

ABORTION –WHO IS RESPONSIBLE FOR OUR RIGHTS?

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INTRODUCTION

Through history, women have practised forms of birth control and abortion. These practices have generated intense moral, ethical, political and legal debates since abortion is not merely a techno-medical issue but "the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood and young women's sexuality are contested" (Petchesky R.P, 1986: vii).

Women have overtly or covertly resorted to abortion, but their access to services has been countered by the imposition of social and legal restrictions, many of which have origin in morality and religion. The norms governing the ethics of abortion have been constantly remoulded to suit the times and the social contexts in which they are set. Despite the dissimilarities in their construct, intent and orientation, these norms have invariably been directed to the fulfilment of social needs that do not recognise women's right to determine their sexuality, fertility and reproduction.

This paper reviews the abortion scenario with particular reference to India. A brief historical account of the role of the medical profession in criminalising and decriminalising abortion services is followed by a discussion on the politics of abortion in India. An analytic review of the abortion situation in India provides the reader with information about legal and illegal abortions and the paper concludes by placing the issue of abortion in the context of social (rather than individual) needs and rights.

THE MEDICAL PROFESSION AND ABORTION

The early abortionists in Europe were lay women healers who practised "medicine" among the peasantry. When the male dominated profession of medicine emerged as a formidable force in the mid-nineteenth century, its practitioners went about the task of weakening competition from all 'non-professional' practitioners, a majority of whom were women and providers of abortion services. Doctors thus spearheaded the first organised attack on abortion. The Hippocratic Oath, which provides the foundation of medical ethics, prohibits physicians from conducting abortions (MacKinney L, 1952). It was to this Oath that the medical profession reverted for its rationale on the question of abortion.

In its 1859 convention, the American Medical Association (AMA) declared that the practice of abortion should be outlawed. This was followed a decade later by the Church when, in 1869, the Apostolic sedis Pius IX pronounced that abortion was a transgression of the faith and a ground for excommunication (Hurst, 1991). Thus, by the 1870s, the medical profession and the Church had joined forces in criminalising abortion and succeeded in prohibiting its practise. As an exception, the induced abortion was allowed only for therapeutic purpose of saving the life of pregnant woman. This decree remained in force for a century till 1973 when the Supreme Court initiated the process of liberalisation through its ruling on the Roe Vs Wade case.

In the UK, the Abortion Act of 1967 liberalised abortion services up to 28 weeks of pregnancy. The British Medical Association (BMA) appends this with a cautionary note. It says that; "the doctor should recommend or perform termination after 20 weeks only if he is convinced that the health of the woman is seriously threatened or if there is good reason to believe that the child will be seriously handicapped" (BMA, 1988: 80).

As the process of liberalisation of the law on abortion spread across various countries, international medical organisations were compelled to make their positions clear. Thus the Declaration of Oslo issued by the World Medical Association in 1970 conceded to the need to provide abortion services. The document stated "where the law allows therapeutic abortion to be

performed, the procedure should be performed by a physician competent to do so in premises approved by the appropriate authority".

Here the definition of what is "therapeutic" becomes important. During the era of criminalisation, "therapeutic" abortions were conducted to save the life of the pregnant woman or to prevent maternal mortality. During the era of liberalisation, however, this definition is widened to include potential or expected medical or psychological morbidity and this is articulated in the form of a number of legal conditions. The concept of the risk to women's life is thus broadened and by treating induced abortion as a "therapeutic" intervention, the medical profession is in a position to accommodate induced abortion in its ethical system with few problems while maintaining its monopoly over the process. Liberalisation of this kind does not empower women with a fundamental right to abortion but merely liberalises their access to services at the hands of medical practitioners. This helps the social relations within a patriarchal system to remain unchallenged and intact.

On the whole, the medical profession has vehemently criminalised abortion but remained ambiguous over its stand on the issue of liberalisation. At no stage, however, did the issue of abortion jeopardise the material interests of the profession: while criminalisation helped it to eliminate competition from indigenous (female) practitioners in the 19th century, liberalisation only empowered it with greater legal and normative authority.

POLITICS OF ABORTION IN INDIA

Liberalisation of Abortion in India

In India, abortions were prohibited (unless medically indicated) till the Medical Termination of Pregnancy (MTP) Act was passed. The demand for a liberalised law did not originate from the women's movement, which suffered the absence of a strong feminist current until the early 1970s. The result was that the movement of the time was focussed on the subversion of criminal law without an independent charter of political demands.

The challenge of persuading policy makers was taken on instead by demographers and doctors who were, in turn, directed by their professional interests and ideologies. While proponents of family planning and population control favoured liberalisation with a view to lowering the birth rate, the medical profession was concerned about the adverse effects that abortions (conducted under unhygienic conditions by non-qualified, untrained and ill-equipped providers) could have on the health of women.

A quick examination of an annotated bibliography of abortion studies conducted in the 1950s and 1960s (Karkal M, 1970) reveals that the research agenda was geared towards understanding and calculating incidence patterns in the context of age, socio-economic background, duration of marriage, pregnancy and contraceptive histories. With the growing emphasis on family planning in the health agenda in the 1960s, academicians interested in population control were prompted to draw a link between liberalisation and population control. In this context, themes such as liberalisation vis-à-vis its birth control potential as well as the possible implications of liberalisation on the social and cultural fabric began to appear. Many scholars also calculated how many abortions were required to save a birth.

In the mid-1960s, the Government of India appointed a committee under the chairmanship of a medical professional, Dr. Shantilal Shah. A report was submitted on December 30, 1966 and in 1971, the MTP Act was passed by parliament.

The Medical Termination of Pregnancy (MTP) Act

The MTP Act in India is founded on the principles of the British act passed by its parliament in 1967. As an opening paragraph states, the MTP Act is designed "to provide for the termination for *certain pregnancies* by registered *Medical Practitioners* and for matters connected therewith or incidental thereto" (emphasis added). In essence, it liberalises and (attempts to) regularise medical practices and institutions in relation to abortion and, consequently, allows medical liberalisation to supersede medical criminalisation.

Clearly, the MTP Act does NOT encompass a fundamental right to induced abortion but is limited to the liberalisation of the conditions under which women may have access to abortion services provided by approved medical practitioners. Medical liberalisation, therefore, necessitates *medicalisation* of the liberalised conditions given in the Act. This is done by expanding the earlier medical indication of saving a pregnant woman to include medical and psychological morbidity or the potential of such morbidity if the woman is forced to carry an unwanted pregnancy to full term. Thus from the medical angle, the termination of a pregnancy becomes a "therapeutic" intervention rather than a right.

The liberalised law confers a position of predominance on medical practitioners who mediate women's access to abortion services- pregnancies cannot be terminated in approved centres unless they are authorised by doctors. The two considerations that are brought into play are the length and type of pregnancy. According to the Act, the termination of pregnancies up to 12 weeks can be authorised by one doctor while those between 12 to 20 weeks necessitate the opinions of two doctors. The Act also enjoins doctors to take cognisance of the "actual or reasonable foreseeable environment" that run the risk of injuring the pregnant woman's health. In this connection, a pregnancy following rape (marital rape not included) or failure of contraception (for married women) are mentioned as specific indicators in two separate explanatory notes. The other health conditions visualised are "physical or mental abnormalities" that might "seriously handicap" the unborn child.

Clearly, the pregnant woman seeking abortion cannot avoid giving an explanation. To say that pregnancy was wanted at the time of conception but is unwanted now disqualifies her. She is required to furnish explanations that fit into the broad liberal though restrictive conditions listed in the Act. This situation keeps the Act open to differing interpretations. The current pre-occupation with population control and the somewhat dubious motivations of the medical profession have, ironically, lent a liberal interpretation of the law. However, the danger that this liberal interpretation could become a restrictive one without a single word of the text being altered remains. This could easily happen under different socio-economic and demographic compulsions.

The Act also requires that abortion be induced legally only by a registered Medical Practitioner "who has such experience or training in gynaecology and obstetrics" and conducted only at a place that is sanctioned by the appropriate authority (if the facilities available follow the standards prescribed in the Rules of the Act). This stipulation is essential and laudable. However, a liberalised law has little meaning for the many women who wish to terminate their pregnancies in the absence of well-developed network of abortion facilities. The MTP Act fails to regard the right to access as a justiciable right and is, therefore, ineffectual in curbing the incidence of illegal abortions.

Liberalisation of Abortion and the Women's Movement

The issue of abortion (let alone its liberalisation) has failed to become an integral component of the agenda of the women's movement even as the feminist current has gained in strength in the last decade. Perhaps this has happened because of the non-combative stand of anti-abortion votaries. This is not the case in many developed countries where the movement is pitted against powerful anti-abortion and anti-contraceptive movements, which are systematically backed up by Christian orthodoxy and right-wing political forces. In some of these countries, abortions are still criminalised. The case of the pregnant 14 year old in Ireland in the not-so-distant past who set off massive people's protest (resulting into an over-rule of the legal order) when she was legally prohibited from undergoing abortion in her country (and abroad as well) and the recent killings of few of the medical persons providing abortions services in the U.S. highlight the context in which priorities of the movement are shaped. As a result, abortion and contraception have become important programmatic components of the struggle of western feminists.

The fact that behind the seemingly liberal availability of abortion service lies legislation that could be easily invoked to restrict access is perhaps also not fully appreciated. For the law does not endorse women's legal right to abortion but ends up being a regulatory mechanism of doctors and abortion centres. In developed countries, which have liberal laws as well, the gains of the women's movement have been transient. For instance, the 1973 US Supreme Court decision on abortion in the Roe Vs Wade case made abortion legally available to women but the subsequent decision in

1989 with the Webster case signalled a retreat from Roe. The task of keeping vigilance after legalisation is, therefore, as important as the struggle for legalisation.

Post-liberalisation Research on Abortion

Research on abortion after liberalisation is marked by the absence of social content. The feminists involved in medical, health care and women's studies have also largely neglected this issue, as is evident from the virtual absence of qualitative and social studies on the abortion. Analysis of state policies, legal provisions, characteristics of providers and the problems of physical and financial access to abortion services explain the complex ways in which the politics of abortion operate in a given society. However, abortion is not merely an issue of the political and legal rights of women but of their reproductive rights as well. This includes the right to have as well as not to have children. The issue of abortion thus needs to be embedded in the context of women's reproductive needs, sexuality, emotions, health status and, above all, their immediate familial, social, economic, occupational and cultural environment. Unfortunately, research from this perspective is hard to come by.

Firstly, studies on abortion practices have been conducted, without exception, from the standpoint of providers, policy makers and the State rather than on the needs of women. Secondly, most of these studies include women in legally approved institutions - usually medical college hospitals and big government or non-governmental organisation hospitals-, which are easy to identify and access. However, the frequent omission of private hospitals and nursing homes in sampling means that the data generated by these studies do not accurately reflect the existing scenario. Thirdly, despite the predominantly rural location of the population, a majority of the studies have been conducted in urban areas. Fourthly, the state of knowledge of abortion shows a great paucity of community or household studies which would make it possible to include the women who utilise unregistered institutions and providers. The only community based study conducted so far (ICMR, 1989) looked into the aspect of "Illegal Abortions in Rural Areas" in five states. Lastly, there is a dearth of psychosocial studies on abortion. Abortion is recognised as a traumatic experience for women both physically and psychologically. In fact, psychosocial support for women undergoing abortion is now considered an integral aspect of abortion services in developed countries. Unfortunately, in India, these factors are not properly recognised and the tendency is to adopt a 'conveyer belt' approach to abortion services and research.

The preponderance of medical studies on abortion has, more or less, precluded social science studies. Research enterprises have failed to focus on women, their problems, and their reasons for making the difficult decision to abort and, above all, the quality of abortion services.

THE ABORTION SCENARIO IN INDIA

Health Services

A review of the distribution of health care services in India brings to light the dominance of the private sector and its urban concentration. Although there were 9,28,072 qualified doctors of all systems of medicine (43% being allopathic practitioners) or one doctor for 967 persons in 1991, a majority resided in urban areas and worked in the private sector. According to the 1981 Census, only 41 per cent of all doctors (and only 27% of all allopaths) worked in rural areas while fewer than 15 per cent worked in the government sector (Jesani A and Anantharam S, 1990).

This picture is borne out by the skewed distribution of institution providing health care in general. In 1992, rural areas were provided with health care services by a network of 22,441 PHCs which covered an average population of 28,009. Most of these do not have facilities for indoor medical care while some of them have facilities for sterilisation operations and wards for post-operative sterilisation cases. With only 22,013 doctors employed in all these PHCs, there was less than one doctor per PHC! For the same period, there were 11,174 hospitals and 6,42,103 hospital beds, defining a ratio of one hospital for 75,739 persons and one hospital bed for 1,318 persons. However, only 32% of the hospitals (with a ratio of one hospital for 1,76,163 persons) and 19.7% of the hospital beds (with a ratio of one hospital bed for 4,970 persons) were located in rural areas.

On the question of quality of services, it is apparent from the wealth of literature available that the public health services are plagued by inadequate facilities and infrastructure, misplaced priorities, inadequate and irrationally utilised finances. An evaluation of the quality of family welfare services provided by 298 PHCs in 199 districts in 18 states and one union territory revealed that only 12 percent of the PHCs (mostly in Maharashtra), fulfilled the required population coverage norm of 30,000. The study observed a substantial shortage of Auxiliary Nurse Midwives (ANMs), unavailability of oxygen (in approximately 40 percent of the PHCs) and supportive drugs in emergencies (in 30 percent of PHCs), inadequate stocks of antibiotics (in 60 per cent of the PHCs), a total absence of records (in one-third of the PHCs) and an absence of a labour room and an operation theatre (in one-fourth to one-fifth of the PHCs). Wherever they existed, they were poorly equipped and managed. What is interesting is that a majority of the PHCs were lacking in functional equipment and/or trained manpower to carry out pregnancy termination even after two decades of the Act (ICMR, 1991).

On the other hand, the flourishing private sector, which is founded on the principle of profit making, is characterised by irrational (often unnecessary) diagnostic, medical and surgical practices, inadequate equipment and facilities, and unstandardised charging practises (Nandraj S, 1994). Micro studies on expenditure on health care show that the per capita expenditure on health care (which is mostly obtained from the private sector) accounts for a substantial proportion of the total consumption expenditure per family. A study in an average district of Maharashtra calculated this proportion to be 7.6 per cent (Duggal R and Amin S, 1989) while another study in two backward districts of Madhya Pradesh calculated this proportion to be 8.4 per cent (George A. *et.al.*, 1993). What is more, this proportionate share of expenditure on health is seen to be steadily increasing among lower socio-economic class families (*ibid*). Therefore, access to private health services is restricted by high costs.

The private health sector is also an unregulated sector. Apart from Delhi and Maharashtra, none of the other states and union territories have any rules, acts, regulatory and monitoring mechanisms over private health establishments (Nandraj S., 1994). Even in those states that have some legislation to go by, the Acts by which nursing homes can be regulated are not enforced.

For instance, in Delhi, out of an underestimated total of 545 private nursing homes, only 25 percent are registered and, according to the Health Ministry, over 20 percent cannot be improved which would result in their closure (Raina J., 1992). Similarly, in response to a public interest litigation filed by the Bombay Group of 'Medico Friend Circle', the Bombay Municipal Corporation (the legal regulatory authority) could not furnish information on nursing homes located in 25 percent of all wards in Bombay. These woeful gaps in information have been matched in the last few years by stories in the local press of medical malpractice and negligence.

The Delivery System for the MTP

MTP services are offered in India through a network of institutions in rural and urban areas, in the public and private sectors. The approved centres include teaching hospitals, district hospitals, rural hospitals, Community Health Centres (CHCs), Primary Health Centres (PHCs), as well as privately-run hospitals and nursing homes in urban and rural areas. Information about its distribution between rural and urban areas, between the public and private sectors is not routinely published by the government (although this could easily be done). However, studies occasionally include databases on the facilities for abortions in a state or in a selected sample. A study analysing data of 46,858 MTPs in Maharashtra over a three year period (1972 to 1975) showed that 93 percent of the MTPs were conducted in urban areas. 71percent of the approved MTP centres in Maharashtra were in the private sector. Nearly half the registered doctors (ie.47.2 per cent) and institutions (i.e.45 per cent) were based in Bombay alone (Rao V.N. and Pense G.A., 1975). Another study covering 88 CHCs/PHCs and 55 private clinics in 11 districts of Gujarat showed that 58.7 per cent of the 816 approved abortion centres in Gujarat was run by an essentially private-for-profit non-governmental sector (Barge S. *et.al.*, 1994). Unpublished data for the state of Maharashtra showed that in 1992-93, 70.3 percent of all approved centres were in the private sector. However, not all approved centres in the public health services perform MTPs. This contention is borne out by the study in Gujarat (*ibid*).

Legal Abortions

Information about the number of MTPs conducted by approved institutions in the various states is published every other year by the Ministry of Health and Family Welfare. In order to understand the availability and utilisation of approved abortion facilities, we have drawn on this data for analysis (refer to Table 1). The data reveals that between 1976-77 and 1990-91, while the number of approved institutions under the provisions of the Act tripled, the number of MTPs conducted only doubled. The average number of MTPs per centre decreased from 130 to 85. Above all, the percentage increase in the number of MTPs has been very poor in the last five years.

TABLE 1 : LEGAL ABORTIONS IN INDIA

Year	Number of Approved Institutions	Per cent Increase in Institutions over Previous Year	Number of MTPs Done	Per cent Increase in MTPs Over Previous Year	Average No. of MTPs per Institution
1972-76	1877	-	3,81,111	-	-
1976-77	2149	-	2,78,870	-	130
1977-78	2746	27.8	2,41,049	-11.4	90
1978-79	2765	0.7	3,17,732	28.6	115
1979-80	2942	6.4	3,60,838	13.6	123
1980-81	3294	12.0	3,88,405	7.6	118
1981-82	3908	18.6	4,33,527	11.6	111
1982-83	4170	6.7	5,16,142	19.1	124
1983-84	4553	9.2	5,47,323	6.0	120
1984-85	4921	8.1	5,77,931	5.6	177
1985-86	5528	12.3	5,83,704	1.0	106
1986-87	5820	5.3	5,88,406	0.8	101
1987-88	6126	5.3	5,84,870	-0.6	96
1988-89	6291	2.7	5,82,161	-0.5	93
1989-90	6681	6.2	5,96,357	2.4	89
1990-91*	6859	2.7	5,80,744	-2.6	85
Totals			75,65,170		

* Provisional.

Source: "Family Welfare Year Book, 1991-92", New Delhi : Govt. of India, 1992

If we consider the average annual percentage increase in five yearly intervals, we find this rate to be 8.9 per cent annum between 1976-77 to 1980-81; 9.8 per cent per annum (i.e. a marginal increase) between 1980-81 and 1984-85; and a mere 0.2 per cent per annum between 1984-85 to 1988-89. Thereafter, the period 1988-89 to 1989-90 saw an increase of 2.4 per cent only to decline between 1989-90 and 1990-91 by 2.6 per cent. In the corresponding periods, the number of approved institutions increased at the rate of 10.2 per cent, 9.9 per cent and 5.6 per cent per annum respectively, and at 6.2 per cent in 1989-90 and 2.7 per cent in 1990-91. Thus, the tempo with which the first institutions were established after liberalisation seems to have waned progressively.

In absolute terms, having over six thousand approved institutions and over half a million MTPs may appear to be high but the distributions are highly skewed between states and in the context of utilisation patterns (Table 2).

TABLE 2 : STATE-WISE ABORTION RATES AND INSTITUTIONS

States and Union Territories	percent of total population	Total number of MTPs Conducted (1972-1991)	Number of MTPs conducted in 1990-91	Induced abortion rate	No. of approved institutions (1991)	Average population coverage by institutions
Maharashtra	9.3	12,15,661 (16.1)	1,22,337 (21.1)	1.55	1,561 (22.8)	50,568
Uttar Pradesh	16.4	13,96,709 (18.5)	1,03,482 (17.8)	0.74	425 (6.2)	3,27,323

Tamil Nadu	6.6	7,91,571 (10.5)	51,263 (8.8)	0.92	456 (6.6)	1,22,498
West Bengal	8.1	5,26,327 (7.0)	41,054 (7.1)	0.60	452 (6.6)	1,50,615
Madhya Pradesh	7.8	3,45,605 (4.6)	28,431 (4.9)	0.43	286 (4.2)	2,31,403
Orissa	3.7	2,84,157 (3.8)	21,977 (3.8)	0.69	169 (2.5)	1,87,336
Kerala	3.4	5,04,113 (6.7)	22,197 (3.8)	0.76	359 (5.2)	81,054
The Others	44.7	25,01,027 (33.1)	1,90,003 (32.7)	0.05	3151 (45.9)	1,17,315
Totals	100	75,65,170 (100)	5,80,744 (100)	0.69	6859 (100.0)	1,22,260
Population (India, 1991), 846,302,688						

Note : Figures in parenthesis are percentages of the vertical total

Source : Ibid.

As Table 2 shows, in 1990-91, three states, viz. Uttar Pradesh, Maharashtra and Tamil Nadu, constituting 32.3 per cent of India's population accounted for 47.7 per cent of the total number of MTPs and 35.6 per cent of the approved institutions. This is compounded by the overwhelmingly urban location of approved institution in all States. Maharashtra having only 9.3 per cent of country's population alone had 22.8 per cent of all institutions in that year. There was one approved institution for 1,22,260 people in 1990-91. The state-wise distribution of approved MTP institutions was relatively good in Maharashtra (one for 50,568) but the worst in Uttar Pradesh (one for 3,27,323) which also accounted for the second highest number of MTPs (17.8 per cent). Three leading states, Maharashtra, UP and Tamil Nadu with little less than one third of country's population accounted for 45.1 per cent of all legal abortions done since 1972 and 47.7 per cent of them in 1990-91.

Illegal Abortions

Since no reliable data on abortions performed outside recognised places is available for obvious reasons, we are compelled to go by estimates and the results of surveys. The *Report of the Committee to Study the Question of Legalisation of Abortion* (GOI, 1966), also referred to as the Shantilal Shah Committee Report, calculated a figure of 3.9 million induced abortions all of which were illegal since they preceded legalisation. Another estimate puts the figure as 4 to 6 million (Goyal R.S., 1978). A multi-centre study conducted between 1983 and 1985 in five States- UP, Rajasthan, Orissa, Haryana and Tamil Nadu -concluded that there were 2.2 illegal abortions per every legal abortion (ICMR, 1989). The latest estimate contends a rate of 3 illegal abortions to one legal abortion in rural areas and a corresponding ratio of 4-5:1 in urban areas (Karkal M, 1991).

We feel that these rates are underestimations. In order to arrive at a conservative estimate for the year 1991, we shall use the ratios mentioned in the Shantilal Shah Committee Report. The Report states: "If it is assumed that for every 73 live births, 25 abortions (i.e. 34.3 per cent) take place annually and of these 15 are induced (i.e.60 per cent), then in a population of 1000 there may be approximately 13.5 abortions (corresponding to the prevailing birth rate of 39) and of these, 8 will be induced". Thus, at the 1991 population of 846.3 million and a birth rate of 30.2 per 1000, in India we had 8.8 million abortions of which 5.3 million were induced. This gives an Abortion Rate of 10.4 per 1000 and an Induced Abortion Rate of 6.2. Of the 5.3 million induced abortions in the country in 1991, only 0.58 million were legal and the rest i.e. 4.72 million were illegal. This gives us a ratio of 8 illegal abortions for one legal abortion.

The main reasons for seeking illegal abortions are found to be due to financial strain, poverty and social factors like an unmarried, widowed or separated marital status (Phillips F.S. & Ghose N., 1976). There are two other important studies on the medical consequences of induced (legal and illegal) abortions by the ICMR. The first was conducted in 1981, "Short term Sequelae of Induced Abortion", and the second, in 1982, was titled, "Septic Abortion". Phillips and Ghose (1976) found that twigs of *Calatropis gigantice* was most commonly used by unauthorised providers of abortion services. In their study "Criminal Abortion in Western India", Bhatt and Soni (1973) found that the introduction of a vegetable stick was the most common practise. Most of the

studies conducted before 1980 have found that, at the village level, induced abortion services are predominantly provided by traditional birth attendants, most of whom are illiterate women.

A community based survey of 10,000 women and 1200 providers (ICMR, 1989) found that although a majority of the women were aware of induced abortions, more than one third (i.e. 38 per cent) were unaware that induced abortions could be labelled as 'legal' or 'illegal'. A dismaying finding for members of the Task Force was that women in PHC villages were almost totally unaware about the availability of MTP services at the PHC (except in UP and Tamil Nadu where they had some knowledge). Women from subcentre villages, where MTP services were not provided, were more aware about this facility. The Task Force discovered that ANMs and Lady Health Visitors, who are not authorised to do MTPs, used government and PHC facilities for conducting abortions in connivance with doctors and thus making illegal abortions more rampant. Interestingly, the study revealed that women were aware of different types of unauthorised induced abortion even beyond a four month gestation period. Even when women went to government and PHC doctors they were made to pay fees for services rendered. Above all, the study found that a majority of abortions are still conducted using indigenous methods. Further, it found that amongst literate and unauthorised providers, the proportion of males was significantly high.

Thus, in the post liberalisation period, the providers of illegal abortions are not only indigenous practitioners but also qualified practitioners who may not have registered themselves for providing MTP services. Similarly, the place where illegal abortions are carried out are not only the homes and clinics of the indigenous and non qualified practitioners, but also well equipped hospitals and nursing homes which are not registered under the Act. Finally, therefore, all institutions properly registered under the MTP Act are not necessarily hygienic nor are all unregistered centres unhygienic.

CONCLUSION

The debate on abortion and the role of a liberal law in a country like India must take cognisance, at the very least, of the provision of general health care services. With about 73 per cent of India's population living in rural areas, the provision of free, rational and universally accessible health care is crucially important at all times to all people (which includes the women who experience morbidity following abortions). However, the foregoing review shows that basic health care services leave alone abortion services, are beyond the reach of many. Moreover, the 'conveyor belt' approaches that most approved centres adopt only ends up making abortion services insensitive to the women who demand them.

For a liberalised law to be effective in providing free, safe and humane abortions on demand, it needs to be accompanied by other social inputs like greater empowerment of women especially in their control over their bodies and their sexuality. In situations where women have relatively better control in decision making and access to contraception (for example, countries in Eastern Europe which provide extensive and reliable data) liberalisation is accompanied first by a rising trend in the incidence of induced abortions which stabilises after a point and finally declines once women improve their skills in avoiding unwanted pregnancies. This has not happened in India.

The knowledge that liberalisation has failed to bring down the incidence of illegal abortions, to improve the health of women and the fact that it is tagged to the population programme, has bred a fair deal of scepticism among some Indian academicians. Through a presumed belief in the accessibility of abortion services as a natural consequence of liberalisation, they believe that women have increasingly been pushed into utilising these services. However, statistics reveal that legalisation has not significantly increased the rate of legal abortions (Table 1). Further, by doing away with legalised abortion services, can a given society reduce abortions and can that automatically improve women's health? Historical and contemporary evidence demonstrates that it is not possible for the state to achieve complete control over women's bodies through its employment of technology, legal prohibitions and repression. In Romania, for example, Ceausescu proscribed abortions for 14 years and bolstered that policy with intensive repressive measures. Yet, in the 1980s, Romania surpassed virtually all other European nations in the rates of abortion and abortion related mortality (Jacobson J, 1990: 5).

The dilemma expressed by the sceptic highlights the limitation of treating abortions as a civil right for individual freedom and privacy. Legality provides only a thin cover, a political legitimacy that is necessary but not sufficient to change that material conditions of women's lives. Firstly, it makes it possible for anti-abortionists, under a conservative political climate, to juxtapose the civil rights of the unborn child with the civil right of the pregnant woman. This has happened in the U.S. opinion polls on the issue of abortion since 1973 show that Americans are deeply ambivalent on the issue of abortion. More than two-thirds consistently say that although they believe abortion to be wrong and immoral, the ultimate decision should be made by a woman and her physician rather than by a government decree (Annas, 1989). Anti-abortionists attempt to translate the conviction that abortions constitute 'an act of immorality' into government sanctioned legal restrictions and have been fairly successful in juxtaposing the civil rights of the pregnant woman with those of the unborn child.

Secondly, a civil right to abortion does not amount to a *social right* which is accompanied by all the necessary enabling conditions that makes it concretely realisable and universally available. Further, a really safe abortion is possible only by embedding abortion services in a full range of social services- health care, pre-natal care, safe child birth, child care, safe and reliable contraception, sex education, protection from sexual and sterilisation abuse, etc. These social services must function under the organised vigilance of women's groups to ensure that women do really get access to such services.

Moreover, abortion is not merely an issue of political and legal conflict but of social, cultural and moral conflict as well. Good social services expand the scope of what is meant by "women's reproductive freedom" and are, therefore, of utmost relevance and urgency. However, this could result only in a partial or total shift in child rearing responsibilities from women to men and ease the burdensome aspect of motherhood (through improved benefits and services). Petchesky argues that "it may also operate to perpetuate the existing sexual division of labour and women's social subordination" and suggests that the realisation of "women's reproductive freedom" will have to be part of the radical transformation in the social relations of reproduction and production (Petchesky 1986 : 16-17). In Hilda Scott's words, "... no decisive changes can be brought about by measures aimed at women alone, but, rather, the division of functions between sexes must be changed in such a way that men and women have the same opportunities to be active parents and to be gainfully employed. This makes women's emancipation not merely a women's question but a function of the general drive for greater equality which affects everyone.... the care of children becomes a fact which society has to take into consideration" (Scott 1974 : 190).

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