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# Abortion in India: An Overview

## Brief Background

PRIOR to the passage of the Medical Termination of Pregnancy (MTP) Act in August 1971, induced abortion was a criminal offence under the Indian Penal Code(IPC). The IPC provided for punitive punishment that could extend upto seven years of imprisonment and a fine for anyone voluntarily causing miscarriage to a woman with child. Punishment for aborting a feotus without the woman's consent could extend to life imprisonment; as also, for a death occuring due to the procedure.

The sole legal exception to the criminality of abortion provided under the IPC was for a medical emergency, when the pregnancy endangered the mother's life. This apart, both the service provider and the expectant mother were considered culpable for the crime. Accordingly, the woman who refused to carry the burden of her pregnancy for whatsoever reason — other than a medically life-threatening circumstance — was reduced to a mere criminal, no matter how pressing her personal circumstances were. The same was the case with the person who gave her relief.

But notwithstanding the severity of the law, induced abortion was widely practised, surreptitiously. With the country's health services witnessing a deluge of septic and incomplete abortions coming to hospital wards, testifying to enormous numbers carried out by unskilled hands in insanitary conditions — estimated by the Shah Committee, an expert group constituted to review the situation in the late sixties, to be nearly 4 million — a national consensus developed to liberalise the law.

## The MTP Act

The Medical Termination of Pregnancy (MTP) Act was passed by the Indian Parliament in 1971. It has been in force since 1st April 1972. According to the original

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MTP Act it extends to the whole of India, except the state of Jammu and Kashmir (J & K). Since 1980 J & K, as also Mizoram, have come under its purview. However, according to reports of the Ministry of Health and Family Welfare, the MTP Act is still not applicable in the state of Sikkim and the Union Territory of Lakshadweep, presenting a discriminatory situation for women in those parts of the country that appears to have gone unnoticed. In 1971, when India passed the MTP Act—without any vociferous demands from organised groups and without any histrionics in society—it was in the vanguard of a handful of nations permitting pregnancy termination on a broad range of social and socio-medico grounds. The MTP Act not only constituted a landmark in India's social legislation on behalf of women and an achievement of consensual politics, but it also introduced a new pathbreaking concept by recognising that the failure of a contraceptive method could be the cause of extreme mental anguish to the woman and according her the prerogative to take unilateral action.

However, the MTP Act, piloted through with the strong backing of the medical lobby, also carried a strong medical bias: its twin objectives were liberalisation of the grounds on which abortion could be possible and strict controls for the conduct of the procedure only by legally-recognised, skilled medical practitioners. Thus, it simultaneously decriminalised and medicalised the procedure-both steps being conceived at the time, without doubt, in the most enlightened interest of women's well being. The new law also provided safeguards for the medical practitioner who undertakes to perform the procedure according to the stipulated rules and regulations.

It is the implementation of the MTP Act, as is the case with so many other social laws in India, that presents an altogether sorry picture. This has raised serious questioning as to whether the law itself is faulty and needs review and amendment, or/and whether there has been a failiure of administrative measures to translate its intent and letter into a practical right for the greater mass of Indian women.

Reviews show that there is a failure on both counts. The law, although conceptualised in the best interest of women with the leadership and support of medical persons, visualised a far too idealistic medical set-up than India has been able to organise in subsequent years. The rules and regulations drawn up in detail to safeguard the woman have also served to strangulate growth of services.

Whatever the reasons, one thing is amply clear that despite the MTP Act's existence on the books for exactly a quarter of a century, it has not brought the intended relief to the greater majority of Indian women. This is evident from the current situation: wherein, a larger number of women are taking recourse to abortion outside the recognised facilities than was their number in the late sixties and early seventies when distress on this score culminated in the legislation.

## Magnitude of the Problem

Official data indicate between 0.5 million to just under 0.6 million pregnancy terminations in the country each year from 1982-83 to 1990-91. In 1991-92 the figure reached what till then was the peak of 0.63 million. This de-escalated to just over 0.6

million the following year, the latest year for which official figures are available, albeit still provisional. The cumulative total of MTPs performed in the approved institutions by approved medical practitioners from the inception of the MTP programme in April 1972 to March 1993, a period of 21 years, is 8.8 million MTPs.

This cumulative total of 8.8 million MTPs is to be contrasted with the experts' estimates of 3.9 million abortions a year at the time of the passage of the bill. Even had there been no possibility of increase in the annual number of pregnancy terminations over the two decades—although this would be self-evident in the face of the dramatically increased size of the reproductive couple base, up from 94 million couples in the reproductive age group in 1971 to 145 million in 1991—the official figures can be seen to have captured less than 11 percent of the earlier expected incidence.

Further, the annual number of conceptions and live births has also spiralled, as the reproductive age group has increased by nearly 55 percent while the reduction in the total fertility rate per woman is much lower.

In an earlier study on the subject by this writer together with Sheel Nuna, a rudimentary attempt was made to guestimate abortions in the nineties, in order to get a rough grasp of the likely dimensions of the problem. The effort was made more to point out the trends for further precise and thorough investigation, than to arrive at any accurate figures. (That would have required a far more elaborate exercise taking into account a range of different variables than the time and resources of the aforesaid study provided.) The main purpose of conducting a limited, and even somewhat simplistic, exercise was to highlight the existence of a far more extensive and alarming situation than what policy makers and the programme have visualised.

To check out our hypothesis of a grim scenario of considerable scale, we utilised the initial assumptions made by the Shah Committee in arriving at their estimates, i.e. that for every 73 live births there are 2 still births and 25 abortions; of the latter 15 induced and 10 spontaneous. The Shah Committee's assumptions had been based on small hospital studies done in India in the late sixties, and the overall numbers were arrived at on the basis of the population size and crude birth rates prevailing at the time.

Our review of the available literature on abortion found that:

> (i) the assumptions made by the Shah Committee corresponded closely with abortion ratios in several international studies, including current global estimates which point to a quarter of all pregnancies ending in termination, (ii) hospital records from the Post-Partum programme in India which covers 534 institutions were found to consistently show up the percentage of abortion cases to obstetric cases as around 1:4. Further, a number of smaller studies and estimates were observed to be highlighting the possibility of enormous differences between the figures captured in the legal stream and the real incidence in the country.

The number of estimated abortions based on the Shah Committee assumptions but corrected for changed population size and birth rates as prevailing in 1991 yielded an

overall projection of 11.1 million; which, according to the Shah Committee formula could be broken up into two thirds or 6.7 million induced abortions a year and 4.5 million spontaneous abortions. With official data indicating only 0.6 million MTPs, these figures indicated that there could be the possibility of 10-11 illegal abortions for every one legal MTP.

## Inaccuracy of NFHS Data

Subsequently, the National Family Health Survey (NFHS) included a question on spontaneous and induced abortion in a nation-wide data gathering exercise for the first time. The NFHS concedes that the data collected on the total number of pregnancies and the percentage ending in abortion, spontaneous or induced, as almost certainly under-estimated. It, therefore, cautions on its intensive interpretation, particularly with regard to induced abortion on which it states information is most likely to be suppressed by respondents. With these caveats it indicates a total of 6 per cent of pregnancies as likely to be ending in abortion, only 1.4 percent induced abortions for 100 live births in the country. The gross under-estimation of induced abortions is self-evident, considering that the official registration of MTPs alone already captures 0.5- 0.6 million MTPs a year for over a decade. With approximately 26 million births occuring annually, the MTP data by itself, notwithstanding unreported cases, shows twice as many induced abortions as captured by the NFHS data.

However, the NFHS results correspond quite closely to the earlier ICMR multicentric 5 state study which had also indicated an overall abortion incidence of 6 per 100 pregnancies and markedly more spontaneous abortions than induced. Unlike the NFHS which has not probed the legal and illegal dimension,the ICMR multicentric study had found the incidence of illegal abortions to be 2.2 times that of legal pregnancy termination.

It is to be clearly stated that the real issue at stake is not whether there are two or ten illegal abortions for each MTP done, but that despite two decades of a liberal law, there do continue to be many more abortions outside the legal stream than within it.That not enough is known about the real situation which continues to be masked. The question that really needs to be probed is: why is this so?

## Key Public Health Issue and Indicator of Unmet Contraceptive Need

What is very obvious is that abortion is a very significant and hitherto neglected public health issue. Our review reaffirmed the initial assessment of abortion in India as an important proxy indicator of a vast unmet need for contraception with the vast majority of abortions being taken recourse to by the married woman wanting to space or limit her family size. Age levels have inched down and parity levels pared a bit over the two decades since the law was brought into effect, but the basic contours are unchanged.

No doubt there is a worrisomely significant increase in teenage and pre or extra marital pregnancy terminations signifying a negative shaking of traditional mores. But,

as yet, it still forms a miniscule fraction of the total number of abortions. These remain, in the main, an essentially marital, multiparous phenomenon.

The essential profile of the woman seeking a pregnancy termination remains as identified in the late sixties/early seventies: mainly below thirty/thirty-five, married with at least 2 or more living children, who has failed to use contraception or whom contraceptives have failed; often debilitated, always desperate, on account of varying personal circumstances and therefore determined not to take on the additional responsibility of yet another child or in any case that particular unwanted preganancy; very often seeking relief with the full support of some family members. The socio-economic and religious factors reflect the general composition of the population, suggesting that the need and incidence cuts across communities, classes, and even cultural and religious backgrounds. A few studies however indicate a lower acceptance—to be noted, only lower acceptance and by no means a refusal—by the Muslim community.

## Searing Testimony of Gender and Conjugal Inequality

The size of the problem, together with the above profile, makes abortion in India a major metaphor of women's poor status and acute helplessness. It focuses attention to intense gender inequality within the conjugal equation, the married woman's lack of right to her bodily integrity and her desperation as the final trigger for action.

Gross male sexual self-indulgence and neglect of the spouse's well being, lack of concern for her physical or psychological preparedness for carrying a pregnancy, thus emerge as major factors in the Indian situation. The more recent phenomenon of the son preference syndrome linked sex-selection abortion on which national and international attention has focused is, in the ultimate analysis, only an outcrop of a more basic inequity in the woman's situation of which her entire burden of multiple, mistimed and unwanted pregnancies are an even more traumatic testimony.

Both the high incidence of married, multiparous pregnancy terminations; as also, the high volume of spontaneous abortions illuminate substantial and unnecessary drain on the woman's health. This one public health issue, more than any other, draws attention to a delinquent social pattern determined by male gratification needs and lineage continuation than with the intrinsic physical well being and inner desires of the woman herself; and equally,the lack of concern for a feminine perspective of sexuality that places more emphasis on a loving relationship and care rather than sheer physicality. But surprisingly, this aspect of the issue has not drawn any emotional angst from women's groups who have concentrated on the issue of female foeticide per se.

## Faulty Pattern of MTP Services

For the woman needing help the country provides a very uneven scenario for the availability of safe, legal services. State level analysis of the major states highlights the best availability of legal MTP services in Maharashtra where there is one approved institution available for 8000 couples. By contrast, Bihar has the poorest MTP network

with one approved institution for 132,000 couples. Irrational differentials exist almost everywhere. In the North-East in Mizoram an approved institution for MTP services exists for every 4200 couples; in Meghalaya the average is for 243,000 couples.

More than half the facilities in the country are concentrated in five states and one Union Territory: Maharashtra, Gujarat, Kerala, Tarnil Nadu, West Bengal and Delhi, although these hold only one third of the nation's population. Uttar Pradesh with 75 per cent more population than Maharashtra has 70 per cent less approved institutions.

Although Maharashtra alone accounts for 22 percent of the country's approved institutions for conducting MTP, even within Maharashtra there is a skew: only 176 of the 1646 functioning Primary Health Centres in the state are recognised for extending MTP facilities. Urban locations account for the majority of MTP institutions in the country, despite the fact of three-quarters of the population being in rural areas. As of 1992, nationwide, only 1800 of the 20,000 PHCs in the country were reported to be providing MTP services. Thus there is a highly skewed provision of services both between states and within states, with large parts of the country and in particular the rural areas being grossly deprived of access to safe, legal services.

Further, wherever recognised institutions do exist, it is not necessary these are functional. An ICMR study (1989) examining 200 PHCs in 100 districts of the country found the overwhelming majority without facilities/adequate facilities. But even where facilities did exist, often, there was no trained physician; while trained physicians could be found posted in non-equipped facilities. Even when equipment facilities and trained manpower are matched, workloads remain lacksadaisical. On an average an approved institution is noted to carry out 1 MTP in 3 days. This is to be contrasted with the expert projections which had anticipated a workload of 3-4 MTPs per trained physician working part time in an approved centre.The tremendous slack in the system is obvious.

## Public Sector Apathy and Private Sector Inadequacy

Client preference for qualified physicians and approved institutions is noted by more than one major study. But poor awareness coupled with poor accessibility, further compounded by the lack of courtesy, compassionate interaction and privacy in the public health system are identified as major drawbacks that serve to push many into the private sector.

There is a considerable number of abortions conducted by the private-for-profit sector, much of it unreported. Non-profit NGOs are peripheral to the size of the task, although there are two major NGO networks reaching out into a number of cities and one metro centre which accounts for nearly half of Bombay's total MTPs. But these three major NGO networks together accounted for less than 100,000 MTPs in 1992-93.

## Amalgam of Legal and Illegal Safe and Unsafe Services

The private sector is found to constitute an amalgam of legal medical services; medically safe but strictly speaking illegal services, because the place or the doctor has

not been registered or the procedure for reporting not followed; and, outright unsafe and illegal services, many of them botching up cases in backstreets and homes.

The earlier study estimated that at least as many more procedures are being done by qualified physicians in safe facilities as are actually reported under the MTP Act. Default in reporting is considerable and consistent for a variety of reasons that range from the enormous red tape in securing clearances for an institution to undertake MTPs to the cumbersome nature of the reporting procedures requiring very detailed and time bound submission.

Even in public health facilities defaulting in reporting is high and across the early nineties as many as 20-30 percent of approved institutions had failed to send in returns. Further, in many places public system physicians are known to be carrying out private practice in or near public facilities; while, private physicians are known to be chary of divulging the full extent of their professional practice for fear of attracting higher tax liabilities than declared. In one of the largest states, a senior health specialist estimated the incidence of safe, skilled but unreported abortion as 100 per cent more than reported figures.

However, a number of studies, including the multicentric 5 state study by ICMR highlight that the number of abortions provided by indigenous providers were far more than those done by qualified allopathic, physicians, public and private. Dais, trained and untrained, are found to be the single largest category of abortion providers, while female paramedics form another significant category.

Untrained physicians from different systems of medicine, operating out of small shop establishments in small mofussil towns and urban slums are another large category of illicit providers. Menstrual Regulation (MR) Kits sales, entirely to the private sector since there has been no provision for MR in the public health system, are mostly to small shop doctors who do not wish to identify themselves. Nearly half the country's sales of MR kits are reported to be in the North where contraceptive prevalence and authorised MTP facilities are the poorest. Bihar with one of the poorest MTP facilities (as also for family planning ) provides one of the most brisk markets for MR kits.

Amongst the literate, unauthorised providers the proportion of males is high. But, altogether, studies reinforce empirical observations that women turn predominatly and preferentially, to female providers within the private, illegal framework.

## Barbaric Illegal Practices Continue on a Scale

The methods used by illegal providers range widely from dilation and curretage, vacumn aspiration and the use of modern oral medicines to the insertion of twigs, foreign bodies, herbs and roots; massages of different kinds, witchcraft etc. An ICMR in depth study of abortion practices documents a number of hair raising methods—from massages that press the foetus till a cracking sound is heard to bamboo sticks soaked in herbal juices and sun dried, besides decoctions of all kinds.

It is heartbreaking to note that very sizeable numbers of women remain vulnerable to primitive manipulations of the worst kind, even as they live in the last years of the

twentieth century. This when, technically, safe abortion is their legal right since almost a quarter of a century.

**Mortality, Morbidity and Growing Problematic Trends**

Official statistics on deaths due to MTP indicate negligible figures. But even official estimates place death rates in abortions conducted by untrained persons at 60-100 per 100,000 abortions. Moreover, the Registrar General of India's Survey of Causes of Deaths in Rural Areas shows a rising contribution from abortion deaths to maternal deaths; in 1989-90 abortion deaths reverted to 11-12 per cent in a marked reversal of an earlier decrease over the latter half of the eighties. Two separate studies from two large teaching hospitals also attribute to abortion a 15 percent share in maternal deaths, while smaller studies have indicated upto 34 percent. Considering the now well-acknowledged high-levels of maternal deaths in the country, the number of abortion deaths, therefore, are likely to be in the region of 15-20,000.

The overall incidence of complications—both immediate and delayed—are found to be low in the case of MTP procedures. But with the number of abortions occuring outside the safe legal stream, the dangers of complications, major and minor, have accelerated. Illegal private providers seldom refer complications to government or private reputable hospitals and, therefore, hospital-based studies inadequately capture the serious and often chronic ill health that arises from unsafe abortion procedures.

An analysis of MTP data shows that four-fifths of terminations take place in the first trimester which is the safest period, because dangers of termination increase substantially with each week of gestation regardless of medical care. But despite this India already has one of the highest proportions of second trimester abortions amongst countries with no legal restrictions. Further, second trimester mortality rates in India are noted to be twelve times higher than first trimester, even in teaching hospitals with all expertise and facilities on hand. But since the mid-eighties second trimester abortion proportions have been further rising, even within MTP cases. Studies (including by 1CMR) have also noted extensive use of private sector facilities, as also the homes of clients for second trimester abortions, the latter making for a most deadly setting for such a major intervention.

The growth of second trimester abortions further raises issues concerning two disturbing and also growing phenomenon: sex selection based pregnancy termination and teenage pregnancy termination. The limited available evidence indicates that both these trends yet constitute only a fractional, part of the overall demand pattern. As earlier stated this continues to remain firmly rooted in the exhausted, multiparous mother phenomenon. But the growing shadow cast by both these trends cannot- and must not - be ignored. Sex confirmation is usually arrived at after ten-twelve weeks of gestation, while the unmarried girl tends to postpone her moment of irrevocable realisation- thus constituting a high risk category. Sex education for both sexes, that is not an euphemism for contraceptive backed promiscuity, but a value orientation towards sexual responsibility and high self esteem that chooses abstinence as the proper way of life in extreme youth

is, accordingly, a vital necessity if the latter is not to grow in today's sexuality permeated environment.

Although a law banning sex selection tests has been passed, its implementation can scarcely hope to have better results than what the MTP law itself is faring, or for that matter the fate of a similiar law in Maharashtra that has been in force for several years now. Here again the answer to this phenomenon will better lie in intensive education of men, women and families to the hazards of second trimester abortion; and, educative and remedial measures with regard to the overall women's status issues, particularly dowry and the ever-rising ostentation at marriages for which the girl's family bears the expense. Merely focusing on the virulence of female foeticide will inevitably engender similiar reservations on the issue of abortion itself, jeopardising the rights of living women in the effort at conscientisation on the rights of women yet to be born.

Another worrisome trend is the slide down in the percentage of women/couples not accepting contraceptive cover after a pregnancy termination. This is all the more surprising considering that contraceptive failure is one of the most important reasons disclosed by MTP seekers and the desire to space or limit the family is identified as the prime reason by almost all studies. Post abortion contraception counselling that is genuinely caring and non coercive but persuasive in the best interest of the woman is an area that will need attention. Here again,the lobbying to remove contraceptive link up to abortion provision in the public health system is misplaced. What is needed is an improvement in the style of interaction to make it supportive and sympathetic enough to get the right results and not an abdication of the contraceptive issue.

### Inadequacy of Administrative Support

The grounding of MTP services in India has been strait jacketed by very rigid rules and regulations, which ironically make no distinction whatsoever between the simpler early pregnancy termination stage and the much more hazardous second trimester termination. The cumbersome registration process and the subsequent detailed reporting requirements appear to have deterred a more widespread, open involvement of the private sector. Within the public health system that has owned the major responsibility of providing the services, it has been a chequered history of central exhortation to states (as a health measure MTP is on the concurrent list) without a concomitant arrangement for adequate funds to stimulate the interest and involvement of a chronically fund starved public health system at the state and below levels.

Renewed consciousness in the early eighties of the impact of unsafe abortion on maternal health and mortality led to the first modest but specific suballocation for the MTP programme within MCH over the Seventh Plan period. But eventually, in execution even the limited MCH budget was hijacked by the Child Immunisation programme.

Mid-nineties, there has been a renewed surge of attention to the problem. 1993-94 saw the allocation for MTP services expansion boosted to triple the previous year: 150 lakhs,with 110 lakhs earmarked for drugs and dressings. The first attempt to provide

a reasonable back up for medical care of the woman herself. It is not clear that given the extensive cuts in health budgets whether this allocation has actually been effectively utilised.

In any event, the mere hiking of the budget for MTP services without any clear cut plan to attend to the manifold problems around the issue is no solution. Rather MOHFW's move to support a law providing 6 weeks leave for MTP shows a paucity of understanding of the issues and a continuation of the mechanistic "suction equipment supply and technique training" approach with which it has, all along, tried to ground the MTP programme - with such poor success, so far.

## Can Abortion Become Controversial Now

Till recently, the issue of abortion has not figured as an emotive, explosive bone of contention in India, as it has in many other countries of the world. Mainly because, till now in India abortion has been the metaphor of women's extreme vulnerability and not sexual assertiveness. It has been used mainly to limit and space childbearing, and even the attempts to postpone the first birth have been largely within the marital ambit.

Reproductive rights and freedom seeking acceptance for premarital sexuality or the single, unmarried mother has not been an issue in Indian society. Unfortunately, the present recognised need for a substantial expansion of legal services is coincidental to a massive media fuelled emphasis on sexuality and the fraying of established social norms of personal behaviour. The new nascent campaigning for adolescent contraceptive services holds potential for the development of a backlash that could hit legitimate needs for expanded and easier MTP availability.

Equally the strident focus on sex selective abortion has had unintended repurcussions in triggering a flip side questioning of foeticide *per se* by prolife groups that had been hitherto dormant.

Perhaps immediately ahead are the most complex challenges for safe legal abortion as a guaranteed right of the Indian woman: institutionalising and making widely known the availability of safe legal MTP services, while retaining the sexual framework of restraint and emphasis on cultural values that does not allow such services to become a source of abuse of the woman herself; safeguarding the woman's right to be the sole arbiter of her decision making in this most intimate concern of her existence, while teaching her to exercise the right both sparingly and with the utmost responsibility.

In this connection there will be need to recognise that the role of the media and other social forces is as vital, if not more, than that of the health services.Failiure to make this connection will only spiral the number of abortions in the country instead of working to the goal of reduced numbers but quality services. If India wants to avoid the clinic wars of the United States the time is now to look at root issues and develop clear cut strategies—not simply to bring in more suction equipment and manpower trained to handle it; but rather, to devise effective ways to minimise the need while optimising the access and safety aspects.