INDUCED ABORTION IN INDIA

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In a society, a woman who is pregnant is pressurized to abort and one who is not pregnant is pressured to control her fertility. The women in societies such as that found in India do not have the choice to remain single and, having gotten married, they cannot choose when to have the sexual relations that make them pregnant. Nor is the choice to continue the pregnancy or not theirs. In India, today many pregnant women make their “only choice” - induced abortions - which may be neither legal nor safe. Free access to abortion is a woman’s right and a major demand of the feminist movement. It has being observed that abortions are damaging the health of women. In a patriarchal society where women have no rights over their bodies, and population control policy is being forced, abortions and abortion services add to being one more instrument for the exploitation of women. To be able to participate effectively in political and social processes, women must have access to information, choice, and control over reproductive technologies. However, as techniques of medically monitoring and managing labour became available, methods of induced abortions are developed.

ABORTION LAWS AND THE ABORTION SITUATION IN INDIA

FAMILY PLANNING LEGISLATION

In the First Five Year Plan (1951-1956), a family planning programme was introduced to improve the health of women and children. It needs to be noted that the fertility regulation programme of the International Planned Parenthood Federation was designated as the birth control programme. However the Indian Planners had the welfare of the family in mind and hence the programme was called Family Planning. The programme was a part of Maternal and Child Health (MCH) under the Ministry of Health. Since the Third Plan (1961-1966) was instituted,

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due to pressures from the international agencies, the objective of the programme has become a reduction in the birth rate.

The year 1965 saw a nationwide famine. There was a shortage of rain in the following year as well. India experienced a serious food crisis and the government of United States discussed the food shortage in the country. The 1961 census showed that the rate of growth of the Indian population continued to be high and it was believed that the distribution of contraceptive methods such as a diaphragm and jelly, foaming tablets, and condoms by the family planning clinics was not effective in reducing the birth rate. The discussion between the government of India and the United States authorities therefore led to the introduction of methods such as the IUD, the use of which was unrelated to the sexual act, was provider controlled, and was expected to be more effective in bringing down the birth rate. The people, who accepted these methods, as well as the staff members providing the services, received financial incentives. The incentives to the participants of the camps were larger. Group pressures and mass motivation worked at these camps. The largest camp was held in July of 1971 at Ernakulum in Kerala. The number of men undergoing vasectomy in this camp was 62,913 (Krishnakumar, 1974). The introduction of the camp approach demonstrated an anxiety about the population problem. The achievements of the programme were due to what came to be informally called "coercive persuasion." The States that took hardest line were Maharashtra and Tamil Nadu. The camp approach was originally developed by the officials of the government of Maharashtra. In September, 1968, Maharashtra also introduced a scheme of disincentives. In 1976 the State introduced a bill for compulsory sterilisation of couples with three or more children.

Abortion in India was legal only to save the life of the mother. The provisions of the Indian Penal Code placed India in the category of those countries with highly restrictive abortion laws. Section 312 of the Indian Penal Code provided: Whoever voluntarily causes a woman with child to miscarry shall, if miscarriage be not carried in good faith for the purposes of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine or with both, and if the woman be quick with child, shall be punished

with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Further provisions of the Penal Code provided severe penalties for abortions performed without the woman's consent, and for infanticide... Until 1971, therefore, abortions in India were governed by the Indian Penal Code of 1862 and the Code of Criminal Procedure of 1898. The latter lays down the procedure to try persons violating the substantive law under the former. The origin of this code was the British Law of the 19th century.

ABORTION LEGISLATION

On August 25, 1964, the Central Family Planning Board recommended that the Ministry of Health create a committee to study the question of legislation on abortion. The recommendation was adopted Late in 1964, and a committee was constituted, with representatives from a variety of Indian public and private agencies. The committee - called Shantilal Shah Committee - issued its report on December 30, 1966. The government decided to liberalise the abortion laws and passed the Medical Termination of Pregnancy Act (MTP Act of 1971). The terminology was specifically designed to make it easy to get the law approved by the parliament. The law was passed as a health measure to protect women from the hazards of untherapeutic abortions. According to the report of the Shantilal Shah Committee, the major concern of the Committee was the hazards of illegal abortions.

The period since the 1990s has witnessed major changes in the field of abortion including the adoption of new legislative measures, the introduction of new technologies and the growing demand for sex selective abortion. Some of these developments, such as the recent amendments to the Medical Termination of Pregnancy (MTP) Act and the introduction of innovative abortion technologies, such as the improved manual vacuum aspiration technique and medical abortion, are expected to increase the availability of safe abortion services.

Legislative measures

Recognizing the failure of the MTP Act of 1972 to make legal abortions widely available, the government amended the Act in 2002. With

the amendment, the authority for approval of registration of MTP centres has been decentralized from the state to the district level. In the year 2003, the government introduced a further amendment to MTP Rules which has rationalized the criteria for physical standards of abortion facilities -- fixing different criteria as appropriate for conducting first-trimester and second-trimester abortions. While facilities such as an operation table and instruments for performing abdominal or gynaecological surgery, and equipments for anaesthesia, resuscitation and sterilization continue to be the minimum requirements for centres offering second-trimester abortion, the MTP Rules 2003 require a gynaecological or labour table rather than an operation table and resuscitation and sterilization equipment but not anaesthetic equipments for centres offering first-trimester abortion. These rules also permit a registered medical practitioner to provide medical abortion services in the case of termination of pregnancy up to seven weeks, provided the practitioner has access to a facility for offering surgical abortion in the event of a failed or incomplete medical abortion. The Reproductive and Child Health Programme launched in 1997 and the National Population Policy, 2000 have also delineated a number of strategies to increase the access to safe abortion at the primary health care level. Amendments have also been introduced in the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act of 1994. This was necessitated as the PNDT Act had failed to curb the practice of testing for sex determination and consequent sex-selective abortion in the country. With the recent amendment to the PNDT Act, preconception and pre-implantation procedures for sex selection are banned in the country. The Amendment stipulates compulsory maintenance of written records by diagnostic centres/ doctors offering sonography service.

ABORTION PRACTICE IN INDIA

MEDICAL TERMINATION OF PREGNANCY (MTP) IN INDIA

Legal Status of Abortion

The Medical Termination of Pregnancy Act, approved in India in 1971 and enacted in 1972, permits abortion (or MTP) for a broad range of social and medical reasons, including: to save the life of the woman; to preserve physical health; to preserve mental health; to terminate a

pregnancy resulting from rape or incest and in cases of fetal impairment. Contraceptive failure also is sufficient ground for legal abortion (United Nations 1993).

Barring medical emergencies, legal abortions must be performed within the first 20 weeks of pregnancy and must be performed by a registered physician in a hospital established or maintained by the government or in a facility approved for the purpose by the government (Mathai 1998). For abortions taking place between twelve and twenty weeks of pregnancy, a second opinion is required except in urgent cases. Women must grant consent prior to the performance of the abortion. In the case of minors (defined as under age 18) and mentally retarded women, written consent of guardian is necessary (United Nations 1993). Critics of the abortion law admit that when it was introduced it was a great achievement for women's health. Nearly 30 years later, the law and associated rules and regulations are considered overly medicalised and bureaucratic, and as such, not oriented toward women's right to access safe and legal abortion services. The law offers substantial protection for medical providers. Note that "doctors . . . receive blanket indemnity under the MTP Act - instead of functioning as for other surgical procedures and taking the consequences of any default or neglect."

Inadequate Legal Abortion Service Provision

Despite the broad range of indications for legal abortion, illegal and unsafe abortions are common in India for many reasons. Women access care from uncertified providers because certified providers are geographically inconvenient; staff at certified facilities tend to not respect women's confidentiality; because women are unaware of certified facilities; because Registered facilities often do not have a trained provider and/or the necessary equipment to provide safe abortion services; and many women are unaware that abortion is legal and publicly available. Cost, coercion, moral dilemma, late knowledge of pregnancy and unmarried status are additional reasons women seek abortion from illegal providers. Some providers do not approve of elective abortion and scold the client as they provide treatment; the pressure to accept sterilization or other long-term contraception after an abortion discourages women from using registered facilities. When the reason a woman elects to abort a pregnancy is not

legally sanctioned, for example for a sex-selective procedure; or when the procedure is highly socially stigmatized, for example to terminate an extramarital pregnancy, women must access the more confidential services of uncertified abortion providers.

Illegal Abortion - Providers and Methods

Because of the barriers preventing women from accessing MTP, women access abortion from unregistered, uncertified providers. Abortion services from unregistered providers range from completely safe - provided by trained medical doctors in appropriate facilities - to life threatening. Uncertified abortion providers can include trained medical doctors and nurses in hospitals, Auxiliary Nurse Midwives (ANM), ayurvedics, homeopaths, dais or traditional birth attendants, family health workers, village health practitioners, pharmacy shop-keepers and village women. Common methods of inducing abortion include vaginal and oral methods. Dais use methods such as inserting sticks, herbs, roots, and foreign bodies into the uterus to induce abortion. Other vaginal methods include pins, laminaria tents, and Fetex Paste. Rural Medical Providers (RMPs or "quacks") sell medicines for oral use to induce abortion. ANMs (Auxiliary Nurse/ Midwives) and ISMPs (Indian System of Medical Practitioners) use intramniotic injections such as intramniotic saline and intramniotic glycerine with iodine to induce abortion. Orally ingested abortificants include indigenous and homeopathic medicines, chloroquine tablets, prostaglandins, high dose progesterone's and estrogens, papaya seeds with high dose progesterone's and estrogens, liquor before distillation, seeds of custard apple and carrots.

Characteristics of women who terminate unwanted pregnancies

The reasons Indian women terminate unwanted pregnancies are many and varied. Conditions that can lead to a pregnancy being unwanted include: financial reasons; already having too many children or having too many female children; becoming pregnant after too short a birth interval; experiencing health problems during pregnancy; becoming pregnant at an older age; becoming pregnant soon after marriage; suspecting husband's infidelity; having an extra-marital pregnancy and becoming pregnant as a result of rape are all conditions that can lead to a pregnancy being

unwanted. For most of these conditions, a more proximate determinant of unwanted pregnancy is lack of access to appropriate contraception. For some women, contraception is not an option because of family pressure. Other women cannot access a contraceptive method appropriate for them. For unmarried adolescents, contraception is generally not available. In such cases, abortion may be the predominant means of birth control. Contraceptive failure and user failure can lead to unwanted pregnancies that can be aborted legitimately in the Indian medical system.

Medical abortion

Medical abortion or abortion by orally administered regimens of mifepristone and misoprostol has recently been accepted worldwide as an effective and safe option for Induced Abortion: Clinical trials in a number of countries, including India, have shown that the use of the standard French regimen,which includes administering 600 mg of mifepristone during the first visit and 400 ?g of misoprostol during a follow-up visit after two days, combined with a follow-up visit after two weeks, is effective in 95% of cases of early abortion (i.e. up to 49 days from the last menstrual period) and safe (major complications were reported in only 0.5% of cases). The Drug Controller of India approved the use of medical abortion in April 2002 given the current situation in India, where abortion-related mortality and morbidity are high, medical abortion offers great potential for improving the access to abortion and safety, as it does not require extensive infrastructure and is non-invasive. Further, as the client does not need to be hospitalized, medical abortion offers women greater independence, control and privacy. However, the potential for misuse is a matter of concern. In fact, although abortion tablets are required to be sold by medical prescription and consumed under medical supervision, these pills are reportedly widely available over-the-counter and unsupervised consumption is rising.

Sex-selective abortion

To give birth to a female child would mean spoiling her life as well as her parent's life. So, we felt it was right to abort the female foetus [27-year-old woman with a Son and a daughter]. "Either you get your abortion before sonography or after, I will

charge you the Same money but if God hears your wish and the foetus are found to be male, and then you can escape from abortion. [41-year-old woman with four daughters narrating her experiences with a provider]".

With the introduction of amniocentesis to detect abnormalities of the foetus, sex determination techniques have been available in India since 1975. The expansion of facilities offering sonography in the mid- 1980s made testing for sex determination widely and easily available. Although the government tried to curb the increase in sex selective abortions by introducing the PNDT Act in 1994, the Act proved to be ineffective in preventing such abortions.

Sex selective abortion is done for "son" preference. sex-selective abortion is reported to be a family building strategy to achieve the conflicting goals of limiting family size and achieving the desired sex composition. The prevalence of sex-selective abortion is found to be higher among women with one or more living daughters but no living sons. However, some studies report that sex-selective abortion is practised by couples who already have a living son or no children. Further, evidence from qualitative studies indicates that sex-selective abortion is perceived and projected as an easy alternative to female infanticide, a way to save girl children from an unhappy life and a means to prevent dowry payment in future.

Profile of abortion-seekers

While women of all age groups seek abortion in India, a recent review suggests that the majority of those seeking abortion are in the age group: 20-29 years. A substantial number of adolescents, both Married and unmarried, also seek abortion services. The vast majority of women seeking abortion in India are married.

The Way Forward

There is also a strong need for efforts to promote awareness of the dangers of unsafe abortion practices and the gestational age at which safe abortion can be obtained. Equally important are communication efforts to remove the stigma associated with induced abortion.

- Given the uneven distribution of existing facilities, efforts to increase the accessibility of safe abortion services to hitherto unserved or underserved areas and population groups, including married and unmarried adolescents, need to be vigorously pursued. The lack of trained manpower needs to be addressed by improving training facilities and facilitating the training of private practitioners. The training curriculum should include new and safer methods of abortion, including manual vacuum aspiration techniques and medical abortion, as well as emphasise the quality of care elements.

- Given the poor quality of existing abortion services in the country, establishing service delivery guidelines regarding technical standards of service, patient provider interaction, confidentiality, pre- and post-abortion counselling and care is critically needed. All existing MTP facilities should be regularly monitored and evaluated.

- The fact that many women seek abortion services to limit family size or space the next pregnancy highlight the importance of improving the access to quality family planning services.

- Finally, given that women, especially young women, have very little say in reproductive and sexual health decisions, including abortion-related decisions, the need for multisectoral activities to raise the Women's status cannot be overemphasized.

Recommendations

Abortion has increased in recent years, but significant gaps in our understanding of the multiple dimensions of abortion-seeking behaviour prevail. The evidence on the prevalence and patterns of abortion is limited, and even the latest available estimates of induced abortion are more than a decade old.

- Abortion-related needs and service seeking patterns of many vulnerable groups including adolescents, and unmarried, divorced or separated women remain less studied and hence there is need for future studies to focus on these subpopulation groups.

- The review highlights that the practice of sex-selective abortion is increasingly becoming common in many parts of the country. An in-

depth understanding of the prevalence/incidence and perspectives of those involved in decisions on sex-selective abortion, clients 'profile and experiences, is needed to formulate effective policies and programmes to prevent this practice.

The quality of abortion services in the country is generally poor. The constraints that providers face in providing quality service need to be explored to design more appropriate interventions. While abortion per se is less studied, the pathways between pregnancy and abortion are even less explored in India.

Source: ABORTION LAWS AND THE ABORTION SITUATION IN INDIA- MALINI KARKAL

Induced Abortion: The Current Scenario in India- K.G. Santhya, PhD and Shalini Verma, PhD

ABORTION PRACTICE IN INDIA A REVIEW OF LITERATURE- Heidi Bart Johnston.

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