Legal but Not Available

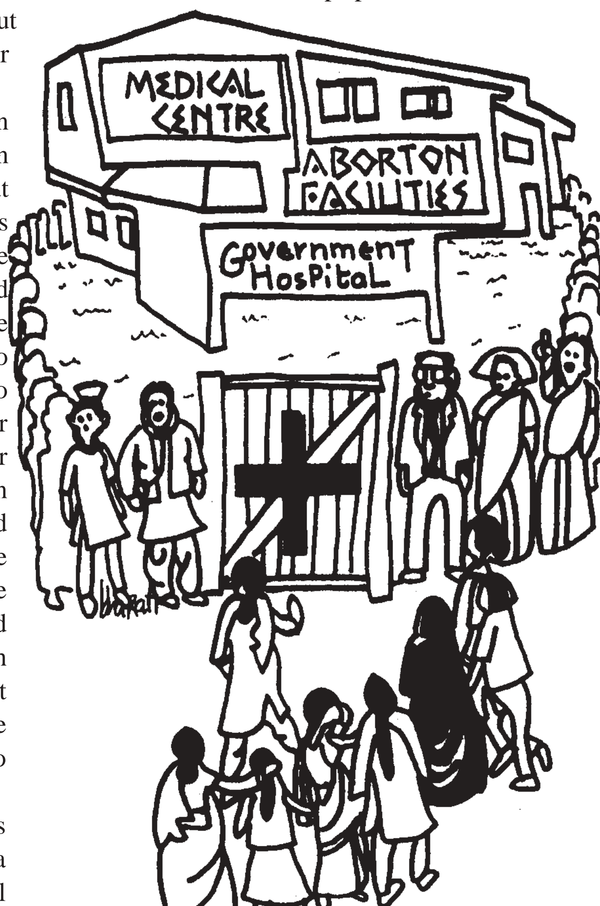
The Paradox of Abortion in India

❍Paige Passano

Abortion has stirred up raging political and legal controversies worldwide. In many countries religious and political groups refer to abortion as murder, while women's rights advocates insist it forms part of a woman's fundamental right to have control over her body. In India, however, such a polarisation of views has been absent. In fact, there was hardly a fight when the Medical Termination of Pregnancy (MTP) Act legalised abortion in 1971. The law passed quietly, without any significant religious or political opposition.

The Act was quite an advanced piece of legislation for its time, stipulating that abortions (up to twenty weeks of gestation) could be performed by registered medical practitioners. The passage of the Act seemed to imply that a woman who decided to terminate her pregnancy would no longer be hindered by the law in making this choice, nor would she be forced to risk her life doing so. However, in the context of an under-funded and unaccountable health care system, much of what was envisaged during the passage of the Act failed to materialise.

To a close observer, this should not come as much of a surprise. In the political climate of that time, concern for women's reproductive health was not a major factor in the passage of this law. In fact, it was expedited largely due to pressure from the population lobby. Notwithstanding the few people involved in the drafting process who were genuinely concerned with improving conditions for women, the main impetus behind the Act was the belief that legalising abortion would help curb the population growth rate.



Additional problems arose due to wrongful interpretation and implementation of this legislation. Even though the Act's criteria outlining eligibility were fairly liberal, the documents used to process requests for abortion were worded in such a way as to disempower women. Medical professionals, instead of women themselves, became the primary gatekeepers of abortion. Lack of accountability kept the power in the hands of doctors with many of them interpreting the conditions of the Act in their own idiosyncratic and often restrictive ways. No systems were in place to follow up on what doctors were saying or doing. Little effort was made to increase public awareness about the fact that abortion was now legal, or to improve access for the poor and uneducated. Moreover, budgetary allocations for abortion facilities were totally inadequate, making it possible for only a handful of physicians to be trained and updated on the appropriate methods of termination for different stages of a woman's pregnancy.

From a legal standpoint, however, the Act seemed to place India at the vanguard of the women's rights movement on the issue of a woman's right

to choose the circumstances of her own childbearing. In the early 1970s, India was one of the first countries in the world to pass such a liberal abortion law. The inclusion of flexible criteria for eligibility such as "contraceptive failure" indicates that the legislation was not meant to be restrictive. In fact, the 1971 law could be seen as similar to laws in other countries which have legalised abortion on request as long as the woman is less than a designated number of weeks into her pregnancy.

Ineffective MTP Act

Over the years, other countries legislated and implemented similar (or more liberal) laws, often in response to the vociferous advocacy of women's groups. In India, however, very little concern about the ineffectiveness of the MTP Act was voiced by women's organisations. This may be attributed partially to the perception that the legal battle for abortion rights was over and that efforts should be focused in other areas.

More recently, many women's organisations have been actively involved in the fight against the introduction of 'the abortion pill' whilst others have focused on spreading awareness about the problem of sex-selective abortions. They may have felt that fighting for access to surgical abortion was incompatible with their primary agenda of opposing particular kinds of abortion, or that making abortion more accessible in general would backfire by encouraging sex-selective abortions. Only a few organisations, such as The Center for Enquiry into Health and Allied Themes (CEHAT) have made serious efforts to understand the problem.

Backstreet Abortions Go On

It has now been almost 30 years since the passage of the MTP Act. Only a token number of abortions — a very tiny proportion of India's crores of abortions that have been performed since then — were carried out safely in accordance with the Act's provisions. The World Health Organisation (WHO) reported that out of the estimated 5.3 million induced abortions in India in 1989, 4.7 million were unsafe. This makes India the site of more unsafe abortions than any other country in the world. To understand the various reasons for so many women being needlessly injured or killed whilst undergoing a procedure that in most cases should be safe, many interconnected issues need to be examined.

Abortion is a subject deeply buried within the culture of silence which obscures most matters related to sexuality. The combination of the social shame surrounding abortion and the government's failure to spearhead an awareness campaign has made it difficult for women to get accurate information. The failure of government to provide the necessary information is not surprising as it is difficult to promote a service that does not exist in most locales. Since so little attention was paid to educating the public about the MTP Act, many women even today do not know that abortion is legal. In one rural, community-based study in Vellore District of Tamil Nadu, it was found that 84 percent out of the 195 women knew where to get an abortion, but only 13.8 percent knew they were conducted by doctors. As so few women know the basic facts about this medical option, it is difficult for them to demand that their right to a safe abortion be respected, especially if they already feel uncomfortable talking about such personal matters. It is hardly surprising, therefore, that women lack vital information about what they can safely do if they need an abortion. To cite a related situation: if the majority of women in a village suffer from various types of painful and untreated infections in their reproductive organs, they are likely to believe that this is just one of the many aspects of a woman's inevitable suffering. As one woman interviewed for part of the study stated, "It"s just like that, we [women] have to suffer pain." (*Aisa hai, hum logon ko dard sahna parta hai*.)

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Outdated Methods

Another major concern is the safety of the methods used by doctors to terminate pregnancies. Surgical abortion by dilation and curettage (D&C) is still the most commonly used method in India. A large percentage of doctors who regularly perform abortions rarely use, and/or are unfamiliar with the less invasive and safer methods of conducting early abortions. D&C is done under general anesthesia and is usually an inpatient procedure.

An alternative method for early abortions is manual vacuum aspiration (MVA). MVA is easier to perform, quicker, portable, safer, and it is not dependent on an electric power connection. It is done on an outpatient basis and there is often no need for general anesthesia, which means there is less risk to the woman. Using MVA requires less sophisticated back-up equipment, hence its use would mean that less equipped places would be able to conduct early-term abortions safely, making the service more accessible. The government has recommended MVA for abortions of all pregnancies under 12 weeks of

gestation. While D & C may be the only method many doctors are familiar with, that is not enough to justify its use in early term abortions since it entails much more risk to the patient.

Better Options Ignored

In the light of current financial pressures and overcrowding in hospitals, the savings in cost, space, and time associated with the use of MVA cannot be ignored. Research from Kenya reveals that the adoption of MVA over D & C reduced hospital stays by 41 to 76 percent, and reduced costs to the patient by more than half. A comparative study conducted in Africa and Latin America found that the average cost of a D & C was US $78.81 compared to the average cost of an MVA, which was only US $8.50. Equally dramatic data comes from Peru, where it was found that the total time spent (pre-operative, operative, postoperative) was 271 minutes for an outpatient MVA as opposed to 2,638 minutes for an inpatient D & C.

Abortion complications can be quite serious. They require an average of two days of hospitalisation and a good deal of doctors' and nurses' time. The majority of government public health centers (PHCs) are not equipped with the basic facilities or staff to perform abortions safely, even though this is supposed to be one of the free medical services provided by them. Nevertheless they are supposed to manage the consequences of a large number of botched abortions by unqualified abortionists, resulting from the use of methods far more dangerous than D & C. According to a 1990 study done by WHO, over one quarter of the maternal morbidity in low-income countries is the result of unsafe abortion. This makes abortion blunders the single most damaging factor in women's reproductive health. Unsafe abortion is also cited as the fourth most common factor leading to maternal mortality, following hemorrhage, indirect causes (such as malaria or anemia), and sepsis.

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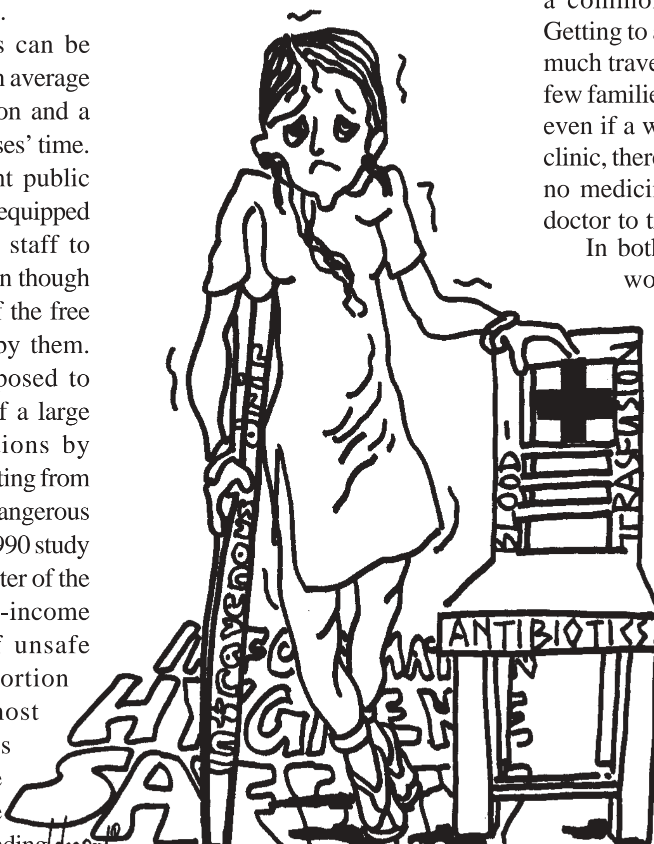
By the time a woman reaches the hospital after a botched abortion, she is sometimes in critical condition and often in need of a blood transfusion, which the hospital may or may not be able to provide safely. To be able to responsibly handle emergency cases, clinics and hospitals need to be in a position to give anesthesia, antibiotics, intravenous drip, or a blood transfusion, as needed.



Govt. Hospitals Avoided

In a series of interviews conducted with female domestic servants and other poor women in the Lajpat Nagar area of Delhi, we found that almost all of them avoided government hospitals when seeking abortions even though it was there that abortions were supposedly carried out without charge. Lack of time (to wait in long queues) was a major factor for all working women. As one woman dryly stated: "Who has the time? By the time you get through the queue your baby would be out on the floor." Other women told us that they preferred traditional doctors or midwives in the neighborhood because "they don't shout at you," "they give you what you want without much trouble," and "they tell you what to do." Disrespect and belittling by medical personnel was a commonly reported complaint. Getting to a clinic simply requires too much travel time and expense, which few families can afford. Furthermore, even if a woman manages to get to a clinic, there is often no doctor on duty, no medicines to give, or no female doctor to treat female concerns.

In both urban and rural locales, women tend to believe that their confidentiality will be compromised if they go to a government hospital or clinic. But the most serious of women's concerns, in both urban and rural areas, is the fear of being pressured into accepting sterilisation. While the amount of coercion which takes place is unclear, this widespread fear indicates there has been plenty of manipulation in the past, and it is probably continuing.

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"It's Actually For You, Isn't It?"

MANUSHI sent a volunteer to a government hospital in Lajpat Nagar to see the way in which an unmarried woman would be treated if she simply wanted to get information about abortion services from a government hospital. The volunteer gave the following account of what happened:

There was a separate family section at the hospital which was filled with women. A male peon sat at the front, stamping forms and distributing condoms. I told him I needed to speak to a doctor about family planning. He asked me how many kids I had. I told him I didn't have any and he told me to go straight into the nurses' room at the end of the hall. Women were lined up on both sides of the hallway. There was no door to the nurses' room so that all the women on the line could hear what I was about to say. In fact, two women in the room stayed to listen to my story, which made it even more awkward. I told the nurses that I had come to find out about how one would get an abortion because my cousin needed one. They wanted to know her age and marital status so I told them she was 19 years old and unmarried. I also told them that my cousin hadn't had her period in two months and was very worried, and had sent me to find out details. One nurse did not believe that the abortion was for my cousin; she thought it was for me and said so openly.

The other nurses were very angry about my cousin being unmarried. They said that the hospital didn't do abortions for unmarried girls. Why hasn't your cousin told her parents?" they kept asking loudly. I said she was ashamed and they said, "She should be ashamed for sending you instead of showing her face." They said that no government organisation would carry out the abortion and told me to go away. Assuming that I must be lying about my cousin, the doubting nurse said that the abortion was going to cost me a lot of money - at least Rs 1,000 - because I was unmarried. Meanwhile, the male peon had come into the room to ask why the nurses were yelling. She said loudly "This unmarried girl wants to get an abortion." (Yeh unmarried girl abortion karvana chahati hai.) The other women were still in the room at that time.

As I was leaving the nurse came outside and called me back. She told me the doctor would see me. The doctor must have asked what the commotion was. The other women sitting in the room were angry because I had skipped the queue and were discussing what was going on amongst themselves. The doctor asked me why I had come and I repeated the story. She asked me if I was sure it wasn't for me.

I said, "No, it is for my cousin."

"How did this happen?" she asked.

"Well, there was some guy..."

I started to say.

"Obviously, there was a boy! Why don't they get married?" she demanded. I replied that marriage was impossible. The doctor lectured me on morals.

"Your cousin is spoiling her honor. If she doesn't even have the courage to come and face me or tell her parents, she's going to run into the problem again. How can this happen in our Indian culture? This sort of thing doesn't happen. We won't do the abortion here. Go to Marie Stopes Clinic down the road and find out the charges. They will charge you double anyway since you're unmarried. Then if you can't afford it, I'll send you to Safdarjang."

I said that my cousin had no money of her own and could not afford to pay a lot. The doctor said that in that case she would write me a referral for Safdarjang Hospital. On the referral form she said, "Do you want me to write unmarried? I am supposed to note it down." I said, "Whatever you think is best." She said that then she would only write MTP and I would have to deal with any questions at Safdarjang on my own. She warned me that the department dealing with abortion would not be at all private at Safdarjang. Other women would be in the room listening and watching just like at this hospital. She advised me that a private clinic would be better for privacy.

She filled out a referral form and as I was leaving, the peon again said, "It's actually for you, isn't it?" I said no, but he didn't believe me. He said I should go to Safdarjang early in the morning on Monday to get the procedure done. He also told me that I should bring some money because it was going to cost me, even though abortions are supposed to be free in government hospitals. I walked out of the hospital. Throughout this period, all the women were staring at me. ❒

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Coercive Package Deals

Although the system requiring hospital staff to meet quotas for sterilisation acceptance was supposedly abolished in 1996, government hospitals are still notorious for offering what amounts to a "package deal" to poor or illiterate abortion seekers who already have one or two children (including at least one son). Women are reportedly told that they can only get an abortion if they agree to a long-term contraceptive method, often one which is irreversible.

While in theory the government claims to provide a cafeteria-style set of family planning options to women, this cafeteria is pretty meagre. Very often pregnant women who seek an abortion are given a single choice – after the procedure, she must agree to either sterilisation or insertion of an IUD. Other choices are available to women who are educated or financially better-off, if they insist on their rights or can pay for a private practitioner who is qualified and willing to provide the procedure they desire. But the system does not respond to the needs of poor or uninformed women in ensuring that the legal options available to them are carefully presented and explained.

Pressure to accept sterilisation is a well-documented fact that has for many decades been a strong disincentive for women coming to government hospitals, whether they are seeking an abortion or other health care. During their medical training, many government doctors and nurses have been indoctrinated into believing that it is their personal contribution to population control. Others believe that it is a path to career advancement. As one government doctor remarked in one of our interviews: "It is our moral duty to try to get them operated. These women don't know when to stop. We don't suggest it to upper and middle-class women because they are no problem. They don't usually want to have more than two anyway." Since there is little regulation, many doctors feel free to tack on all kinds of conditions for eligibility for an abortion in accordance with their personal beliefs, instead of those stipulated by the law.

Underhanded Pressures

The compulsion to accept a long-term method of contraception doesn't exist anywhere in the MTP

Act. However, a careful look at Form II of the MTP Regulation Form (to be completed by a medical doctor after each legally-performed MTP) demonstrates a clear bias in favour of the over-zealous population control campaign that has saturated the entire family planning program. After requesting details of the name and location of the doctor's clinic, the duration of the pregnancy, the reason for the termination, and other details, the form asks whether the doctor was able to get the patient to accept sterilisation or Intra Uterine Device (IUD) along with the MTP. No other options are listed, nor is any further space provided for the doctor to mention if any other methods were considered. This type of underhanded bureaucratic invitation to coercion interferes with a woman's right to freely choose which available method of contraception, if any, suits her best.

It is important that such a bias is removed from the paperwork and that providers are trained to be more sensitive and respectful of women's decisions. There are many ways to educate women about the overall health benefits of contraception without pushing *only* sterilisation or *only* long term methods that may not suit their circumstances and generally end up scaring them away from birth control altogether. De-emphasising non-permanent methods is both misguided and hypocritical when the number of young women entering their reproductive years is growing so rapidly. It ignores a very fertile segment of the younger population that is probably not interested in long-term methods.

Turning to the Unqualified

If poor or uninformed women decide not to go to a legally approved place to get an abortion, their only other choice is to turn to untrained, and often unsafe, providers. These abortion providers levy fees based on the ability to pay, degree of guilt felt, and extent of secrecy desired. Sadly, after the anxiety and expense of choosing this alternative, women are often left with serious disabilities and sometimes suffer fatal consequences from incomplete or septic procedures. (For a view of the unsafe health care providers in rural Maharashtra, see Ashtekar's "Health Care in Bharat" in MANUSHI 92-93).

By seeking abortions from unqualified quacks and midwives, the vast majority of women effectively bypass the government's family planning system. It is not uncommon for illegal abortion providers to simply terminate a woman's pregnancy without attending to her other medical or family planning needs, leaving her with no accurate information, should she experience problems afterwards or if she should need a referral.

This lack of reliable information, and quality follow-up care, even when high quality contraceptives are

given, can have all sorts of long-term repercussions. For example, if a woman starts taking a birth control pill such as Mala- D and later gets a sexually transmitted disease (STD) from her husband, she may assumed that the symptoms are related to the pill and may therefore discontinue it. Within the next month, she may be pregnant again with an untreated infection that is not only painful but puts herself and her unborn child at great risk.

Involving Local Providers

As mentioned earlier, confidentiality and speed of services are two major priorities for most women who seek abortions. Local providers are preferred for several important reasons. First, they are familiar to community members, and second, they also distribute medicines for ordinary illnesses, so people are less likely to suspect the real reason for the visit. The main concern for most women is to get in and out of the clinic as quickly as possible, preferably the same day, before any neighbours or acquaintances find out and start spreading gossip. Never-ending domestic work and family responsibilities also make it hard for them to take out the required time for a safe abortion. Therefore, they tend to resort to trusted providers who have no formal training and use extremely high-risk methods without basic hygiene, such as the washing of hands or the use of sterile instruments.

This points to a glaring oversight on the part of the MTP Act: it is a law that excludes the unlicensed abortion providers to whom the majority of poor and rural women turn. The medicalisation of abortion has resulted in ignoring these providers rather than creating special programmes to train, supervise and hold accountable non-medically trained abortionists in order to improve their performance. There is a much slimmer chance for education and basic standards to reach them if they are engaged in an illegal, unlicensed activity. Furthermore, there is no incentive for them to change their techniques as long as they continue to make a good living and women are not aware of other viable options. Efforts of NGOs to train traditional birth attendants (TBAs) have met with mixed success. Further efforts to work with practicing midwives and untrained providers would be worthwhile as

these individuals will continue to carry out abortions. The main factor leading to complications is sepsis, an outcome that is avoidable with basic training, supervision, and careful maintenance of appropriate equipment. The behavior modification required to improve the techniques of the untrained is often relatively minor and, therefore, feasible.

Need for Accurate Data

Another obstacle impeding an improvement in the situation is the lack of accurate, area-specific data on abortion demand, abortion services, and related morbidity and mortality. A major contributory factor to this lack of information is that many doctors view the clumsily drafted reporting requirements of the MTP Act as harassing and burdensome. Consequently, data collected on the insignificant number of abortions dutifully reported on government forms simply gathers dust in government offices. Little use is made of such records except for some sporadic tabulations which are more likely to spread misinformation about the prevalence of abortions rather than give an accurate notion of social reality. This excessive red tape hardly encourages the medical professional to follow the letter and spirit of the law. Those who stop reporting drop quietly into the illegal sector regardless of how well their actual practices meet the standards of proper patient care, further contributing to the misleading data about which practitioners are legal, which ones are illegal, and the implications of this on women's safety and health.

Lack of Accountability

It is important to realize that it is not just unqualified doctors who endanger women's lives, rob them of their rights and charge them exorbitant fees. Dr Vijay Sharma (not his real name) explained how doctors use their power and status to ignore patients' rights:

"In some countries pregnancy related deaths are recorded and inquired into. Not in this country. Nobody wants it. The patients' families themselves do not want the embarrassment of an inquiry, let alone anyone else. Everybody wants to hush it up. So it is all forgotten. It boils down to the same thing. The patients are not organised; the doctors are. If, following an abortion, a woman doesn't get her periods or gets a severe infection, three doctors will join hands to convince a woman that it is due to her fate and fortune and not due to the complications of the surgery. Suppose she has vaginal discharge, pain, fever, backache, infertility, or suppose she even dies. No doctor is willing to stand up against another doctor in court and say, 'Yes, this was because of faulty or improperly sterilised instruments.' The curious thing about our profession is that only doctors can

say for sure that another doctor went wrong."

This type of malpractice is not blind to caste, class, and familial status, but strikes at each end of the socio-economic spectrum. When a poor, uneducated, or intimidated patient steps into a clinic or hospital, doctors recognise the power imbalance instantly. If, by chance, a doctor's negligence leads to a tragedy, they have nothing to fear. On the other hand, women from powerful and influential families who find themselves victims of abortion related malpractice are just as likely to be silenced by their own families, leaving the doctor to go unpunished.

While malpractice that results in bodily injury is the most serious concern, overcharging is a more common result of corruption. According to Dr Sharma, "the fee often depends on how much a doctor can legally and logically extract out of a patient without the patient making a hue and cry and running away to the competition. So what we call *shubh labh*, which is the logical, legal, justifiable fee, is open to discussion…" When a doctor decides on the fee, his/her next decision must be how much of that money is to be spent on the procedure and how much of it will be profit. As Dr. Sharma explains:

"In order to maximise their profits, people just start cutting corners. Instead of using disposable instruments, they start re-using instruments that are supposed to be disposable. Instead of doing an abortion in an operating theatre, they start doing these procedures in the back room of the clinic, where it is physically impossible to maintain sterility… "

The medical profession and the government need to deal squarely with the reality that with the exception of a certain number of upright doctors, the majority of doctors are ordinary, fallible human beings. Incentives to act in unethical ways are as strong as those that promote the ethical treatment of patients. Unless this fact is addressed directly it is possible that the profit motive will override all other concerns, including the integrity of women's bodies.

Things have deteriorated to such an extent that the poor are now choosing to circumvent "free" government facilities by paying unqualified doctors in a desperate attempt to get the services they need.

Profits and Corner Cutting

Even though there is a long standing tradition in India of providing food and medical care at no cost to the poor, things have deteriorated to such an extent that the poor are now choosing to circumvent "free" government facilities by paying unqualified doctors in a desperate attempt to get the services they need. Turning a blind eye to this situation reveals the false rhetoric of some policy makers who insist that the poor are well served by the existing laws and public health facilities.

While many private clinics in Delhi specialise in abortion, this fact is not openly admitted by most clinic operators. The common assumption among doctors is that anyone who performs a lot of abortions is probably in it only for the money. One private doctor in Lajpat Nagar told us that early term abortion is by far the most profitable obstetric procedure. Early term abortions only take about 15 minutes to perform. With the addition of pre- and post-abortion counseling, the procedure is still likely to be completed within the hour. Despite these facts, some doctors charge almost as much for an early term abortion as they do to perform a normal delivery, which requires round-the-clock care.

Market Failure

The puzzle remains: if this procedure is so profitable, and the demand for safe services is high, why hasn't there been a vast increase in the number of safe providers? In ordinary circumstances, an increase in reliable providers would create sufficient competition and lead to price-cutting, eventually settling on a reasonable market price for safe abortion services. None of this has happened. The market has failed in weeding out the unqualified providers and has also failed in regulating prices.

One likely explanation for this market failure is the lack of sufficient consumer awareness and access to

information. Ignorance about available options coupled with inadequate advertising of prices and procedures makes it difficult for consumers to make rational decisions that are in their best interest. The poor and the uneducated are at a particular disadvantage because their lack of time and low level of education make them more vulnerable to choosing providers who not only fleece them but who use dangerous techniques on them. Without more agreement about proper standards, both on the side of the consumers and on the side of the providers, normal market forces will fail to provide quality abortion services.

The challenge of establishing appropriate incentives and establishing a fair price for abortion services are areas that need to be considered in depth. Incentives must be set so both sides benefit. Doctors must be able to see for themselves that performing safely is profitable and women must realise how they benefit by avoiding the risk that comes with choosing unskilled providers. Our impression from interviewing doctors and women in several areas of Delhi is that safe early term abortions could be offered at a price competitive with what most poor urban families, are spending for dangerous abortions. Finally, one must determine what other factors besides safety and price will also encourage women to rule out potentially harmful providers and choose safe providers.

What Can be Done?

Clearly, the situation surrounding abortion requires considerable attention in order to transform the theoretical right to a safe abortion into a service that is truly available and safe. There is a need to initiate a campaign to:

➢ Raise public awareness of women's rights under the Act, including a major outreach effort to inform people where services are available and about which procedures are safer than others. Public service announcements on TV and radio, and information posted on bus stands or on billboards (targeted to both men and women) would be a logical first step.

➢ Work towards a more efficient distribution of resources in existing medical facilities to ensure adequate equipment, supplies, and staff.

➢ Remove or substantially reduce the extraneous paperwork that discourages proper reporting by medical providers.

➢ Develop incentives for doctors to get specific professional training in the least invasive and safest methods of conducting abortions.

➢ Work towards legal reform to change the clause in the MTP Act that insists that all legal providers must be registered medical practitioners. This would open up new possibilities for extensive training of health workers to conduct MVA under supervision.

➢ Work as advocates to make the public health system accountable to the millions of people for whom it is supposed to be designed, with a special consideration for the rights of the poor.

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