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Women and Abortion

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Women and their right to determine their sexuality, fertility and reproduction are consideration that have seldom, if ever, been taken into account in the formulation of policies related to abortion

THROUGH the broad sweep of history, women have practised various forms of birth control and abortion. These practices have generated intense moral, ethical, political and legal debates since abortion is not merely a medico-technical 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 con tested" [Petchesky R P, 1986: vii].

Women have demanded abortions but their access to services has been restricted by a number of social and legal hurdles. Far from being static, the norms governing the ethics of abortion have been modified from time to time and from one social context to the other. However, it is noteworthy that regardless of their (restrictive or permissive) orientations, abortion norms (and laws) have been directed, almost invariably, towards the fulfilment of extrinsic social needs. Women and their right to determine their sexuality, fertility and reproduction are considerations that have seldom, if ever, been takep into account. Further, in the formulation of policies related to abortion, it is the medical profession (andnot women's groups) that has played a vital role.

The Hippocratic oath, which provides the foundation of medical ethics, prohibits physicians from conducting abortions [MacKinney L C , 1952]. Given the medical profession's historical link with ancient Hippocratic physicians, it is not surprising that the first organised attack on abortion came from doctors. In its 1859 convention, the American Medical Association (A M A) demanded that the practice of abortion be outlawed. Interestingly, the church took a clear-cut position on this issue only one decade after the AM A passed its resolution: in 1869, the Apostolicae sedis Pius IX regarded abortion as a transgression of the faith and a ground for excommunication [Hurst J 1991]. In the US, the church and the medical profession joined forces and succeeded in getting abortions prohibited during the 1870s. This decree remained in force for one century till 1973 when the US Supreme Court initiated the process of liberalisation in the Roe vs Wade case. In the U K, the Abortion Act of 1967 liberalised abortion services up to 28 weeks of pregnancy. Still, the British Medical Association, cautions the doctor to "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' ' [D M A 1988:80]. As the process of liberalisation spread across various countries, international medical organisations were compelled to make their positions clear on the issue, In 1970, the World Medical Association conceded in its famous *Declaration of Oslo* that,' "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''.

Therefore, while the medical profession has been vehement about the criminalisation of abortion, its stand on the issue of liberalisation has been ridden with ambiguities. In either case, the profession has benefited: while the criminalisation of abortion helped it to eliminate competition from indigenous (female) practitioners in the 19th century, liberalisation only empowered it with greater legal and normative authority.

The liberalisation of abortion services in India took place in 1972 in relative isolation from the women's movement. Till then, the efforts of the movement were concentrated on subverting criminal law without politically articulating specific demands. This may partly (but not wholly) be attributed to the absence of a strong feminist current within the movement during the 1960s and early 1970s (for despite the growing strength of feminism during the last decade, abortion continues to be an issue receiving low priority). Secondly, anti-abortion votaries in India are not as belligerent or as strident as their counterparts elsewhere; as a result, feminists have not been driven to adopt abortion as a programmatic issue. Thirdly, the low priority may be engendered by the unawareness of the fact that legalisation has not actually been buttressed by safe and humane abortion services.

In many developed countries where the women's movement is pitted against powerful anti-abortion and anti-contraception movements that are systematically backed up by Christian orthodoxy and right-wing political forces, the issues of abortion and contraception have become important programmatic components. In some of these countries abortions are still criminalised. The instance of the pregnant 14-year old woman in Ireland who set off massive protests and an overruling of the legal order when she was legally prohibited from undergoing abortion in her country and abroad, highlights the context in which the priorities of the women's movement are shaped.

Still the gains of the movement have been transient even in those developed countries that have liberal laws. In the U S, the 1973 Supreme Court decision in the Roe vs Wade case resulted in the legalisation of abortion services. However, the court's 1989 decision in the Webster case signalled a retreat from Roe. The task of keeping vigilance after legalisation is, therefore, as important as the struggle for legalisation. 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 consider 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 G J 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. This is the reason why these feminists have begun to recognise the drawback inherent in treating abortion merely as a civil right and have linked it with the demand for reproductive freedom. In India, abortions were prohibited (unless medically indicated to save the pregnant women) till the Medical Termination of Pregnancy (MTP) Act was passed. Two shades of opinion were in evidence. At one end were proponents of family planning and population control who favoured liberalisation with a view to lowering the birth rate. At the other end were those who were concerned about the ill effects of abortions conducted by non-qualified, untrained and ill-equipped medical practitioners under unhygienic conditions. A quick examination of an annotated bibliography of abortion studies conducted in the 1960s and 1970s [Karkal M, 1970] reveals that the research agenda was geared up 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 were prompted to draw a link between

the two. In this context, themes such as liberalisation *vis-a-vis* its birth control potential as well as the possible implications of liberalisation on the social and cultural fabric began to appear. Thus, the two actors who persuaded policy-makers to liberalise abortions were demographers and doctors both being motivated by their own material interests and ideologies. In the mid-1960s, the government of India appointed a committee under the chairmanship of a medical professional Shantilal Shah. A report was submitted on December 30, 1966, and[1] in 1971, the MTP Act was passed by parliament. The MTP Act, as an opening paragraph states, was designed 'Ho 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 regulates medical practices in relation to abortion but does not even begin to provide women with the means to control their reproduction. The act, therefore, allows medical liberalisation to supersede medical criminalisation.

Secondly, the act confers a monopoly on medical opinion in matters related to the length and type of pregnancy. Accordingly, pregnancies up to 12 weeks necessitates the authorisation of one doctor while those between 12 to 20 weeks necessitate the opinions of two doctors. The act enjoins doctors to take' 'pregnant women's actual or reasonable foreseeable environment" into account. This would involve risk of injury to health. In this connection, a pregnancy following rape (marital rape not included) or failure of contraception (for married women) are specifically mentioned as indicators in two separate explanatory notes. Another clause refers to the possibility of the child suffering from "physical or mental abnormalities as to be seriously handicapped".

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 easily disqualifies her. She is required to furnish explanations that fit into the broad liberal—and yet, restrictive—conditions listed in the act This situation keeps the act open to differing interpretations. Ironically, the current preoccupation with population control and the somewhat dubious motivations of the medical profession have engendered 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 creates two major legal restrictions to the accessibility of abortion services. It stipulates that abortion can be legally induced only by a registered medical practitioner "who has such experience or training in gynaecology and obstetrics" and that it can be 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).

There is no dispute on the necessity of having properly trained medical personnel and well-equipped centres. With about 73 per cent of India's (mostly indigent) population living in rural areas, the provision of free and accessible health care is more than just an essential prerequisite for the maintenance and improvement in health status of the people (and especially of women who experience morbidity following abortions). However, the ground realities are quite different.

In 1988, there were 8,23,241 qualified doctors of all systems of medicine in India, 40.3 per cent of whom were trained in allopathy. The doctor-population ratio was 1:967. However, according to the 1981 Census, only 41 percent of all doctors (and only 27 per cent of all allopaths) were located in rural areas. Further, less than IS per cent of them worked in the government sector. In 1990, rural areas were provided with health care services by a network of 20,531 Primary Health Centres (PHC). Experience shows that most of these are ill-equipped to render even the most basic indoor medical care. Only some haye facilities for sterilisation operations and wards for post-operative sterilisation cases. Only 20,248 doctors were employed at all these PHCs defining a ratio of one doctor per PHC. On an average, a population of 40,334 was covered by each PHC in 1990. Further, only 31 per cent or all hospitals and 16 per cent of all hospital beds were found in rural areas [Jesani and Anantharam 1990].

An even more depressing picture of rural health services is conjured up by the ICMR Task Force Study (1991) which evaluated the quality of family welfare services at the PHC level during 1987-89. This was the largest study ever conducted spreading over 398 PHCs from 199 districts in 18 states and one union territory. They found that only 12 per cent of the PHCs (mostly in Maharashtra) subscribed to the norm of one PHC per 30,000 people. A "substantial shortage of Auxiliary Nurse Mid wives" at the PHCs and sub-centres was observed. "... the labour room and operation theatre which are essential infrastructures required for the delivery of good quality of family welfare services, were generally observed to be poorly equipped and maintained at the PHC level. Furthermore, the fact that majority of the PHCs was lacking in functional equipment and/or trained manpower to carry out pregnancy termination even after two decades of the MTP Act was a serious concern ... Approximately 40 per cent PHCs did not have any stock of oxygen readily available ... (there was) a total absence of records in one-third of the PHCs and grossly deficient in the remaining...".

One might be tempted to believe that private health services are more efficiently run than public health care. However, the information that comes to our notice does not paint a very rosy picture. Access to private sector health care is restricted by its high costs. In a survey of household health care expenditure in one district of Maharashtra, Duggal and Amin (1989) computed that as much as Rs 192 was spent per capita per annum, thus making private health care exorbitantly high for the indigent.

In spite of the health care services being dominated by the private sector, there is practically no regulation over it. The Medical Council more or less confines its role to the supervision of medical education and private nursing homes and hospitals are not always governed by regulatory mechanisms. Even if mechanisms for regulation do exist, this is often inadequate and suffer from a

TABLE 1 : LEGAL ABORTIONS

Year	Number of Approved Institutions	Per Cent Increase in the No of Institutions over the Previous Year	Number of MTPs Conducted	Per Cent Increase in the No of MTPs over the 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	5,82,156*	-0.5	93
Totals			63,88,06		

Source: *Family Welfare Year Book, 1988-89*, Government of India, New Delhi, 1990.
* Provisional figures

lack of will and intent. For instance, 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. Similarly' in Delhi, out of 545 private nursing homes (which is a gross underestimation), only 134 (i c, 25 per cent) are registered and according to the Health Ministry, over 20 per cent of them cannot be improved which means that they will have to be closed down [Raina 1992]. These woeful gaps in information have been matched, in the last few years, by stories in the local press about medical malpractice and negligence. If this is the condition in urban areas, one can only imagine the worst in rural areas.

Given this scenario, it is imperative for legal liberalisation of abortions to be buttressed by the adequate, safe and humane services. In the absence of the latter, liberalisation will have little real meaning for many of the pregnant women who seek abortions. The MTP Act fails to regard the right to access as a justiciable right. This, partly, accounts for the continuance of the practice of illegal abortions even 20 years after legalisation.

Table 1 presents the percentage increase in the number of approved MTP centres and the number of legal abortions conducted in them. It is apparent that while the number of approved institutions under the provisions of the Act tripled between 1976-77 and 1988-89, the number of MTPs conducted only doubled. The average number of MTPs per centre decreased from 130 to 93. Moreover, the percentage increase in the number of MTPs has been very poor in the last five years. If the average annual percentage increase in five-year periods is considered, we find that the increase in the number of MTPs was 8.9 per cent per annum between 1976-77 to 1980-81; 9.8 per cent per annum between 1980-81 and 1984-85 (a marginal increase) and a mere 0.2 per cent per annum between 1984-85 to 1988-89. 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. Thus, the tempo with which the first institutions were established after liberalisation has progressively waned. In absolute terms, having over 6,000 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.

As Table 2 shows, tlirec states—Uttar Pradesh, Maharashtra and Tamil Nadu—that contained 17 per cent of India's population in 1988-89 accounted for 47.4 per cent of the total number of MTPs and 34.1 per cent of the approved institutions. Maharashtra with only 4.8 per cent of India's population, boasted of 23.2 percent of all institutions in that year.

There was one approved institution for 1,34,095 people in 1986-87; one for 1,29,903 in 1987-88 and one for 1,29,123 in 1988-89. The statewise distribution of approved MTP institutions was relatively good in Maharashtra (one for 51,763) but worst in Uttar Pradesh (one for 3,09,723) which also accounted for the second highest number of MTPs (18.6 per cent) in 1988-89. In that year, two-thirds of all abortions performed were in the seven 'leading' states accounting for less than one-third population of the country. They also had half the number of approved institutions. These states accounted for two-thirds of all MTPs that have been done since April 1972. This is compounded by the overwhelmingly urban location of approved institution in all states. The argument that legalisation has not been adequately matched by the provision of legally approved services is further reinforced by the observation that the induced abortion rate (i e, the number of legal MTPs per 1,000 population) in 1989 was only 0.72.

Since data on illegal abortions is both unreliable and unavailable, 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* (popularly referred to as the Shantilal Shah Committee) calculated a figure of 3.9 million induced abortions all of which were illegal since they preceded legalisation. Goyal (1978) estimated the annual number to be four to six million. According to Malini Karkal (1991), in rural areas there are three illegal abortions performed for every legal one. She contends that this ratio in urban areas is 4-5:1. 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 for every legal abortion [ICMR 1989].

However, we feel that the calculations by Malini Karkal (1991) and the appraisals by the ICMR Task Force (1989) may, in fact, be underestimation. In order to arrive at a conservative estimate for the year 1989, we shall use the ratios calculated by the Shantilal Shah Committee. 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 percent), then in a population of 1,000 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 1989 population of 812.2 million and a birth rate of 31 per 1,000 in India, we had 8.8 million abortions of which 5.3 million were induced. This gives an abortion rate of 11 per 1,000 and an induced abortion rate of 6.5. Of the 5.3 million induced abortions in the country, only 0.58 million were legal and the rest, i e, 4.72 million were illegal. This gives us a ratio of eight illegal abortions for one legal abortion. Thus, not only are abortion services poorly developed, but their skewed distribution only serves to keep it beyond the reach of the women who seek it. This could be one explanation for the large numbers of illegal abortions.

CONCLUDING NOTE

The knowledge that liberalisation has neither resulted in a reduction in the magnitude of illegal abortions nor an improvement in women's health and the fact that it is tagged to the population programme, has bred a great deal of scepticism among some academicians. In a article 'Abortion Laws and Abortion Situation in India' (1991), Malini Karkal argues, "introduction of a liberal law in a country where women have little say in most matters and where there is no strong health education programme, can only defeat the purpose of defending women's right. And in a country where a national programme encouraging smaller families is in full force, one can only expect a rising number of abortions resulting in hazards to women's life''. Though her arguments are compelling, her scepticism is built on only a partial appraisal of facts. Through a presumed belief in the accessibil-

TABLE 2: STATEWISE ABORTION RATE AND INSTITUTIONS

States and Union Territories	Percentage Share of Population (1989)	Total Number of MTPs Conducted between 1972-89	Number of MTPs Conducted in 1988-89	Induced Abortion Rate (1989)	Number of Approved Institutions (1988-89)	Average Pop Coverage by Institution (1988-89)
Maharashtra	4.8	9,74,273 (15.3)	1,15,201 (19.1)	1.53	1459 (23.2)	51,763
Uttar Pradesh	8.7	11,89,900 (18.6)	1,06,135 (18.2)	0.80	425 (6.8)	3,09,723
Tamil Nadu	3.4	6,86,113 (10.7)	54,452 (9.4)	1.00	261 (4.1)	2,07,633
West Bengal	4.2	4,34,709 (6.8)	37,930 (6.5)	0.58	452 (7.2)	1,44,474
Madhya Pradesh	4.0	2,84,882 (4.5)	28,481 (4.9)	0.54	273 (4.3)	2,32,031
Orissa	1.9	2,37,599 (3.7)	25,998 (4.5)	0.85	161 (2.6)	1,89,340
Kerala	1.7	4,57,563 (7.2)	22,666 (3.9)	0.80	238 (3.8)	1,18,906
Other states	71.3	21,23,025 (33.2)	1,19,293 (32.9)	0.33	3022 (48.0)	1,19,820
Totals'	100.0	63,88,064 (100)	5,82,156 (100)	0.72	6291 (100)	1,29,123
[Population: 81,21,81,627]						

Note: Figures in parenthesis are percentages over vertical totals.
Source: *Family Welfare Year Book*, 1988-89, Government of India, 1990.

ity of abortion services (a natural consequence of liberalisation), she advances the hypothesis that women have increasingly been pushed into utilising these services. However, statistics reveal that legalisation has not significantly increased the rate of legal-induced abortions (refer to Table 1). Further, by doing away with legalised abortion services, can a given society reduce abortions and can that automatically improve women's health ? I Iistorical evidence demonstrates that it is not possible for the state, through its employment of technology or legal prohibitions or repression, to control women's bodies completely. 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]. Instead of evaluating the contribution that a liberal law makes to the health of women and the choices that they make, the discussion should turn to an appraisal of whether liberalisation has been supported by the provision of free, safe and, above all, humane health care (and abortion) services. Further, the social, economic and cultural aspects of the issue, which have a fundamental bearing on the position of women, should be inspected with great care.[1]

The dilemma expressed by the sceptic, in fact, highlights the limitations of treating abortions as a civil right for individual freedom and 'privacy'. Legality provides only a thin cover, a kind of political legitimacy that is necessary but not sufficient to change the material conditions of women's lives. There are two reasons why legalisation, as seen as a mere civil right, is not sufficient. 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 US. In India, sceptics have been juxtaposing the right of women to health care over their right to safe abortion services and have thus failed to appreciate that legalisation *per se* is not responsible for women's ill-health.

Secondly, a civil right to abortion does not amount to a social right carrying all the necessary enabling conditions that make it concretely realisable and universally avnil able. Further, a really safe abortion if possible only by embedding abortion services in the full range of social services—health care, pre-natal care, 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.

Further, abortion is not merely an issue of political and legal conflict but of social, caltural 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 is not the only answer to the issue at hand. One argument avers that, at the most, this could result in a partial or total shift in child rearing responsibilities from women to men and ease the material burdens of motherhood (through improved benefits and services). Petchesky (1986:16-17) 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.

In Hilda Scott's words (1974:190), "...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."

Notes

1 Analyses 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 any 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. In this context, it is significant that studies on abortion practices have been conducted, without exception, from the stand point of providers; policymakers and the stale 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, obviously, more feasible from the point of view of research. The research samples, therefore, arc not entirely representative given the fact that a majority of the approved institutions are in the private sector. Thirdly, despite the fact mat three-fourths of the population reside in rural areas, a majority of the studies have been conducted in urban areas. While it is true that MTP centres tend to be concentrated in urban areas, the relative neglect of the rural situation (where the out-migration of men in search of employment only complicates the condition of women), means that studies have adopted only a one-sided view of the subject at hand. Fourthly, the state of knowledge of abortion shows a great paucity of community or household studies which make it possible to include the women who utilise unregistered hospitals/institutions and 'illegal' providers. The only comprehensive community-based study conducted so far [ICMR 1989] looked into the aspect of 'Illegal Abortions in Rural Areas' in five states. The preponderance of medical studies on abortion has, more or less, precluded social science studies. While one does not expect to be inundated with social science studies, surely, it is not unreasonable to expect more studies from an inter-disciplinary perspective. However, these attempts are conspicuous by their absence. As a consequence, mere are some studies which view abortions in the context of state policies and the provision of services by the government. However, the qualitative aspects of abortion practices and the manner in which societal processes modify and redefine state policies are missed out completely.

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