermittent bleeding and feeling of weakness for many days, but she didn't go to a doctor, as she could not afford any more costs (31).

Limitations related to provider-training

According to the MTP Act, medical professionals other than qualified gynaecologists have to undergo in-service training in a designated MTP training centre. In many instances, in-service MTP training is available only in teaching hospitals and therefore not accessible to private practitioners (30). This seriously limits the number of trained providers who can provide safe abortion.

Dilatation and Curettage remains the most common method of abortion used by all except traditional providers. Even when vacuum aspiration is used, curettage is done (5, 22-23). Providers' unfamiliarity with methods other than D&C makes abortion unavailable in facilities lacking in infrastructure and equipment necessary to provide this procedure.

Where medical abortion is available through qualified providers, women have found it quite acceptable and were increasingly requesting it (32). Medical abortion, a safe technology which does not need sophisticated medical equipment or facilities, remains unavailable in public health facilities, making medical abortion inaccessible to women who cannot afford to pay for it.

Attitudes of the service provider

When barriers related to availability and access to a trained provider are overcome, women may yet be refused abortion by the provider. The MTP Act is not a legislation that acknowledges women's right to abortion, nor does it provide for abortion services on demand by the woman. It casts the service provider in the role of gate keeper, and requires that a registered medical practitioner (two of them, in case of a second trimester abortion) with the requisite training, approve the procedure based on an opinion formed in "good faith".

Providers tend to view women seeking a pregnancy termination as irresponsible, and may discourage women from having an abortion. A 1996 study from a Tamil Nadu district with a nationally renowned private hospital and a district hospital found that 65% of 46 abortion seekers interviewed had used an untrained provider. The women said that they did not go to the private hospital because doctors there tended to discourage women from having an abortion and advised them to continue with the pregnancy (33).

Another issue is providers' insistence on spousal consent. The Abortion Assessment Project-India's study in six states found that 55% of the facilities insisted on the signature of the husband or a family member in addition to the woman's signature (26). Nothing seems to have changed in this respect close to a decade after this study. In Maharashtra, a 2008 study that included detailed discussions with government medical professionals and officials reported that "In case of adult women, husband's consent is a mandatory requirement in most of the facilities but in some facilities, any other adult's consent is accepted. The service providers were of the opinion that in order to safeguard the doctor and the hospital it is important to take the husband's consent. Though none of them were able to recollect actual instances, all seemed to narrate (fictitious?) cases wherein husbands who did not consent to their wives undergoing MTP created problems for the hospital (34).

In the case of unmarried women, doctors seemed to think that it is their moral responsibility to reprimand the abortion-seeker and make abortion access really difficult. The following two instances from a study of adolescent abortion seekers illustrate this (20, p.82).

"You village girls are all the same. Illiterate and stupid. Cannot keep yourself out of trouble. Do you not understand anything?"(Male gynaecologist, large city hospital).

"I insist on a signature. I tell them, bring your husband, bring your mother. Not that it is really needed. But otherwise everything is too easy for these girls. They will go on doing such things and then coming for abortion" (Woman gynaecologist, large city hospital).

Others who may be denied abortion services in health facilities are women living with HIV, because of health providers' fear of infection while at the same time practising poor infection control procedures overall.

Rude behaviour towards women seeking abortion services appears to be routine behaviour in many government hospitals. A study from Tamil Nadu provides a graphic description of an outpatient department in a taluka hospital:

"From 10.00 to 12.30 I counted 13 MTP cases [among others]. They had come on their own, along with their mothers or other women. The doctor said to several of them 'When we ask you to accept a method...you don't accept...Where is your VHN³? Has she not motivated you? As if I am meant to do only this...so that you come for termination. I am not here for doing all this nonsense. Please go away from here'. She then turned to me and said" 'See these stupid people. How many times do we have to tell them...to use some method." (25, p.68).

It also appears that providers do not feel accountable to clients seeking abortion services. According to a Village Health Nurse in rural Tamil Nadu, VHNs were afraid to refer abortion cases to the district hospital because some women had ended up with complications, and when the VHN went back to the provider, she denied having ever performed the abortion (22). According to another study, when a woman went to consumer court after suffering serious post-abortion complications after a procedure in a Tamil Nadu taluka hospital, all gynaecologists in taluka hospitals started avoiding MTP procedures, referring women to higher facilities (25).

Unfavourable policy environment

In this section, we address two issues. One is the international policy environment influenced by the Global Gag Rule of the United States Government which has seriously hampered donor funding for

(3) VHN is the Village Health Nurse

abortion, and created a climate where safe motherhood is promoted while turning a blind eye to unsafe abortion. The second is a specifically Indian problem, where abortion services are becoming even less available than before because of the desire to prevent sex-selective abortion of the female foetus.

The Global Gag Rule and its fallout

The 'Global Gag Rule' refers to a policy of the United States government which stipulates that all non-governmental organisations that receive federal funding may neither perform nor promote abortion services in other countries. The policy first came into effect during the Reagan administration and was in place between 1985 and 1993. Bill Clinton ended it when he took office in 1993, but it was reinstated by George W. Bush in January 2001. After a nine year period, the policy has been rescinded in January 2009 when Barack Obama took office.

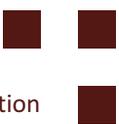
Several international agencies no longer received a portion of their funds from USAID even if they were using non-USAID money for providing abortion services. Several others chose not to mention the "A word", nor engage in abortion research or service provision, in order to protect their funding source. A major setback for women's sexual and reproductive rights is that prominent UN organisations such as the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) either do not address abortion as a health issue at all, or relegate it to the bottom of their priority list. According to a UN Fact Sheet, United Nations organisations did not promote abortion as a method of family planning, and believed that "the legal status of abortion is the sovereign right of each nation" (35).

While lack of funding for abortion services was definitely an issue for many countries, for a country like India with low donor dependence for health and family welfare, the main issue was the silence on abortion as a public health issue by the international academia. A culture of self-censorship and fear seems to have entrenched itself in many public health institutions when abortion is at issue.

One cannot but comment here on the doublespeak in international policy discourse which promotes safe motherhood even while censoring access to safe and legal abortion, knowing fully well that unsafe abortions contribute significantly to maternal deaths. Assurances of health services for "post-abortion complications", found in the ICPD Programme for Action and in many subsequent policy documents add insult to injury.

The Campaign to prevent sex-selective abortions turns anti-abortion in effect

The misuse of pre-natal diagnostic techniques to determine the sex of the foetus and selectively terminate pregnancies involving a female foetus first came into limelight in the late 1970s. Civil society groups organised themselves to prevent such misuse as early as in 1982. The Bombay-based Forum Against Sex Determination and Sex Pre-Selection came into existence in 1985. It was one of the main factors behind the "Maharashtra Regulation of Use of Prenatal Diagnostic Techniques Act, 1988."



Following this, the Government of India passed the "Pre-Natal Diagnostics Techniques (Regulation and Prevention) of Misuse Act, 1994". The Act aimed at providing regulation for the use of pre-natal diagnostic techniques for the purpose of detecting genetic abnormalities or certain congenital malformations or sex linked disorders and for the prevention of misuse of such techniques for the purposes of sex determination. The Act was amended to the "The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of sex selection) Act, 2003", to bring pre-conception sex-selection techniques within its purview.

The PC PNDT Act of 2003 prohibits the determination and disclosure of the sex of the foetus through use of pre-conception or prenatal diagnostic techniques. It also bans any advertisement related to pre-conception or pre-natal sex-determination. It should be noted that the law makes the act of sex-selection illegal while remaining silent on the legality of the abortion that may follow it. Thus, there is no ban on any abortion - sex-selection or otherwise - and eligibility for abortion is to be assessed according to the provisions of the MTP Act.

The selective abortion of the female foetus is indeed a major manifestation of gender discrimination in society, and a campaign to prevent it, is to be supported by all who stand for gender and social inequality. It is however, unfortunate that this campaign has been more successful in denying women access to abortion rather than changing patriarchal forces that devalue and discriminate against women and girls. In a sense, the campaign has been derailed by the media attention it has received. The media has loved to sensationalise the "missing girls" and made anti-abortion language such as "female foeticide" household terms.

Popular belief appears to be that most abortions and especially second trimester abortions take place for reasons of sex-selection. The gender and poverty factors underlying unwanted pregnancy and need for an abortion have been discussed earlier in this paper. Other empirical evidence also shows that sex-selection cannot be the major reason for abortions. One major study analysing data from NFHS-2 for more than 90,000 women from all major states of India found that between women who had all boys and women who had all girls, there was no significant difference in the probability of their having an abortion (6). In only one state, Haryana, (of 26 states) women whose previous child was a girl were about two times (1.8) more likely to terminate the current pregnancy than other women (6).

Sex-selective abortions do take place, but they are nowhere near the scale of hundreds of thousands. One study covering 133,738 births that occurred in 1997 (36) found a sex ratio of 899 females to 1000 males. This was seen as conclusive evidence that sex-selective abortion was happening at a very large scale. However, it may not be right to assume that all deviations from the "normal" sex ratio of 952 females to 1000 males (105 males to 100 females) are caused by sex-selective abortions. Sex ratio at birth is not a constant, and is known to vary from the "normal". For example, far fewer boys than girls are now born in many European countries, and the causes are still being explored. A number of other factors such as birth order, timing of conception, trained attendance at birth, and

psychosocial stress factors have been found to influence sex ratio at birth (37-39).

Other studies indicate that the proportions of abortions that happen for reasons of sex-selection are very small. Estimates based on NFHS-2 data show that only 14% of pregnancies used PNDT, and that no more than 17% of those using PNDT may have aborted a female foetus. In other words, PNDT was not generally misused, and less than 3% of all pregnancies resulted in a sex-selective abortion of the female foetus, following sex-determination using PNDT (40). Similar findings emerge from a number of other studies from specific states. For example, in Madhya Pradesh, among a sample of urban women who had abortion, one in five (19.1%) went for a pre-natal diagnostic test. The corresponding figure for rural areas was less than 1 woman in 20 (4.5%). Only 3.2% of urban and 1.7% of rural abortions were because the foetus was found to be female (9). In Tamil Nadu, the incidence of sex-selective abortion was reported to be too low to be captured even by a sample of more than 4000 ever-married women (8). Maharashtra seems to be among states (like Haryana) with a higher incidence of sex-selective abortions, where according to one study, unwanted sex of the foetus was the reason stated by 12.5% of abortion seekers: 19% rural and 5.8% urban respondents (7).

Media campaigns to prevent sex-selective abortions have caused confusion about the legal status of all abortions in the country. Materials about sex determination and sex-selective abortion seem to have been much more widely disseminated than information about abortion itself (41). A study analysing the content of materials about sex determination tests noted that powerful visual images such as knife cutting a rose bud, and of a foetus being squeezed in a fist, with the slogan "Garbh me mujh bachi ko math maro" (Don't kill me, the girl child, in the womb) in posters produced by the Rajasthan Government, implicitly equated all abortions with murders and implies their illegality (41).

Second trimester abortions have become virtually unavailable in all government facilities. Government health personnel in Maharashtra interviewed for a 2009 study confirmed that second trimester abortion services were not provided in most public facilities. Members of the District Level MTP Committee said that most second trimester abortions are sex-selective, and as government officials they were responsible for not letting these happen. According to them, there was an informal understanding within public hospitals not to conduct any second trimester abortions. In some districts women were not only denied second trimester abortion but also tracked by health authorities till the time of their delivery (34). Anecdotal evidence from other states corroborates this trend. In Tamil Nadu, official statistics show a 13% decline during 2003-08 in the number of MTPs provided in approved facilities (42).

4. Call to Action: Uphold women's right to safe abortion services

Evidence shows that most women seeking abortion are young and married and seek to terminate an unplanned or unwanted pregnancy. Serious inequities exist in availability of abortion services by rural or urban residence, economic and marital status. Gender power inequalities create numerous barriers to accessing safe abortion services. The poor quality of care and negative provider attitudes



in public health facilities are further hurdles that women have to cross before they can get safe abortion services. As if these many hurdles were not enough, the campaign against sex-selection seems to have inadvertently made safe abortion services even more difficult to access, especially for those who are from poor and marginalized sections of society. Unsafe abortions result in the death of 15,000-20,000 young women in India each year, and causes ill health in thousands of others (43). Every one of these deaths and disability can be avoided, and it is a matter of social injustice not to do so.

Women's right to terminate an unwanted pregnancy is implied and supported by several international treaties and instruments. For example, access to safe abortion services is essential for the protection of women's right to health, and of their right to life. Women's right to enjoy the benefits of scientific progress and its applications, enshrined in the Covenant on Economic and Social and Cultural Rights, also implies that women should not only have access to safe abortion, but also to the latest methods, including medical abortion, deemed safe and effective for inducing abortion (44).

Freedom from discrimination is enshrined in every international human rights document. Since only women need abortion services, restriction of access to abortion services is viewed as discrimination against women (31). Recognition of women's right to make decisions regarding their own bodies - including the right to physical integrity, the right to decide freely and responsibly on the number and spacing of their children - is found in many international documents. Many governments have committed themselves to respecting, protecting and fulfilling these rights. In order to do so, governments have to make abortion services legal, safe and accessible for all women who seek an abortion (44).

In India, the National Rural Health Mission (NRHM) has made significant investments in promoting institutional deliveries through improvements in infrastructure and recruitment of doctors, as well as attempting to remove demand side barriers through the Janani Suraksha Yojana (JSY). These interventions maintain a palpable silence around maternal deaths from abortion.

India has been a pioneer in making abortion legal. It is indeed a tragedy that we have not yet succeeded in making it safe for all women. Policy makers and programme managers have for long known what needs to be done, and we see no need for this article to end with a predictable list of recommendations.

At this moment in history, however, we need to reaffirm women's sexual and reproductive rights including access to safe abortion services. We need to focus on abortion as one important aspect of reproductive health, which has backward and forward linkages. Unwanted pregnancies and the unmet need for contraception have to be addressed through quality contraceptive services. Issues of gender inequality and gender discrimination that impact on both abortion and sex selection have to be tackled with utmost seriousness. Sex selection has to be dealt with as an issue of gender

discrimination at its worst, addressing its structural causes. In the short run, sex determination through the misuse of technology should become the point of intervention, and not prevention of abortion. Above all, we need to create common ground between the discourse on women's right to safe abortion and the discourse on prevention of sex selection.

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CommonHealth Thematic Areas

Maternal Health

Make every instance of maternal morbidity and maternal death count.

Advocate for safety, quality and respect for women's rights in delivery care.

Promote health system strengthening and accountability through community mobilization.

Neonatal Health

Generate and disseminate information on neonatal health.

Encourage labour monitoring for improving perinatal and neonatal outcomes.

Advocate for right to health for newborns, through

- a. Counting of stillbirths and newborn deaths.
- b. Attention to newborn outcomes by promoting safety and quality in delivery.
- c. Legal, policy and economic measures to support newborn care.
- d. Greater participation of men, families and the community in essential newborn care.

Safe Abortion

Carry out sustained campaigns to promote access to safe and quality abortion services for all women irrespective of marital status, especially those from disadvantaged sections.

Support the prevention of sex-determination through stringent implementation of the PC-PNDT Act and campaigns against gender discrimination, without compromising on women's access to safe abortion services.





CommonHealth - a Coalition for Maternal - Neonatal Health and Safe Abortion

We are a coalition of concerned individuals and organizations from across India, who have come together to work towards changing the unacceptable situation around issues of maternal-neonatal health and safe abortion.

Vision

A society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities in India.

Mission

To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged.

To mobilise advocates from different constituencies to:

- a. ensure effective implementation of relevant policies and programmes.
- b. contribute to the development of new policies and changing of existing ones when needed.
- c. build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

