ABORTION NEEDS OF WOMEN IN INDIA:A CASE STUDY OF RURAL MAHARASHTRA

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The Indian Medical Termination of Pregnancy (MTP) Act came into force in 1972, in response to the high mortality and morbidity associated with illegal abortion. However, 25 years on, both restrictions in the law and the way it is implemented through service delivery have failed to meet the abortion needs of large numbers of women. Using data from a larger qualitative study in rural Maharashtra, this paper explores women's perceptions of their rights and needs in relation to abortion. The women were ambivalent about abortion, based on their roles and identity as mother, but they saw the necessity for abortion and supported each other to have abortions. They had conflicting feelings with regard to abortion on grounds of fetal sex, and problematic issues of sexuality, especially for single women in relation to abortion, also rose. Provided with the details of India's abortion legislation, which they knew little about, the women had suggestions for making the law more women-sensitive. Their experiences make it clear that vast improvements in abortion policy and service delivery are needed in India.

Pompted by the widespread problem of unsafe abortion endangering the health and life of women, the Government of India set up a Committee in 1966 to examine abortion legislation. The Committee recommended the liberalisation of the Indian Penal Code of 1860, which treated abortion as a criminal offence, to permit abortion under medical supervision. In 1971, the Medical Termination of Pregnancy (MTP) Act was passed by the Indian Parliament and came into force in 1972.

The Act allows the termination of a pregnancy by a registered medical practitioner with experience and training in obstetrics-gynaecology, and training in performing induced abortions from either a government hospital or institution, or at a training centre approved by the government. The Act permits abortion if the doctor believes in good faith that '…. the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped'. The Act also permits abortion on grounds of rape or contraceptive failure.

Various concerns about the implications of the MTP Act have been voiced, for example, that it may contribute to the exploitation of women's sexuality under patriarchy, even by progressive women [1.2]. Unlike in many countries, the liberalisation of the law was not driven by the women's movement in India, which was not well established at the time, but by the government. There have also been concerns that the MTP Act was meant as a tool for population control. The report of the 1966 Committee refers to this possibility[3], and at the time the focus of family planning, introduced in 1951-56, had shifted from the welfare of the family to reduction of the birth rate.

It would appear that women's right to control their sexuality, fertility and reproduction were not the basis on which the Act was formulated or interpreted. Rather women are required to fit the categories in the Act: single women have to say pregnancy resulted from rape, while married women must blame failure of contraception, since only a doctor can decide if there is a risk of physical or mental injury to health.

The situation is rendered even more complex as a consequence of the widespread practice of sex-selective abortion of female fetuses in India. Opinion among feminists and health advocates is divided as to whether it would be appropriate to restrict the availability of abortion following a sex determination test[4].

The ideology of male control sometimes governs the issue of abortion. For example, a High Court in the state of Punjab allowed a man to divorce his wife on grounds of cruelty because she underwent an abortion twice against his wishes[5]. Furthermore, the public health services may ask for a husband's signature of consent to an abortion, which is not required under the Act.

There is a skewed concentration of MTP centres in the cities, in spite of the fact that 74 percent of the Indian people still live in villages[6]. The public health services provide abortion free, but put pressure on women to adopt a contraceptive method after the abortion. On the other hand, the private sector provides abortion at a cost. Often, women are charged unreasonably, especially if the abortion is 'illegal', i.e. outside the provisions of the Act. Women, caught in a web of shame and secrecy, are also unable to demand good quality care in the existing abortion services, either in the private or the public sector[7]. As a consequence of these barriers to accessing either type of

service, abortion complications contributed to as high as 12 percent of maternal deaths in India in 1991[8].

The skills of local abortionists have been totally ignored or criminalised, in spite of the fact that they are more accessible and affordable for women. Safety is a highly-debated issue in such abortions and it may be worthwhile, to consider some formal training in menstrual regulation for them, as licensed practitioners are not easily available in remote villages.

Most studies of abortion in India have been hospital-based and conducted mainly from the standpoint of providers, policymakers and the state[9]. Quantitative surveys have helped draw attention to the high prevalence of illegal abortion in India. Yet women's abortion needs and what they feel and want with respect to abortion services, their knowledge of the law and their perceptions about women's rights in relation to abortion have remained largely unexplored.

This paper presents some of the findings of a qualitative study in rural Maharashtra in India, whose aim was to explore these issues and understand women's perceptions and needs regarding abortion.

METHODOLOGY

Six villages in Pune district, Maharashtra State, were selected from among the villages we have worked with over the past eight years. Selection was on the basis of access to health services: three villages have relatively good access and three have poor access to any health facility. Population size ranging from 1500 to 3500 people, and ease of access by road to neighbouring towns, were also considerations.

Interviews were carried out with 67 women who had participated in eight focus group discussions during monthly meetings, over a period of eight months. These discussions covered topics such as women's reproductive health problems, abortion needs, and perceptions and expectations of health services. Women with and without a current, steady sexual partner from among various caste, class and age groups were included. The majority were 20-40 years of age, ranging from ages 17 to 60.

The semi-structured interview schedule was based on data obtained from these discussions, and covered perceptions of abortion and whether it is a right of women irrespective of age and marital

status; selective abortion of female fetuses and those at risk of serious anomaly; knowledge of the MTP Act; what kind of abortion law they would formulate; and access to and experiences of abortion in the public and private health sector. Through this process, the women revealed their fears, opinions, grievances and aspirations. Representative examples of their views are presented here. Care was taken to preserve the idiom of women's language during translation.

Local people acted as contact and support persons for the study as well as serving on an ethics committee for the study to examine our methodology and interactions with respondents. Informed consent was obtained from all the women participating, and they has the option to leave the study at any point. The information collected, as well as the preliminary analysis of findings, have been (and are being) presented to them for their comments and corrections.[10]

ABORTION AS A WOMAN'S RIGHT

The majority of women-a resounding 70 percent – supported abortion as a woman's right over her body and her right to control her fertility, and said that it was not just a means to help her avoid loss of face. While a quarter of the women did not think abortion should become a woman's right, most of them did support abortion as a face-saving solution for women.

If I'm a widow, then abortion can help me save face. Within marriage you have the choice to keep it or drop [abort] it.

It should be available at least in dificult moments. The law shouldn't make things difficult ....

When husbands refuse [women] sterilisation, it is good to have abortion as a right for women.

Most of the women felt that abortions were especially needed by women who become pregnant outside marriage, without having to make false claims that the pregnancy resulted from rape. All but four of 67 women said that widows, divorcees and deserted women should be permitted to have abortions by law. The four who did not mainly intended to challenge the double standard of morality for men and women. They believed that every woman, irrespective of her marital status, had the right to continue a pregnancy to term.

Of course they will have to! It's the woman's virtue that will be mud, not the man's. As if the man loses his virtue!

Naturally she will have to drop the thing. People will ask her how she got pregnant even when her husband is dead. The whole village will be croaking with gossip. Won't the child ask embarrassing questions later on ?

Similarly, 90 percent of the women said that unmarried girls should abort their pregnancies, while the rest felt that continuing the pregnancy might lead to a marriage. However, most of the women were cynical about this sentiment.

It is better to have an abortion because she has to get married later on. Her whole life will change if no one marries her.

Even if she marries the same boy, she should first drop the thing. Her in-laws might start wondering about the child's paternity.

Interestingly, contraceptive failure did not get overwhelming support as a reason for abortion. When asked whether women should undergo abortions if there was a failure of sterilisation, 33 percent said yes, 42 percent said no, and 25 percent cent said the decision would depend on the situation of the woman concerned. As regards failure of reversible methods of contraception, 40 percent thought abortion was justified, 48 percent were against it, and 12 percent said it depended on the situation.

If the husband is sterilised and he is a suspicious man, then she will have to abort it. If it is her own sterilisation that failed, then she may keep it, because her husband will trust that it's his own.

Since she got sterilised because she didn't want any more children, she should abort it.

Mistakes happen. Let it be born. Why torture a woman's body with abortion? It costs money, too.

Seventy-five percent of the women believed that abortion was different and more difficult than delivery.

Is there no difference between squeezing the pulp out of a ripe mango and a raw mango?

Delivery was a natural process whereas an induced abortion was an artificial way of ending a pregnancy. Unlike delivery, which takes place at home without doctors or medicines, abortion

was seen to involve medical intervention. Some said that post-abortion weakness was more severe than post-delivery weakness, and the fact that women hardly get any chance to recuperate after an abortion does not help either.

SELECTIVE ABORTION FOR FEMALE SEX

Strong sex preference exists in India and modern technology is utilised for prenatal sex determination, after which almost exclusively female fetuses are aborted. The law that prohibits testing for fetal sex is a direct result of a decade long campaign conducted by women's groups all over India. In Maharashtra, sex determination tests have been banned by law since January 1988. However, women continue to have abortions after prenatal sex determination tests even today.

Most of those in the study (73 percent) were aware of ultrasonography (39 women) and/or amniocentesis (10 women) as a method of sex determination.

It's a TV. Only doctors can understand what they see.

They take out water from the fetus and check it.

Forty-five percent approved of abortion of female fetuses following prenatal sex determination, whereas 55 percent did not approve. Of those who did approve, 27 of the 30 women said the main reason was to 'hasten the birth of a son'. Economic reasons were given by eight women, while dowry was mentioned by five and reduction of population by five others. Fear of domestic violence and social pressure were mentioned by two women and saving a woman from repeated deliveries by one.

Not right, but what can people do? No rains, drought! Girls cost their parents so much money. Boys are cheaper to bring up. You have to keep dropping girls until you get a boy.

On the one hand, it's wrong. If the couple is educated, they sometimes get operated on [sterilised] after two daughters. But if the husband or his family want a son, then even the educated wife fears that her husband will remarry as soon as she gets sterilised. So she undergoes the test under pressure. In this case, one can't say that she is wrongs.

People do it. It may be right or wrong. I may feel terribly against it. But what can I do if my husband insists?

Those who were against it said:
It's not right. Let whatever it is be born. Why should we commit a sin? Daughters and sons come from the same source, don't they?

Why should one cause destruction? Maybe there's an Indira Gandhi in there, who knows! Out to destroy even before we can find out for ourselves! A millionaire's son can also become a drunkard and squander the wealth away. Let whatever there is be born.

A girl has the right to be born.
What did they think would be the consequences if more and more couples selectively aborted female fetuses?

Each girl will have to marry two or three men.

Girls will lose all value, they will become trash. Women have at least some respect today.

ABORTION ON GROUNDS OF FETAL ANOMALY

Only four women were that ultrasonography and amniocentesis were intended for the detection of congenital anomaly. Sixty-seven percent approved of abortions in these cases while 25 percent did not; the rest said it depended on the social situation of the pregnant woman.
Why nurture such a thing? Who wants to bear a lame-blind thing. So much trouble to raise it, and it still won't understand anything. Why bring it forth? Is it of any use? Better to reduce their numbers.

We should keep him. Later on we can fix artificial limbs. We can increase his intelligence too. If he can't think, at least he can work in the fields. As if we are going to get him married, so let him be! If it's a disabled girl, we shouldn't let her be born. When we get her married, she'll devastate someone else's household.

We shouldn't drop it. Only see if treatment is possible. If all children born to us are disabled, are we going to abort all of them? Why should we abuse and destroy our bodies with our own hands?

THE LAW ON ABORTION

Only 18 percent of the 67 women knew that abortion was legal in India while 64 percent said abortion was not legal and 16 percent were not sure. Only one woman knew that abortion was allowed but not on grounds of fetal sex determination.

Even those who knew abortion was legal had inadequate, and at times incorrect, information about the contents of the law. The eligibility for abortion and the time limits within which it is permitted were not well known. Nine of the women believed (incorrectly) that the law required the service provider to obtain the husband's consent for the abortion.

What kind of abortion law would the women like to have? Of the 55 women who thought abortion was not legal, just over half did not think abortion should be legalised, three could not make up their minds and 22 felt there should be a law permitting abortion.

Those who did not support the legalisation of abortion had many reasons for their disapproval, ranging from the belief that abortion constitutes murder and that selective abortion would increase, to a concern for women's health. A few thought that women would become promiscuous, that abortion could lead to sterility or that it could hamper population growth.

The most important reason why those who supported legal abortion did so was as a means of protecting women from the stigma attached to abortion. They also wanted abortion to be available to enable women to space their pregnancies and to avoid deterioration of their health from repeated and unwanted pregnancies and births.

All but one of the 20 women who described the abortion law they would like to have said that abortion should be permitted up to the fourth or at most the fifth month of gestation. After that, they were concerned about the increased risk to the woman, increased pain with a later abortion, increased cost, and the fact that once the pregnancy was visible social stigma would not be prevented and this would defeat the very purpose of the abortion. In addition, they felt that the fetus gains life in the latter part of pregnancy, and that it may not be morally correct to have an abortion once movement can be felt.

Almost all women who favoured legalisation felt that doctors, especially lady doctors (women gynaecologists), should be performing the procedure. Hospital-based abortions provided legally was their first choice.

Opinion was divided on whether the husband's approval should be required, with 13 for approval and 9 against it. The former felt that this would make the husband feel more responsible for his wife's health, encourage mutual consent, avoid domestic conflict and keep women's sexuality under some control. Those who categorically opposed the need for the husband's signature said that often the husband is not available at the time of the abortion, that men were likely to seduce or cheat a woman and then deny paternity, and because abortion should solely be a woman's decision. They expressed frustration that doctors' insistence on a husband's written approval reduced women to begging their husbands to sign and grant permission for them to have an abortion.

We described the contents of the MTP Act to all the women, and asked them to suggest any modifications and recommendations to it. However, it was our impression that the women felt overwhelmed by the legalities and the complexity of the Act and inadequate to reply to most of our questions.

Sixty-nine percent of the women felt that abortions should be legally available at any time and under all circumstances, whereas 16 percent said that abortion should be allowed only under specific conditions. Suggestions for modifications in the present law included extension of the legal period for abortion from three months to four and making legal all abortions for extramarital pregnancies. One woman said that the law should make abortions following sex determination legal.

EXPERIENCES WITH ABORTION SERVICES

Though very few women knew about the MTP Act or whether abortion was legal in India, most knew that abortions were routinely provided by doctors in government hospitals and by private practitioners, as well as by local village abortionists. Most said that abortions were usually provided in 'big hospitals', whether private or public.

Most women did not know how to describe the abortion procedure. Of the rest, induction of labour was most frequently mentioned, followed by D & C, which was referred to as 'washing the

bag' or 'emptying the bag'. Most did not know how long these procedures took but three hours was the guess of many of them and a few thought up to 24 hours or more.

A few woman also mentioned local methods, such as inserting the roots of certain plants, still wet with sap, inside the cervix. In their perception, the root eventually 'comes out with the whole thing', which may take between a few hours to a day or more. Many women, however, said that abortions were no longer conducted in their villages.

Almost half the women thought abortions were performed up to five months of pregnancy in public hospitals, 11 said only during the first trimester, while six women said that even third trimester abortions were available in public hospitals. About a third (20) did not know. Fourteen women said that private hospitals performed third trimester abortions too.

Half the women did not know how much an abortion cost. Among those who responded, most said the cost ranged from Rs 100 to Rs 1200, but some mentioned amounts as high as Rs 5000 (especially after sex determination). Costs were higher when the procedure had to be conducted in utmost secrecy-usually involving an unmarried girl. Doctors sometimes charged according to the number of months pregnant, i.e. the more advanced the pregnancy the more the abortion cost.

A husband's signature is considered a means of guaranteeing legal immunity for the doctors. Thirty-seven women reported that, in their experience, doctors providing abortions had insisted on the husband's permission prior to the procedure, and 28 of them said that this was true in both the public and private sector hospitals. In the case of abortions performed by village abortionists, 13 women said that the abortionist and the woman having the abortion take the responsibility themselves.

INCREASING WOMEN'S ACCESS TO ABORTION SERVICES

The women identified a number of constraints against getting a legal abortion, even if the woman knew what was permitted under the law. The two most important reasons were when the pregnancy was outside marriage and when abortion was being used for birth spacing.

Often, Indian women are unable to use a contraceptive because of family pressure. Abortion therefore becomes a means of birth control until the woman has a sterilisation. On the other hand, pressure to accept sterilisation or provider-controlled and long-acting contraceptives after an

abortion also reduces women's willingness to use the free services that the state offers. In Maharashtra, another very important reason is that abortion following a sex determination test is illegal. Women who seek abortion on grounds of fetal sex would therefore tend to look for a private practitioner, because the abortion would not fall within the purview of the MTP Act.

Fifty-four women felt that more women would utilise public services for abortion if they knew about the Act. An equal number believed that women's access to abortion services would greatly increase if services were available at the village level. On the other hand, 11 women pointed out that those who would like to preserve confidentiality would not make use of services in their own village.

Even if you go outside the village for reasons of confidentiality, people do get to know anyway. If women started getting abortions in the village it might actually reduce the number of unwanted pregnancies. Men would be frightened that their names would become public if the women openly aborted the pregnancy in the village.

Women would benefit, though a lot of them, especially the widows and deserted women, might not be able to use the facility. They would have to go to distant places where they were not recognised. People would have to trust the quality of services in the local facility before they started using it. It would save a lot of travel expenses.

Nobody would use the facility, not even married women. In the village you have to behave with decorum. Even drunkards hesitate to walk in front of the village temple. Then how could women abort in the village itself? Most would go out [of the village] to hide the abortion from family members.

Two-thirds of the women interviewed thought abortion services should be made available exclusively through public health facilities, while a quarter thought both public and private services would be better; only six women expressed a preference exclusively for private sector facilities.

A good clinic is must. They shouldn't speak obscenely to a pregnant woman when she goes there. At our PHC [Primary Health Centre] they say horrible things to women during delivery.

It should be available in both places [public and private]. In private practice they charge too much and in the public services they ask you to come back so many times. They ask for the husband's signature and they force you to put in a Copper-T. A woman cannot afford to wait because her pregnancy advances by the day. Quick service is available in private practice. The poor go to the public services. The rich throw money around and get attention in a private hospital; who cares if the poor live or die?

DISCUSSION

The women we interviewed in this study had much to say on the subject of abortion, some of it contradictory. For example, at one moment they said that abortion should not be legalised or that the husband's consent should be sought, and at another moment that abortion should be woman's right. This is easily explained.

In the focus groups, the women tended to provide 'morally or socially correct' answers as far as possible. Yet if a woman is faced with the possibility that an abortion may not be allowed for social or legal reasons, she begins to speak more assertively in favour of abortion. Knowing that the husband may not always give his signature willingly, a woman says that she would like to have the abortion 'as a right'.

Even though women see a number of abortions being performed for the sake of family honour, especially in the case of single women, they also know that as cohabiting women, many a time they or their friends have had abortions without their in-laws 'or husbands' knowledge. Depending entirely on family support to get an abortion is a tricky affair. Even when a natal family 'helps' an unmarried daughter to have an abortion, the girl faces violence, humiliation and rejection. Family honour may come as a support to women, but at a terrible cost. For a married woman, on the other hand, family interference may well work against her when she needs an abortion. Thus, the issue of 'rights' emerges where saving face for the household is not the driving force in seeking an abortion.

Women are often confronted on the one hand with a family that may not allow them to exercise birth control, and on the other hand with government services pushing contraceptives. Whereas they are frightened of the family, they are suspicious of the health services. It is in this context that women want the right to abortion. While they are uneasy with the legalisation of abortion (as

though they are frightened of their own feelings and sexuality), they also know that they and perhaps their daughters may need to undergo an abortion at some point in their lives.

Contempt for extra-marital relationships and a fear of women's sexuality also featured in their responses and the uneasiness of purposely ending a pregnancy through abortion. The fact that one has destroyed an embryo/fetus was distressing to some of the women, especially as pregnancy and motherhood are cherished goals. Aborting one pregnancy often does not mean that a woman's reproductive responsibility is reduced: it may merely be postpones to a later date. In the case of abortions after sex determination, the load may actually be increases because a woman may have to undergo repeated abortions until she bears the requisite number of sons for the family.

Abortions often fill the gap in time between the decision to undergo sterilisation and the actual operation. This happens especially if the youngest child is a son and the family are not ready to risk a permanent method for a couple of years until the son's survival is more assured.

There was considerable ambiguity in the women's approach to the question of fetal sex determination and an abortion following the test when the fetus is female. Although 45 percent of the women said they approved of the test, we could also see the helplessness and the fear of violence and bigamy, which added to the expressed desire/need to bear a son at any cost. The 'unwantedness' of pregnancies that would bring a girl child into the world are contextualised by many of the women's feelings against bringing children with physical or mental handicap into the world. The discomforting eugenic feelings of not wanting disabled children are related to the sexism of not wanting daughters- in both cases, the children are expensive to bring up, they need more supervision and attention, they bring stigma and shame, and they are not 'useful' to the family.

Confronted with the chilling fact that she is herself dispensable in her husband's household, a woman feels she has no choice if she is expected to go through a sex determination test. However, the women in this study were more articulate in expressing their reasons for opposing testing for fetal sex as compared to their uneasiness about abortion. The women in our larger study sample who had an abortion after a sex determination test were traumatised compared to those who had an abortion for other reasons. When asked about their feelings after abortion and whether they would undergo it again if required (or suggest it as a possibility to other women), all

the women who had undergone abortions because they were carrying female fetuses categorically said that they would never repeat the experience, whereas the others said that they would approach abortion more positively and would have no qualms in helping other women to access an abortion too. [11]

It would therefore be wise to differentiate between the 'right to have an abortion' that the women in this study speak about from the right the women's movement articulates. The women we interviewed approached the issue of abortion tentatively, with some guild and as something that is necessary to bail them out of a no-choice situation. For them, abortion is neither desirable nor dispensable. They speak about the personal reality of abortion, whereas the women's movement articulates women's human and political rights. Each position complements the other.

Women's needs and aspirations are at cross purposes with the MTP Act in many ways. The Act is far from accommodating women's abortion needs; rather, women have to disguise their needs to fit within the conditions of the Act. Hence, many of their abortions are rendered technically illegal. For example, if a woman says she needs an abortion because of failure of contraception, she can hardly resist if a doctor insists that she must now use a so-called foolproof contraceptive method. Nor can she argue that she is capable of handling her contraceptive needs effectively. Hence, she is more vulnerable to the already existing pressures to use a permanent or long-acting method. In the Indian context, where women have limited access to good quality primary health and reproductive health care and where the state has a strong bias in favour of population control, their bargaining power while accessing abortion-services is significantly lowered, in spite of their own need for abortion and safe contraceptives.

There is also very little space for a woman to acknowledge her sexuality overtly when she needs an abortion, especially if she is single. Either she has to say that pregnancy is a 'husband's' or that the pregnancy resulted from coercion or rape. Being forced to tell lies-in addition to being seen as 'immoral' and 'heart-less' -makes women feel even worse than they already do about having an unwanted pregnancy. All this turmoil occurs at a time when a woman needs care, support and reassurance. Instead, the law, the biases of health professionals as well as socio-cultural norms act against her.

In addition, a woman is distinctly disadvantaged when a doctor insists upon the husband's signature at the time of abortion. Husbands are sometimes away or absent for long periods of

time. Requiring a husband's signature may ensure legal immunity for doctors, but it also reflects the patriarchal values of Indian society. Children belong to the husband; hence, a woman must get his permission to abort a pregnancy. The rights of the father overrule the rights of the woman to regulate her fertility. On the other hand, if a man denies paternity, neither a single or even a married woman can get an abortion unconditionally. Some of the women in our study said their husbands would not practice contraception themselves, nor allow their wives to do so. The women undergo repeated abortions as a consequence, while the husbands say the pregnancies must be illegitimate.

These problems point to important ethical considerations related to the decision to have an abortion, which are rarely taken into account, eg. that sex should be safe and non-coercive, that men should take responsibility if they contribute to starting a pregnancy, and that women and their offspring should have recognised legal rights.

Whereas women feel able to express their demands for quality of care in general health care, they are willing to trade off quality of care for their single-most overriding concern when it comes to abortion-confidentiality. Women tended to accept poor quality abortion services because they were in a fix. Single women are the worst sufferers in this respect.[7]

The Indian state has to make abortion law and policy more answerable to the needs and social conditions of women. The MTP Act was hardly formulated to given women autonomy over decisions concerning their bodies. As long as it retains moralistic, paternalistic and population control overtones and as long as women are victims of society's double standards regarding sexuality, the decision to abort will be overshadowed by shame, fear and stigma, at the cost of women's physical and emotional health.

Placing abortion in the overall context of a comprehensive public health infrastructure, and providing good quality services which are physically and financially accessible to all women, should be the priority of the Indian state, irrespective of women's marital status and without precipitation guilt. Aborting a pregnancy is in itself a difficult and painful decision for most women; the law and the health services need not add insult to injury.

The women's movement in India needs to debate the issue of abortion beyond the limited context of selective abortion of female fetuses. To make the State answerable to the needs of women,

their collective and organised voices have to be heard, taking up advocacy, lobbying and campaigns to make safe abortion a women's rights issue.

Finally, research documenting women's opinions, experiences and aspirations, with wide-spread dissemination of the findings to ordinary women and men, as well as lobbying of policymakers, NGOs and health care providers, are all urgent tasks at this juncture. Such efforts, however modest, are essential in order to empower women to make the demand for safe abortion services a woman's right.

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