

# UNSAFE ABORTION

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*Women in India are fortunate in having access to legal abortion services, made possible through the Medical Termination of Pregnancy (MTP) Act, 1971. The act passed by the Indian Parliament is considered revolutionary for it allows women to both avail abortion care due to failure of contraception and have access to abortion without the husband's consent.*

The government and policymakers deserve kudos for decriminalising the act of abortion (criminalised by the Indian Penal code 1860, a legacy of the British): this while women the world over are still striving to get abortion legalised. This battle continues in many countries irrespective of their development status, religious orientation, political ideology and despite being signatories to various international treaties and covenants, indicating that it involves complex dynamics.

Unfortunately, the potential of the act has not been put to the best use either for women or the nation. Perhaps if we could identify the problems, it might help us locate the solutions. However, in doing so, it is essential that the magnitude of ill-health that is attributable to unsafe abortion care services be fathomed and acknowledged. This article attempts to locate unsafe abortion as an issue of public health concern. This is done in the wider context of quality of abortion care that prevails today on the one hand, and the socio-cultural and demographic context of abortion on the other.

The non-availability of quality data on abortion continues to be troubling. The perspective, therefore, has to evolve by placing our micro-level empirical research findings into the larger context of state and national level statistics on abortion and related issues from other sources. Towards the end, it is argued that the, need of the hour is to shift focus from unsafe abortion as an issue of public health concern to safe and legal abortion as a women's right issue.

The most important factors determining a nation's abortion policies are the nation's population concerns, priorities and policies. For instance, experience the world over shows that while pro-natalist governments safeguard their interests by denying women access to abortion anti-natalist governments project and implement liberal abortion policies to achieve the state's goal of population control. In either case, women are viewed merely as reproductive machines. The cause of women's ill-health an account of undergoing unsafe abortion, therefore, is deep rooted in this grossly mis-articulated philosophy behind allowing or denying access to abortion as a means to achieve the interest of society at large. The mathematical equation that is constructed out of this philosophy thus only messes up the situation, not only for women but for nations too.

Where does India stand as regards legislative measures and the motivation behind it? The story of abortion in India on the count of passing of the MTP Act reads well and is encouraging. However, one cannot stop frowning upon medicalisation and the restrictive nature of the act on the one hand, and raising one's eyebrows over the loopholes that it leaves to interpret liberally or restrictively according to the larger societal needs and demands on the other (Jeasani 1993). Currently the government's anti-natalist policy and strong conviction about the need to bring down population

growth rates, coupled with the interests of the medical fraternity, allows a liberal interpretation of the act. Despite that, women's access to quality abortion care has yet to become a reality more than a quarter century after the MTP Act was implemented. This is what makes the story of abortion India an ill-fated one.

What is the Indian scenario as regards abortion mortality and morbidity? The estimates about the rate of abortion, proportionate induced abortions, mortality and morbidity attributable to abortion are startling. According to a conservative assumption, for every 73 live births there are 25 abortions of which three-fifths are induced. Based on these assumptions, an average estimate for the current decade is five million legal and illegal induced abortion per annum in India (Bandewar 1999). The Indian Survey of Death reports that nearly 18% of maternal deaths result from abortion (GOI' 91-95). Data from various other sources suggest that maternal mortality resulting from unsafe abortion ranges from 4.5 to 16.9% (Bhatia 1988; RGI 1988; Reddy 1992). An estimated ratio of illegal abortions ranges between 3 to 1 and 8 to 1 (Bandewar 1999; Karkal 1991).

Why is the situation so grave despite a provision for legal abortion? Unsafe abortion as a public health issue is not a difficult riddle to fathom though it may defy easy solution. The foremost factor that has a direct bearing on the outcome of an abortion procedure is the quality of abortion care that a woman receives. The concept of quality of health care has come of age today. Over the decades and centuries of knowledge and experiences in medical care, and with new waves of interdisciplinary approaches to understanding the issue at hand, the concept has become an all inclusive and multifaceted one.

It refers to the availability of, accessibility to and approachability to abortion care facilities; availability of minimum physical standards and qualified and adequate human power to offer such care; nature and texture of the interpersonal communication between the staff at the health care facilities and women; the content of communication and counselling; the quality of outcome of the procedure; women's satisfaction about the services than they receive and the biomedical indicators; the status as regards post-operative complications and so on.

Thus, this comprehensive concept of quality of care takes note of both the quantitative and qualitative aspects of health care. The empirical research on the quality of abortion care, conducted in the 1990s, reveals a pathetic and gruesome state of affairs and should solve to a great extent the riddle of alarming statistics about abortion morality and morbidity. Macro-level data on many of the aspects mentioned above is not available and thus small scale empirical research assumes significance.

Are abortion care facilities required to be registered under the MTP Act? For the reader to get an idea about the poor quality of abortion care that women receive, we present data on some of the gross indicators of quality of care from our empirical research we conducted research in nine tehsils of Pune and Ratnagiri districts of Maharashtra. The nine tehsils included in the study had 159 health care facilities which offered abortion care services. In case of abortion care services, the facility needs to be registered under the MTP Act.

Our data show that on average, for every single MTP registered abortion care facility (ACFs) there were around three non-registered ACFs, the ratio varying between 1:1 to 1:5. National level statistics on MTP centres suggest wide variation across the states. However, in general, MTP facilities remain inadequate. In India, in the mid90s there were

9271 centres, while the number of MTPs reported was 609915 (Family Welfare Programme in India, Year Book, 1993-94).

Are abortion care facilities accessible, approachable and adequate? Our study shows that the distribution of ACFs was grossly skewed, spatially sparse and uneven. A total of 159 ACFs from nine tehsils were situated in 44 villages/townships, concentrated mostly in townships and in villages with a population of 5000 and more. These ACFs supported the population from 1447 villages of the nine tehsils of which about 69% were connected by some state transport facility. Tough terrain and lack of transport facilities not only caused inconvenience but added to the cost women bear in terms of time and money.

According to our study the number of women between 15-49 years of age who may need abortion care facilities varied between 172 to 1007 per urban based ACF and 3124 to 21553 per rural based ACF. The number of abortions per facility ranged between 54 to 480. For India, for the year 1994, there were 62.7 MTPs per MTP facility.

How do public health care facilities help in abortion care? Availability of abortion care services at public centres clearly means free of charge services. In our study, of the total public health care facilities eligible for abortion care service, the proportionate share ranged between 9 to 56% in selected tehsils. Overall, of the total eligible public facilities about one-fourth provided abortion care services. The percentage at the national level is as low as 8%. According to unpublished data for the state of Maharashtra, 1992-93, about 70.3% of the approved centres were in the private sector (Jesani and Iyer 1995). Our data show that of the total, only about 8% of the qualified abortion providers were based in public health care facilities.

Are the abortion care service providers qualified as defined in the act? The proportion of non-allopathic to allopathic abortion service providers varied between 1:1 to 1:4. Of a total of 207 abortion service providers, about 56% were not qualified under the MTP Act. Of the total, more than one-fourth were non-allopaths. Such a massive indulgence of the medical fraternity into illegal abortion care service provision, even in institution based abortion care delivery, naturally exposes women to unsafe abortions. Many studies have recorded the involvement of other service providers-ranging from local abortionists and magicians, trained and untrained dais, ANMs and ayurvedic and homeopathic practitioners. Of the 2189 abortions studied, about 67% were by non-allopaths, assuming that those done at public health care facilities were by allopaths. This not only highlights poor implementation and monitoring of the act, but also raises the question as to why such rampant indulgence prevails. A mass exodus of specialised allopath medical providers towards developed and urban areas even at the risk of saturation, almost inhibiting non-allopaths from entering the market complemented by women's lack of purchasing quality care, provides a partial answer.

Are abortion care services affordable? The cost of abortion care varied between Rs 300 to Rs 3,000. The cost of travel that women bear and some times for drugs to be purchased being over and above the medical costs at the institution. Interestingly, in addition to rational determinants of cost such as type of method used, a woman's marital and socio-economic status and the extent of her vulnerability often determine the price of service she receives.

There is a lack of standardised pricing of health care in general. Many other micro-level studies have shown a similar range. An average per capita income of Rs 3168 (1984-85) for Maharashtra (NFHS 1992-93), 37% of the population

falling below the poverty line (GOI 1997, Appendix 4, as quoted by Mooij 1999) for Maharashtra and a minimum wage of around Rs 35 highlight the various hazardous options that women face. In such situations, women either resort to unsafe intervention by a local abortionist, or place themselves in debt to seek institution based care.

How are abortion care facilities placed vis-à-vis minimum physical standards and professional competence of the service providers? We studied 115 out of 159 ACFs for detailed indicators on the quality of abortion care. Only 16% ACFs met the criteria of minimum physical standards as regards abortion care; 46% ACFs were supported by qualified abortion service providers stipulated in the MTP Act. On further analysis to understand comprehensive quality of care as regards 'structural aspects – minimum physical standards (equipment, instruments, essential drugs) and qualified abortion service provider and anesthetists' – the number of ACFs, appropriately equipped and supported by qualified professionals came down to a mere 13 (of 115). One is often cautious about making generalisations based on such micro-level empirical research. Nonetheless, it would not be erroneous to suggest that this represents the abysmally poor status of abortion care services in general, with some regional variations.

Where do the existing abortion care services stand as regards their soft facets, such as client-provider interpersonal communication and counselling? Our study indicates an unsatisfactory situation regarding the significance of 'counselling' in our health care delivery system. Both the content and texture of these communications were not conducive for encouraging women's participation in the process. They were inadequate and cryptic, and maintained the power hierarchy between the 'knowledgeable medical professional' and 'ignorant lay women'. The former's moralistic positions about abortion led them to penalise women who were often beleaguered with a feeling of guilt about the 'crime' they had committed. Rarely did the providers engage in conducting minimum preoperative tests such as blood group and count and post-operative checks, or checking for infections. Nor were they particular about communicating the do's and don'ts of post operation, or informing patients about indications of post operative complications. In the absence of post operative care facilities and women's constraints in utilising them, the chances of mortality and morbidity only increase. It is, therefore, essential to change prevailing attitudes of both women and providers towards abortion.

How are the providers supported through training and continuing education to update themselves with the advances in medical sciences? There are no serious efforts towards upgrading skills of abortion care providers keeping pace with advances in medical techniques (methods and equipment/instruments) vis-à-vis abortion procedures; abortion care providers still prefer using the conventional methods foregoing the safety advantages of the former. More than 60% of the abortion care providers/facilities still use dilation and curettage (D&C) for the first trimester abortion procedures instead of safer vacuum aspiration methods (Barge, et al. 1994; REAP/CEHAT, unpublished). In general, the prevailing MTP training facilities are inadequate and deficient.

Where do we locate the problems of persistent poor quality of abortion care? It could be located in poor implementation of the MTP Act and low compliance, absence of accountability and self regulation on the part of the medical fraternity, it may be noted that the so called registered MTP ACFs do not necessarily meet all the legal criteria about essential minimum physical standards and qualified human power for conducting abortion procedures. This

highlights the fact that legislative measures do not necessarily ensure women's access to safe abortion care. A paucity of adequate budgetary allocation underscores these lacunae.

How does the socio-cultural fabric of abortion affect women's access to safe abortion care services? What are its implications for women's health? A health care delivery system is only one side of the story. Patterns of utilisation of health care services in general, and abortion care in particular, are a result of the interfacing of a complex socio-cultural fabric and the health care services – its mode of delivery, nature and profile. The social stigma attached to an act of abortion, women's status in the family, her lack of negotiating power in the sexual relationship with the husband only makes the situation worse. Also, the state's pressure to limit family size and space children, social pressure on the couple to prove fertility immediately after the marriage, the pressure to produce the right gender mix of children and, above all the pressure to compulsarily produce a male child to feel 'honoured' and allow a continuation of the family lineage, pushes women to use abortion as a coping mechanism.

Community based qualitative studies to understand women's abortion needs, their decision-making process, their concern for quality of care and choice of provider show that in addition to the inherent complexity of the decision, a lack of consensus and support from family members, which is normally the case, forces women to operate on their own, often trading quality for confidentiality. Their overriding concern for maintaining confidentiality also constrict their choice of provider (Gupte, et al, 1999). It is thus not unusual that women resort to clandestine abortions, exposing themselves to risk.

Women's abortion needs are not contingent upon their class, caste or religion. However, women from marginal groups are more likely to have poorer access to quality abortion care services. In sum, it is clear that skewed, sparse and uneven distribution of inadequate abortion care facilities make women's access to abortion care difficult. Even if women manage to access these facilities and overcome the range of hurdles arising from the socio-cultural context of abortion, the struggle is far from over and safe abortion care is not always assured.

What strategies would help improve women's access to safe and legal abortion care services? While bringing about changes in the social fabric is an ongoing and gradual process, sensitive and thoughtful changes centred around women's health and well-being at the programmatic and planning level should certainly facilitate women's access to abortion care yielding positive results for women's health in a tangible period of time.

We have to acknowledge the fact that abortion care facilities, or for that matter most of the reproductive health care services, are situated within the larger health care delivery system. Thus, streamlining and strengthening the existing health care delivery system, including measures to correct the skewed distribution of health care facilities and health care providers, is an essential prerequisite. Moreover, it is fundamental to incorporate women's specific needs to make them meaningful to women. A nuanced understanding of women's health concerns and needs and impact of the socio-cultural fabric on women's utilisation patterns of general and specific health care services gathered through empirical research needs to be translated into policy planning and delivery of health care services.

Where do we move from here? In the Indian context there has been a tendency to treat and project abortion as a public health issue, not naively but strategically. However, if we continue on this path in the future, there is a danger of

loosing sight of the new challenges as a consequence of globalisation, cultural revivalism and global strengthening of fundamentalism. The pressure and push of the pro-life movement, including their intimidating strategies in the West, have been responsible for a regression of the pro-choice stream. In this changing context it would not be a surprise if we end up losing the battle that we had won in the past.

All religious fundamentalist movements are prejudiced against abortion as a women's right. With the upsurge of Hindutva and rightist forces at the national level, the moral argument over abortion as an issue of public health could easily be slammed at us, conveniently sidetracking unsafe abortion within the framework of women's right to safe and legal abortion. Already billboards damning abortion are a common sight in Mumbai. This should serve as an adequate warning to those concerned about women's well being and rights.

The other challenge relates to a rising number of sex selective abortions and a range of other sex selective practices. Despite a legal ban on prenatal diagnostics to identify the sex of the foetus, often with the intention to abort in case of a female foetus, its rampant use is an open secret. This battle has now to be joined afresh on two fronts : a) to pressurise for effective implementation and (b) to make legislation more inclusive against the backdrop that newer genetic technologies are being developed to enable pre-conceptual sex selection which the existing legislation does not take not of. Argument articulated around the negative consequences of abortion for women's health can go against women's right to abortion and hence may provide to be self-defeating. The protest against sex selective practices has to continue based on the core argument that it is sex discriminatory and, therefore, violative of human rights.

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