# Urgent Concerns on Abortion Services

*While the Medical Termination of Pregnancy Act (MTP Act) has existed for 33 years, certified and legal abortion facilities account for only a quarter of all such private facilities in the country. Neither the public nor private abortion services have fully measured up to the needs of the abortion seekers.*

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For many decades now maternal health has been recognised as a crucial area of concern. Access, safety and legality issues regarding abortion and abortion services in India have assumed serious dimension in the context of women's reproductive health needs. The Abortion Assessment Project-India (AAP-I), an all-India research study that commenced in August 2000, was initiated with the objective of assessing ground realities through rigorous research.

Facility surveys in six states, household based surveys in two states, nine qualitative studies in seven states, a policy review and nine working papers undertaken in this project highlight the inadequate attention given to abortion within the health and population policy of the country and reiterates the often voiced concern that even the recent reproductive and child health programmes have failed to address.

Abortion facilities mapped in six states (Kerala, Madhya Pradesh, Orissa, Rajasthan, Haryana and Mizoram) reveal that there are four formal (medically qualified though not necessarily certified/ registered to provide abortions) abortion facilities per 1,00,000 population in India. This adds up to 40,000 facilities or 48,000 providers (each facility averages 1.2 providers). Of the formal abortion providers 55 per cent are gynaecologists and 64 per cent have at least one female provider, with each facility performing 120 abortions per year on the average. This adds up to 4.8 million, with one-third being conducted in public facilities. There are more or less similar numbers of informal (traditional and medically non-qualified) abortion providers handling about one-third of cases handled by formal providers. Based on these studies our estimate is that about 6.4 million abortions are performed annually in India.

While the Medical Termination of Pregnancy Act (MTP Act) has been around for 33 years, certified and legal abortion facilities account for only 24 per cent of all private abortion facilities in the country. The 380 facilities (285 private) across the six states covered in the study provide evidence that those who were certified had obtained certification on an average within a month and of those who were not certified, 68 per cent had not even attempted to obtain certification. Thus the problem lies largely in the domain of the medical professionals who have not shown interest in registration, probably because they do not want to be accountable to the authorities. This is when two-thirds of the providers in the non-certified facilities had the requisite training or qualification as per MTP Act to conduct abortions; thus a majority of uncertified facilities are perhaps providing safe abortions. The latter was confirmed by the fact that with regard to technical aspects and infrastructure facilities the difference between the certified and non-certified facilities was small. Lack of ethics in medical practice and absence of self-regulation amongst the profession is largely responsible for the present state of affairs – including the proliferation of sex selective abortion.

Our studies also found that 73 per cent of abortions were conducted for less than 12 weeks gestation. Dilatation and curettage (D and C) seems to be the preferred method for nearly 89 per cent of induced abortions. Even amongst those who use vacuum aspiration the practice of check curettage is very common. This obsession with curettage both adds to the cost of the procedure and contributes substantially to post-abortion complications and infections.

While physical access seems to be reasonably good, social access remains restricted since providers, especially in the formal and certified facilities, do not provide services to women if they come alone and/or if the spouse or some close relative does not give consent. In the household and qualitative studies women said that the decision for undergoing an abortion is rarely their own; more often than not their spouse or some relative decides for them. This affects the woman's freedom to access such services. So, to protect her confidentiality and privacy she may often resort to providers who may not be very safe. As regards reasons for seeking induced abortions, only 15 per cent of them fall into what is permitted under the MTP Act (failure of contraceptives, threat to the woman's life, biological reasons), the rest were unwanted pregnancy, economic reasons and even unwanted sex of the foetus. The household based household surveys in Maharashtra and Tamil Nadu, qualitative studies and working papers all indicate the prevalence of the practice of sex-determination and female-selective abortions.

Public investment in abortion services is grossly inadequate. Only 25 cent of abortion facilities in the formal sector are public facilities, and 87 per cent of the abortion market is controlled by the private sector; the average (median) cost of seeking abortion in the private sector is Rs 1,294, which is 7.5 times more than the cost in public facilities. This constitutes a major barrier for women from poorer or other disadvantaged social groups. The household studies under this project reveal that women from poorer classes and from dalit and adivasis communities have significantly lower rates of induced abortion because they often do not have the purchasing power to access abortion services from the private sector or travel long distances to access public services. This makes a strong case for both strengthening as well as expanding public abortion facilities across the country.

The eight qualitative studies revealed that the overwhelming reason for seeking abortion among married women was to limit the family size. When women were asked to indicate the situations in which they would seek abortion or had actually sought abortion, the majority of the women in studies conducted in Maharashtra, Gujarat, Andhra Pradesh and Tamil Nadu reported limiting the family size as the

main reason for abortion. Equally disturbing was the finding that non-use of contraception rather than contraceptive failure was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. Actual contraceptive failure was reported in very few cases. Though all respondents across studies reported knowledge of sterilisation as a method of limiting family size and a majority of the women knew about the reversible methods of contraception such as condoms, oral pills and IUD for spacing births, yet this knowledge did not translate into practice for a range of reasons – fear about its effect on health, pain and discomfort, irregular supply and problems with obtaining permission from husband. Use of condoms for contraception was rare. Paradoxically, there was a perception that abortion was safe and did not have any long-term adverse health consequences. For some respondents it was seen as a 'safer' option than the use of IUDs and other spacing methods!

Also, almost all women were aware that sex selective abortion was illegal, and admitted that women approach different facilities for ascertaining the sex of the foetus and for abortion. Awareness of the new PNDT Act was far greater among women and service providers in comparison to the details of the MTP Act. Group discussions invariably turned spirited when sex selection was discussed. While most respondents admitted that sex selective abortion is indeed illegal, they expressed helplessness as their status in the family and sometimes the very survival of their marriage depended on their ability to produce sons. The studies also revealed that when couples have more than two female children, then female selective abortion was approved by the family and condoned by the community. There was no social stigma associated with sex selective abortion – especially for mothers with many daughters. Women from Gujarat and Haryana also reported that while they were not comfortable with abortion per se, when it was done for the sake of the family, then they accepted it.

There was an overwhelming perception that private facilities were better. The reason for preferring private providers was quite wide, suggesting that the women and their families do weigh the alternatives before deciding where to go. Reasons cited by women were:

– Abortion in private facility takes much less time – everything is done in one visit, meaning that they do not waste time waiting and going through formalities (as most government hospitals are not client-friendly) and that everything could be wrapped up in one visit.

– Private doctors have better facilities and equipment and that they are not in a hurry to discharge women soon after the procedure if they need rest for an hour or so before going home. In public hospitals, on the other hand, given a shortage of beds women are asked to leave as soon as possible.

– Private doctors treat women with dignity and ensure confidentiality.

It was accepted that while private providers are expensive, visits to the government hospitals were not cost-free because women had to pay for medicines separately. They were sometimes required to make repeat visits before the abortion was performed. The long waiting period implied that the time of the service seeker and of the accompanying person (generally women do not go alone to impersonal large facilities) was wasted, leading particularly in poor families forgoing wages for that time. The cost varied according to the type of provider and the gestation period. For example, the cost in private facilities in urban Gujarat varied between Rs 400-600, similar to what women in urban Andhra Pradesh had to pay.

In a two-day National Consultation with experts working on reproductive health issues across the country, held in Delhi in November 2003, the following issues were flagged as needing urgent attention:

– Changing the mindset of providers through their professional associations to accept certification on a universal basis.

– Integrating abortion services under primary health centres and community health centres through a strengthened RCH programme – which would automatically enhance women's access to abortion care services.

– Promoting safer technologies by changing the mindset of providers away from unnecessary use of curettage.

– Strengthening regulation of abortion facilities to evolve minimum standards for quality care and accreditation.

– Promoting safe spacing methods of contraception to reduce the need to resort to abortion as a spacing method.

– Broadening the base of providers by training paramedics for early trimester abortions as is done in many countries like South Africa, Bangladesh, etc.

– The need to widely display certification status of abortion facilities so that women can recognise a safe abortion facility.

– The need to educate providers on ethics of sex-determination tests and respecting the provisions of the PNDT Act.

– The need for medical associations to get active in training abortion providers, especially those in the private sector.

– Promoting apprenticeship as a method of training

– Reskilling of traditional providers to play alternative roles like accompanying/supporting abortion seekers to safe abortion facilities.

To conclude, the various studies undertaken under the aegis of AAP-India project clearly indicate that neither the public nor private abortion services have fully measured up to the needs of the abortion seekers. While private providers need to be regulated and made accountable to the law as well as educated about safer technologies for improvement of both safety and quality of abortion services, the public sector needs to extend its presence, especially in rural areas, as well as strengthen the provision and quality of existing services to measure up to the satisfaction of abortion seekers. The RCH second phase being planned currently needs to factor the issues flagged above in their strategy if reproductive health and healthcare are to improve in India. EPW