Safe Abortion: Women's Health and Rights Issue

Worldwide, 210 million women become pregnant every year, of which about 42 million women faced with an unplanned or unwanted pregnancy terminate their pregnancies 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 is likely to suffer sever complications. Almost 70,000 women die from these complications every year (1).

1. Unwanted pregnancy and unsafe abortion are gender issues

Gender-power inequalities between women and men underlie many unwanted or unplanned pregnancies. 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

When I express reluctance for sex saying that I am worried about getting pregnant, he says, “I will take care of if it happens.” If I object strongly he shouts: “Are you sleeping with someone else?” After my first childbirth, he called me for sex within a month. When I objected, he beat me. This is a regular happening in my life.
Younger woman, ever-user of abortion, Tamil Nadu (31).

My husband is a drunkard and does not bring home any money. He just loves to sleep with me. After I conceived 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 this 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 (32)

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. When a woman chooses to terminate an unplanned or unwanted pregnancy, she may not always have access to safe abortion services. An abortion by a trained professional under safe conditions is one of the safest procedures. However, a large number of women worldwide are forced to resort to unsafe abortion using methods that can give rise to life-threatening complications. Many of the reasons for unsafe abortion are again gender-related, and include women's own lack of information, financial resources or decision-making power because of gender power inequalities in society; as well as government policies that restrict access to abortion through laws, poor availability or cost of services.

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.

It is generally believed that the need for induced abortions would eventually disappear with increasing use of contraceptives. However, even where family planning services are widely accessible, unwanted or mistimed pregnancies occur because of contraceptive failure or irregular use or as a, result of sexual violence. A woman may be unable to continue with her pregnancy because it poses a danger to her life or health. For all these reasons, and many others, there will always be a need for safe abortions services even where contraceptive prevalence rates are very high. For example in the US and in some East European countries, about a half to three-fifths of all pregnancies are unintended and resolved through induced abortion (2).

2. The abortion situation in India

Induced abortion has been legal in India since 1971, to prevent deaths from unsafe abortion. More than three decades later, eight per cent of all maternal deaths in India are from abortions, claiming the lives of 15,000-20,000 young women every year (3, 4).

Legislation on induced abortion

India's Medical Termination of Pregnancy (MTP) Act of 1971 allows termination of pregnancy (abortion) up to 20 weeks, if

- 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 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. This was intended to minimise delays in approval of service delivery points. The amendment also permits provision of medical abortion 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[2] in case of incomplete or failed abortion.

Abortion numbers and rates

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 NFHS-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).

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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 misoprostal, a prostaglandin drug , given 36-48 hours later.

Profile of abortion seekers

The majority of abortion seekers are married women in the age group 20-29 years (10). 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 rates than less educated, rural women from low-income groups (6, 7, 5, 11). 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 rates of abortion, for these same reasons (7).

Timing of abortion

The vast majority of abortions (70-95%) take place within 12 weeks of pregnancy (7, 10, 12-16). The most important reason why second trimester abortion occur is because women are unable to reach an abortion facility earlier. For example, in rural Maharashtra second trimester abortion was three times more common among rural as compared to urban women, while in Mumbai, only 3.5% of all abortions took place after 12 weeks of gestation (7).

Unmarried women face significantly greater delays in seeking abortion, for a number of reasons. They may not associate amenorrhea with pregnancy because of lack of knowledge (17), be in a state of denial, or conceal their pregnancies till they can no longer be hidden (18). 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 (18).

The perceived need for spousal consent and lack of money for meeting the cost of services are also important reasons why women delay seeking termination of pregnancy (17, 18).

HIV positive women are often able to seek a pregnancy termination only in the second trimester because they are able to know of their status following antenatal HIV testing only then. Most foetal anomalies are diagnosed in late second trimester or even later (18).

Providers and methods

There are large regional variations in providers and methods that women use for terminating a pregnancy. In states with poor access to formal providers, women have to depend mainly on informal providers who use unsafe and invasive methods (14). Informal providers include not only traditional female herbal practitioners but also ANM, RMP and chemists (19). Rural women are especially at a disadvantage. A study from Madhya Pradesh reports that while 77% of urban women 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 (19).

Dilatation and Curettage (D&C) remains the most common method of abortion used by all except traditional providers. Even when vacuum aspiration is used, curettage is done (5, 14-15). Where medical abortion is available through qualified providers, women have found it quite acceptable and were increasingly requesting it (20). Medical abortion, a safe technology which does not need sophisticated medical equipment or facilities, remains unavailable in public health facilities, making it inaccessible to women who cannot afford to pay for it.

Health outcomes

Information on the extent of prevalence of abortion-related morbidity is limited. Hospital-based studies report a rate of complications as low as 3-4% (16), while community-based studies based on self-reporting find that between 33%-70% of women develop a post-abortion complication (7, 9, 14). If only health problems that persisted beyond a week and required medical attention are considered, the complication rates range between 6% and 18% (7, 14, 19). The most common problems reported are severe prolonged bleeding, fever, pain and vaginal discharge.

Providers rated as unqualified and unsafe caused a much higher rate of post-abortion complications (14-15). A Tamil Nadu study reported that incorrect medical abortion regimens used by doctors especially for second trimester abortions could be causing excessive bleeding (20).

3. Women's reasons for seeking abortion

The vast majority of women (70-88%) 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, 11, 16-17, 21-22). 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.

> *Already I have five sons and my husband was not cooperating with me…I decided to abort and informed him of my decision. He didn't agree, so I went to my mother's and had the abortion. My parents paid for all the expenses.*
> *Older woman, ever-user abortion,Tamil Nadu (31).*

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 (22).

Pregnancy in an unwed girl is almost always terminated unless access to abortion is unavailable for some reason (17). In a Manipur study, unwed mothers belonging to 15-24 age group constituted the majority of those seeking termination of their first pregnancy (11).

Sex-selection as a reason for abortion

It is generally believed that the desire to prevent the birth of a girl is the major reason why women in India terminate their pregnancies. There is no doubt that some of the abortions are for reasons for sex-selection. Women are often forced into this situation by their circumstances and social pressure.

The hope for a son was so much that I didn't have any other feeling. I felt sad, but what to do? One has to burn one's mind. There are two daughters, what to do with a third daughter? Nothing else, a son is wanted. Only that is in mind.
23 year old with two daughters, after having a second sex-selective abortion (33)

After three girl children, when I conceived again I was afraid that this might also be a girl. Even that did not bother me as much as my husband's obscene remarks about my sexuality. For this reason, every time I got pregnant I tried to commit suicide. But this time I decided to abort the fetus. But the doctor advised me against an abortion, as it was too late to have it. So, I threatened the doctor saying that I would commit suicide right inside the hospital, if she did not perform the abortion. Only then she agreed and aborted the fetus. But it turned out to be a male child. Still there was pleasure in the abortion, as this time my husband could not suspect the child and me."
38 year old woman, Tamil Nadu (32)

However, information from many studies indicates that unintended pregnancy rather than sex of the child underlies demand for most abortions.

One major study analysing data for more than 90,000 women from all major states of India from National Family Health Survey-2 (NFHS-2) 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).

Another study, also using NFHS-2 data estimated that about 14% of pregnancies used ultrasound scan usually as part of routine antenatal care; and that no more than 17% of those using ultra-sound scan may have aborted a female fetus. *In other words, less than 3% of all pregnancies resulted in a sex-selective abortion of the female fetus, following sex-determination* (23). Similar findings emerge from a number of other studies from specific states. For example, a study from Madhya Pradesh (9) found that among those who had had abortion in urban areas, 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 fetus 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 fetus was the reason stated by 12.5% of abortion seekers: 19% rural and 5.8% urban respondents (7).

4. Safe, legal abortion is a woman's right

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.

Among those who do seek abortion, the vast majority have unsafe abortions. Between two to eleven illegal abortions, many of them also unsafe, are estimated to take place in India for every legal abortion (28).

Many reasons underlie women's unmet need for safe abortion. Women's limited access and control over information and financial resources and lack of decision-making power erect formidable barriers to accessing safe abortion services. Unmarried women, widows and single women face additional barriers due to the social stigma attached to pregnancies outside marriage. Abortion services may be unavailable or inaccessible because of lack of public health facilities and high costs in private health facilities.

For women who cross these barriers, there are also barriers at the provider and facility level. Providers tend to view women seeking a pregnancy termination as irresponsible, and may discourage women from having an abortion. Spousal consent may be sought or abortion may be made conditional on sterilisation acceptance. Some facilities may lack infrastructure and equipment necessary to provide Dilatation and Curettage (D&C); providers' unfamiliarity with other, safer technologies like manual vacuum aspiration (MVA) and medical abortion means that abortion services cannot be provided in such facilities. Women living with HIV/AIDS may be denied abortion services in health facilities because of fear of infection.

In recent years, attempts to prevent the selective abortion of female foetuses have inadvertently contributed to making safe abortion services even less accessible. Media campaigns to prevent sex-selective abortions have caused confusion about the legal status of all abortions in the country. Providers are wary of providing second trimester abortions because they fear that these may be for sex-selection. Evidence from some states shows that the number of MTPs provided in health facilities is declining. For example, Tamil Nadu shows a 13% decline during 2003-08 in the number of MTPs provided in approved facilities (29).

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

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 (30).
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 (30).

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. Let us commit ourselves to making safe abortion services accessible to all women; let us prevent needless death and disability from unsafe abortions.

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