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Legal but Not Always Safe: Three Decades of a Liberal Abortion Policy in India

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Resumen

La legislación sobre Terminación Médica del Embarazo de 1971, que permite el aborto en un rango amplio de escenarios médicos y sociales, liberalizó en forma importante el acceso a la interrupción del embarazo en la India. A más de 30 años de su implementación, el aborto inseguro continúa siendo un problema importante. A pesar de la existencia de una política de aborto aparente liberal, las deficiencias importantes en su aplicación han llevado a una situación poco común en la cual la legalidad no se puede equiparar con la seguridad. El pobre acceso a proveedores de aborto certificados, las inconsistencias en la calidad de los servicios legales y la falta de conciencia a nivel comunitario sobre la legislación y los factores socio-culturales, han contribuido a la predominancia continua de aborto inseguro en la India. Las investigaciones y la militancia reciente, sin embargo, han sentado los precedentes para una reforma legislativa que puede equiparar la legalidad con la seguridad. La introducción reciente de nuevos métodos de aborto, como la aspiración manual endouterina y el aborto médico tienen el potencial de incrementar el acceso a métodos seguros de aborto.

Palabras clave: Aborto, India, política, legislación

Introduction

In 1971, the Indian Parliament legalized abortion on a wide range of medical and social grounds. With only three countries having more progressive abortion legislation in the early 1970s, the Medical Termination of Pregnancy (MTP) Act was hailed as landmark legislation. In addition to the medical indications permitted in many other countries, including physical danger to the mother's health, rape, and

Summary

The Medical Termination of Pregnancy Act of 1971, which permits abortion on a wide range of medical and social grounds, greatly liberalized access to pregnancy termination in India. Over 30 years after its enactment, however, unsafe abortion remains a significant problem. Despite the existence of a seemingly liberal abortion policy, important deficiencies in its implementation have led to an unusual situation in which legality cannot be equated with safety. Poor access to certified abortion providers, inadequacies in the quality of legal services, lack of awareness of legislation at the community level, and socio-cultural factors have all contributed to the continued predominance of unsafe abortion in India. Recent research and advocacy, however, are paving the way for legislative reform that may put legality on a par with safety. The recent introduction of new abortion methods, such as manual vacuum aspiration and medical abortion, are also likely to increase access to safe abortion.

Key words: Abortion, India, legislation, politics

fetal malformations, the MTP Act permits abortion in cases of potential injury to the mother's mental health and among married women, contraceptive failure. In determining whether a pregnancy poses risks to the woman's physical or mental health, the MTP Act allows providers to consider the woman's actual or reasonably foreseeable environment. Abortion is permitted up to 20 weeks of gestation and no spousal consent is required, although parental consent is required for women under 18 years of age.¹

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Thirty years after enactment of the MTP Act, however, the proportion of illegal abortions in India is believed to be two to ten times that of the legal component and unsafe abortion is estimated to account for 9 to 20% of all maternal deaths.²⁻⁷ Despite the existence of a seemingly liberal abortion policy, limited availability of legal services, significant barriers to quality services, pervasive confusion regarding abortion legalization at the community level, and socio-cultural factors have all hindered widespread use of safe abortion services. In this paper, we describe the process that led to legislative reform on abortion in India and describe the realities of abortion service delivery there. Finally, we discuss how successes and failures in over 30 years of implementation of a liberal abortion policy in India can be applied to the development of abortion legislation in other countries. Much of the information presented here has appeared elsewhere in more detail, and we refer interested readers to these publications.^{8,9}

Legislative Reform: Paving the Way for Safe Abortion

The move for liberalization of abortion in India began as early as the mid-1960s, at the same time that many feminists in Europe and the U.S. began advocating for access to abortion in their respective countries. In contrast to nearly every other country where legislative reform ensued in the 1960s and 1970s, however, demand for liberalized legislation in India did not originate from the women's movement. Rather, demographers and physicians paved the way for policy discussions regarding abortion. While demographers argued that access to abortion would help curb the growing population (something the existing Family Welfare Programme had been unable to do despite an active family planning program), medical professionals advocated for liberalized legislation in an attempt to reduce morbidity and mortality from poorly performed illegal abortions.⁴

In 1964 in response to pressure from these two groups, the Government of India appointed an 11-member committee to consider legalization of abortion. The committee, largely comprised of physicians or individuals closely allied with the medical community, reviewed published studies of complications of abortion and prevailing abortion legislation in a number of other countries, including Britain, India's former colonizer. They also conducted an opinion survey of national- and state-level policy makers, influential medical providers, family planning officials, religious leaders, representatives of the legal community and the nascent women's movement, although the vast majority of the 570 responses received were from the medical community. After 2 years of deliberation, the committee provided recommendations for liberalization of abortion, and 5 years later in 1971 after further input from the vocal medical community access to abortion was liberalized.¹⁰

Implementation: The Promise of Reproductive Freedom Cut Short

As the Indian Penal Code of 1860 permitted abortion only to save the life of the woman and called for any person performing an abortion (including a woman who induced her own abortion) for any other reason to be imprisoned and/or fined, the MTP Act of 1971, which went into effect on April 1, 1972, significantly liberalized abortion laws in India. Ultimately, however, significant problems in implementation of the MTP Act have cut short its promise of reproductive freedom.

Access to Services

In addition to liberalizing access to abortion, the MTP Act also included a number of provisions regarding delivery of services that have proved to limit access to safe abortion: for example, abortions can only be performed by gynecologists or physicians who have had 6 months of training in gynecology or have undergone abortion training and certification at a government-approved training facility. Physicians trained in indigenous systems of medicine, nurses, and midwives are not permitted to provide abortions. Additionally, abortions can only be provided at public sector facilities or at private clinics that have received certification from the government. Abortions performed between 12 and 20 weeks' gestation require approval from two physicians.¹

Not surprisingly given these restrictions, access to legal abortion services remains largely inadequate: while India currently has approximately 10,000 certified abortion centers with a population of one billion, this translates into only 10 abortion centers per million people.¹¹ Additionally, distribution across and within states is starkly uneven. For instance, the four large northern states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh account for over 40% of the country's population, but have only 16% of all approved abortion centers. In contrast, Maharashtra, a state on the western coast with less than 10% of the country's population, has more than one fifth of the nation's legal centers.^{3,4,12} Moreover, the vast majority of abortion facilities are located in urban areas, while over 70% of Indian women live in rural areas.

According to the MTP Act, public-sector facilities at the primary-care level and higher are to provide abortion services. In reality, however, abortion services are generally available only at higher levels of the health-care system. A four-state study of abortion facilities conducted in 1996 found that only 24–58% of primary health centers were providing abortion services, although all are mandated by law to do so.¹¹ A recent national facility survey conducted by the Government painted an even bleaker

picture, finding only 5% of all primary health centers offering MTP services. Nearly 90% of the centers not offering services lacked providers trained in abortion.¹³

Given the public sector's inability to meet the demand for abortion services, the private sector provides the bulk of legal services. For instance, in the state of Maharashtra the private sector accounts for two thirds of all approved abortion centers.¹⁴ At the same time, many trained gynecologists provide abortions in facilities that remain unregistered and therefore illegal, largely due to the bureaucratically complex registration process for private providers.^{8,15,16} In addition to a trained and certified physician, private clinics must have access to an anesthetist and on-site equipment for general anesthesia and abdominal surgery. As the clinic needs to be approved by state- and district-level authorities, the registration process requires several site inspections and may take several years. A recent survey of 118 members of the Federation of Obstetric and Gynecological Societies of India (FOGSI) who were providing abortion services found that 44% of respondents encountered difficulties in navigating the registration process, including 13% who reported delays of 1–7 years in registering their facilities.¹⁷

While studies have shown that when women have access to services, they prefer providers they perceive as qualified or safe,^{18–20} given problems in accessing safe services in both the public and formal private sectors, the informal sector, comprised of a multitude of illegal and untrained providers—chemists, traditional birth attendants, registered medical practitioners, nurses, and physicians qualified in other systems of medicine—remains a common source of abortion services in many rural areas.^{21,22} Services provided by the informal sector range from the provision of non-invasive abortifacients, such as ergometrine derivatives, antimalarials, oxytocics, and ayurvedic preparations, to performance of invasive procedures, such as vacuum aspiration and foreign body material insertion.^{18,21,22}

Quality of Care

A number of important barriers to the provision of quality abortion services exist in India. Physicians trained in abortion are often unavailable, inadequately trained, or not confident in performing abortions.^{11,12} Gynecologists are reluctant to work in rural areas and with only 240 recognized abortion training centers nationwide, non-gynecologist physicians do not have adequate opportunities to be certified. While there is little information on the number of physicians trained per center, most centers function well below capacity and cater primarily to physicians from the public sector. With no standardized training curriculum and small caseloads, the majority of physicians are

certified without having received sufficient practical experience to confidently and safely provide abortion services. Indeed, one study in Maharashtra revealed that trainees assisted in or performed an average of 12–13 abortions, as opposed to the prescribed norm of 25.¹¹ Furthermore, few training centers include manual vacuum aspiration, medical abortion, or non-clinical aspects of quality service delivery such as counseling in their curriculum. Not surprisingly then, despite ample evidence in favor of vacuum aspiration sharp curettage is still often used to terminate pregnancies in the first trimester.^{12,20,23}

Even when appropriately trained, providers often selectively refuse to provide services. Concerns about risks of providing services in facilities lacking adequate equipment, supplies, or medications to handle complications have prompted government physicians to be unnecessarily cautious when accepting clients and to reject potential clients on unsubstantiated health grounds such as advanced pregnancy and anemia.²⁰ One study showed that concern about potential litigation under the Consumer Protection Act was the reason for refusal of services to all but the safest cases at a secondary-level hospital.²⁰ Some providers also refuse services on moral grounds, even in legally acceptable situations.¹¹ Many also widely approve of and require spousal consent, although not mandated by law.¹⁹

Deficiencies in basic facility infrastructure further limit provision of quality services, particularly in the public sector. Functioning centers often work under poor hygiene conditions. Many lack water or toilets and are unable to offer clients a clean procedure table or privacy. Shortages of suction machines, cannulae, dilators, analgesics, and anti-hemorrhagic medications and an irregular power supply all impede consistent service provision.¹²

Poor treatment of clients and lack of counseling also affect the quality of abortion services. Indeed, it is not uncommon for women seeking pregnancy termination to experience judgmental, unsympathetic, or even abusive behavior, particularly in the public sector, where there is little incentive to invest in good client communication.^{20,24} Counseling is not a routine part of abortion service delivery. While family planning services are linked to abortion services, great emphasis is placed on long-term, provider-dependent methods such as the intrauterine device (IUD) or sterilization, and the majority of women are not provided with counseling on the range of possible contraceptive options. Coercive contraception is not unheard of.^{12,19,24}

While quality of care in the public sector, poor or otherwise, can be monitored, little or no information exists concerning functioning of private abortion centers. Certification, once given, is permanent, with no periodic monitoring of quality for standards of care, and compliance with reporting requirements is rare.

Knowledge of Legislation

Awareness of legal rights under the MTP Act remains nearly as low as at the time of legalization, further hindering use of legal services. Only 16% of men and women in a recent survey in Rajasthan, a state in northwestern India, and 15% of women in Madhya Pradesh, a state in central India, knew that abortion is legal in India.^{22,25} Similar findings have been reported in studies conducted elsewhere in the country, including one in which 25% of women who reported recent terminations stated that abortion was illegal.¹⁸ Confusion and misperceptions regarding the MTP Act are pervasive even among men and women who reportedly know that abortion is legal, with many unaware of correct gestational limits and indications for abortion. While the law does not deny access to abortion based on marital status, pre-marital intercourse remains culturally stigmatized; thus, many men and women erroneously equate abortion legality with an individual's marital status.^{18,22} Similarly, community-based studies have found that nearly all male and female respondents incorrectly believe that spousal consent pre-abortion is mandated by law.^{19,22}

Socio-Cultural Issues

A number of socio-cultural factors also limit the use of safe abortion services in India. Among the most important is the high prevalence of selective abortion of female fetuses. While the Pre Natal Sex Determination Tests Act of 1994 rendered sex detection tests illegal, the cultural premium on producing male heirs coupled with increasing small family norms and widespread availability of ultrasound has led to frequent use of such tests in the early second trimester and if the fetus is female, pregnancy termination near or beyond legal gestational age limits. Lateness of the procedure and its illegality further jeopardize women's safety.²⁶

Similarly, the need for confidentiality often outweighs safety considerations for never married adolescents, widows, and separated/divorced women and may drive them to unsafe informal providers even when safer services exist. Confidentiality considerations have also been found to delay abortion seeking until the pregnancy is more advanced, further adding to the risk of complications.²⁷

The Road Ahead: Efforts to Remedy the Situation

Not all is bleak as far as the abortion situation in India is concerned, however. In an attempt to reduce bureaucratic delays and hurdles in clinic registration, the Indian Parliament recently passed an amendment to the MTP

Act that decentralizes coordination of clinic registration to the district level.²⁸ Moreover, recognizing the need to increase access to safe abortion, the Government's National Population Policy (NPP) of 2000 recommended enhancing service provision efforts at primary health centers. The NPP also suggested a shift away from electric vacuum aspiration to manual vacuum aspiration (MVA) in rural areas where electricity supplies are often erratic, and endorsed introduction of medical abortion.

Acting on the guidelines of the NPP, the Government in collaboration with FOGSI initiated a pilot program to integrate MVA into abortion services at primary health centers in eight states. Similarly, in April 2002 the Drugs Controller of India approved the antiprogesterin mifepristone coupled with the prostaglandin misoprostol for pregnancy termination in gestations of 7 weeks or less. Three Indian pharmaceutical companies quickly began selling mifepristone and misoprostol, thus making medical abortion a viable option for Indian women seeking early pregnancy termination. Considerable in-country research on medical abortion conducted over the past 10 years demonstrated that non-invasive abortion methods can be integrated into family planning services and provided in rural areas.^{29,30} In March 2003, less than 1 year after approval, the Government will be hosting a National Consensus Meeting on Medical Abortion to discuss regulations for use in the public sector.

Recent years have also witnessed a resurgence of interest in abortion research and advocacy. Numerous research studies, many collaborative efforts by a number of non-governmental organizations (NGOs), are unearthing data on prevalence of abortion in various states, quality of abortion services, and women's perspectives on access and quality. Women's health advocates, providers, researchers, and policy makers have all been involved in lobbying for changes in clinic registration process and for adopting simplified certification requirements for first trimester pregnancy terminations.¹⁷

Concluding Remarks

At the time of its enactment in 1971, India's MTP Act was hailed as landmark legislation. The medical and population communities, which were intimately involved in lobbying for legislative change and in eventual drafting of the Act, hoped it would improve maternal health and curb population growth. Over the past 30 years, the Government of India has attempted to ensure broad access to safe abortion services down to the primary-health care level. Unfortunately, this goal has been inadequately met and mortality and morbidity due to unsafe abortion remain significant. Provisions built into the MTP Act regarding who can provide abortion services and where they can be provided, combined with

significant problems in the quality of existing services, lack of awareness regarding legal rights at the community level, and socio-cultural factors have led to an unusual situation where legal services may not necessarily be safe and illegal services, safe or unsafe, remain the most accessible of all.

What can other countries striving for access to legal abortion services learn from the Indian experience? Perhaps most importantly, providers and policy makers need to form partnerships with other important constituencies, including women's health advocates, when lobbying for legislative change. Such consultation is likely to ensure that policy, when developed, is as useful and realistic as possible. Given the lack of representation of the women's movement in the development of the MTP Act, it is not surprising that the legislation is devoid of any mention of human rights and does not affirm women's right to pregnancy termination *per se*. Additionally, information, education, and communication strategies must quickly follow legislative change to ensure that women, men, and providers are all aware of legal provisions with regard to abortion. Extensive efforts to effectively meet the demand for abortion services are equally critical, so that women do not continue to turn to unsafe providers once legislation supports legal abortion services. At the same time, conducting in-country research on medical abortion for nearly a decade prior to approval of mifepristone and misoprostol has proved critical in developing a cadre of national experts ready to take the method forward. Such research should not be put on hold until the method is available.

While liberalization of abortion is an important step in providing access to safe abortion, over 30 years of implementation of a liberal policy in India have demonstrated that legislative reform does not necessarily guarantee safety. Policy makers, physicians, women's health advocates, and other constituency groups must continue to work together to ensure that women's reproductive rights are adequately met.

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