Dissemination Of Key Findings
On Abortion Assessment Project – India (AAP-I)
At Chennai Entrusted To
Rural Women’s Social Education Centre (RUWSEC)
Chengalpattu

Introduction

Abortion Assessment Project carried out on an all India level in 2000 covering some of the main states have brought out issues related to maternal health which is recognized as a crucial area of concern. The key finding of the study was disseminated at a one-day conference organized at Chennai on the 25th August 2004 entrusted to RUWSEC. Around fifty participants of the conference were delegates from Tamil Nadu government health sector, health activist, and NGOs working in the area of health representing various districts of Tamil Nadu. Participants list is attached as annex I.

The two main areas that need to be assessed are, women’s control over decision-making and choice and secondly, abortion services that are available in India – which are serious concerns in the context of women’s reproductive health needs.

Despite the fact that abortion has been legal for the past twenty years, limited availability and poor quality have kept safe abortion beyond the reach of most poor women. The growing tendency to misuse sophisticated prenatal diagnostic techniques to abort female fetuses suggests the disturbing possibility of increased abortions and repeat abortions.

As a result complications resulting from unsafe abortions exact a heavy toll and constitute a major source of reproductive mortality and morbidity: over ten percent of all maternal deaths are due to abortions. Safe abortion services are available only in urban areas since registered practitioners are rarely available in rural areas. Nor is information and counseling about legal termination services available in rural areas, there is limited publicity about the law and there is a widely held perception that abortion is illegal. Also abortion can involve cost to the patient, and this cost can be prohibitive for the average rural woman. And finally, the quality of abortion services and care at approved centers can be impersonal and intimidating. Frequently, for example women who seek abortion are denied confidentiality or are coerced to accept an IUD or sterilization as a pre condition for abortion.

The meeting agenda is attached as annex II.

Agenda Item 1: Inaugural Address

Data on Abortion as assessed by Government of Tamil Nadu, Provisions of MTP in Tamil Nadu - Mr. Jayaraj

Unsafe abortion as a result of unintended pregnancy and unprotected sex is of greatest concern confronting women’s reproductive life. This is the result of the general failure to deliver the knowledge and means of fertility regulation. Globally it is estimated that 50% of the maternal death is caused due to unsafe abortions.

In Tamil Nadu among the 1074 approved institutions 75% are functional among which many private hospitals and NGO sector health setups do not report on MTP conducted at
thir centers. There is a gradual increase in the performance of MTPs since late 90’s. In India around seven million abortions are performed legally and unofficially. Therefore there is an urgent need to prevent this occurrence and efforts should be taken for the same. The MTP Act has been modified to the extent that the District can grant approval to the district health centers, this avoids the long complicated process of awaiting for approvals.

Generally the number of MTPs performed in the government hospitals are low, whereas there is a marginal increase of the same in the private sector. MTP supplement the Family Welfare Programme to a very large extent. Measures are taken to prevent quacks from performing unsafe abortions. Outreach programmes are targeted on promoting contraceptive methods to all beneficiaries within the reproductive age group. Field level functionaries are trained to motivate and mobilize clients towards safe maternal health procedures.

The Family Welfare Programme is carried out in three dimentions. They are the health rationale, human right rationale and democratic rationale. At present a new scheme CEMOC centre is being introduced by the Honorable Health Secretary to reduce maternal mortality. As per ICPD resolution the Government is also very much concerned about reducing unsafe abortions.

**Agenda Item 2: Introduction of the study**

**By Dr. Vimala Ramachandran, Health Watch, India.**

The APP-I study, when initiated in 1990 was given much impetus by the government of India, which encouraged the team to do this project. The issue of abortion was so enormous that it was just not the question of legality or not legality but much more than that. The presentation of facts by the government of Tamil Nadu substantiates the findings on APP-I. Looking at the issue of abortion under five major dimensions is as follows:

Information as to who are the providers, the government and private sector - are they registered approved service providers? There are quacks and the chemists as well who provide medicines. It was difficult by the Ministry of Family Welfare to give the exact figures on service providers.

Qualitative aspect of the study: After 1970's abortion were identified as a Family Planning Programme. From a women's health perspective is it safe for a woman to have repeated abortions? More number of couples choose the private hospitals than the Government health units, why? Therefore the qualitative aspect of the study.

Estimation as to how many women have undergone abortions-through community based studies in a given area. The Family Health Survey has no direct data but only inferences upon which abortion is looked as a reproductive history of women.

Looking at the policy conduct - available documents for reference and work on advocacy which is possible through systematic networking of various stake holders, NGO's, funders, Government. This study is a multicentric, multistate and multi organization study started in 2000. The findings of the study were brought out in a book “Seminar Issue”.
She raised three important questions towards Tamil Nadu, which needs serious consideration. They are:

1. Abortion as a social issue - there is an increasing rate of abortion in States such as Tamil Nadu and Kerala and mostly amongst the literates, why do they choose this method? Abortion is now an 800 crore industry in this country, doctors do no give proper advice to their patients about contraceptives. The general thinking is that abortion is completely and totally safe, but at what cost?

2. Sex selective abortions is on the rise in states like Haryana, Gujarat and also in Tamil Nadu, now apart from educating the women, it’s equally important that the medical people need to be educated. In this situation what impact does it create on society?

3. Thirdly as many as 68% of the doctors who provide abortions never tried to register themselves as abortion providers. Since Tamil Nadu is a progressive Govt. was requested to find ways by which they could talk to doctors and find ways of registering them. Finally all the required data on the study were available on CEHAT website for dissemination of research findings as an important method to help other like-minded organisation to gather information and work on advocacy.

**Discussions followed after the presentation**

It was agreed that abortions were on the rise in Tamil Nadu and this is because of the reporting system available in our state, like wise in Maharastra the accountability of the practice gives us reports of the services.

It was also pointed out that traditional abortion providers have stopped invasive methods of abortion, they refer the patients to registered practitioners for a commission, this change has to be recognized.

A delegate from JIPMER, Pondycherry added that at their institute 80% of the MTP are performed amongst the educated. They advise couples on sterilization and temporary contraceptive methods. Research is still in process to promote the use of implant methods and use of Herbal medicines at ICMR.

**Agenda Item 3:**

**Abortion Assessment Project – India, Key Finding - Tamil Version of the study Presented by Mr. P. Balasubramanian, RUWSEC, Tamil Nadu.**

The Abortion Assessment Project – India (AAP-1) an all India research study commenced in August 2000, was initiated with the objective of assessing ground realities through rigorous research.

Abortion has indeed become a major global issue in the context of reproductive rights of women. World wide of the 210 million pregnancy outcomes each year 46 million or 21% are estimated to be induced abortions. It is reflected that 13% of maternal mortality world wide being due to unsafe abortions. Given this scenario the women’s movement and health groups have taken up proactively various concerns related to abortion. They tried
to draw the attention of policy makers and administrators in order to improve the availability, safety and use of services, including: Abortion perceived as an extension of the government’s population stabilization programme.

The overall objective of the project were

- Review Government policy towards abortion care, and policy/programme environment in the country.
- Assess and analyse abortion services, including organisation, management, facilities, technology, registration, training, certification and utilization in the public and private sector.
- Study user perspective with special focus on women’s perception of quality, availability, accessibility, confidentiality, consent, post-abortion contraception and attitude of service providers.
- Study social, economic and cultural factors that influence decision-making. Impact of changing social values, male responsibility, family dynamics and decision-making.
- Estimate rate of abortion, resultant morbidity and mortality, causes of spontaneous and reasons of induced abortion.
- Document cost and finance issues related to the above.
- Disseminate information on abortion issues widely and develop an advocacy strategy on issues of concern in the context of reproductive rights of women. To achieve the above objectives a wide range of studies with differing methodologies were undertaken.

There were five dimensions of this study

1. Overview paper on policy related issues, series of working papers based on existing data / research and workshops to pool existing knowledge and information in order to fed into the project.
2. Multicentric facility survey in six stated – Kerala, Rajasthan, Haryana, Madyapradesh, Orissa and Mizoram.
3. Eight qualitative studies on specific issues to complement the multi centric studies. These have been done by researchers, grassroots groups and medical establishments in six states – Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Gujarat and Haryana. Also a multicentric qualitative study of informal providers was undertaken in Rajasthan, Maharastra, Madhya Pradesh, Karnataka, Uttar Pradesh, Haryana and Delhi.
4. Community based studies to estimate abortion rate and out-of-pocket expenditures in Maharastra and Tamil Nadu.
5. Dissemination and advocacy programmes through workshops, consultations and meetings with various stakeholders and analytic literature / publication dissemination both via academia and NGOs and through popular media.
Key Findings In Brief

1. Abortion facilities across six states (Kerala, Madhya Pradesh, Orissa, Rajasthan, Haryana, and Mizoram) showed amongst 380 abortion facilities there were 4 formal abortion facilities per 100,000 population in India. This accounts to 40,000 facilities or 48,000 providers with an average 120 abortions per year which adds to 4.8 million abortions being handled in formal abortion facilities annually. In addition to this there are informal abortion providers (traditional or medically non-qualified) which gives us an estimate of about 6.4 million abortions annually in India.

2. As per the MTP Act, though amended in 2003 to facilitate better implementation to certify legal abortion facilities accounts for only 24% of all pvt. Abortion facilities in the country. Among the 380 facilities across the 6 states in the study (285 Pvt.) obtained certification on an average of one month than those who were not, 68% had never tried to obtain certification. Lack of ethics in medical practice and absence of self-regulation among the profession is largely responsible for the present state of affair.

3. **Method of abortion:** The study found that 73% of abortions conducted for pregnancies with less than 12 weeks gestation. Dilatation and curettage (D&C) seems to be preferred method for nearly 89% of induced abortions. This adds to cost of the procedure and also causing post abortion complication – affecting quality of care. Pvt. facilities had better equipments and infrastructure, Public facilities seem to have better information provision and counseling to clients.

4. **Referrals:** Almost two third of the facilities referred cases to higher facilities and one fifth referred more than 50% of the cases. Particularly Pvt. practitioners do not take a chance when it was second trimester, medical risk and when it’s an incomplete abortion, which are commonly referred to Govt. hospitals.

5. **Accessibility:** Physical access seemed to be good, whereas social access remain restricted. Certified facilities did not accept women if they came alone or did not get the consent of spouse or close relative. This restricts women’s freedom to access such services and hence to protect her confidentiality and privacy. She may resort to providers who may not be safe. Majority of women seek abortion due to unwanted pregnancy, economic reasons or even unwanted sex of the foetus. Household surveys revealed the prevalence and practice of sex determination and sex selective abortions.

6. Public investment in abortion services as grossly inadequate, only 25% abortion facilities in the formal sector and 87% of the abortion market is controlled by the Pvt. sector. This is a major handicap to women from the poor class and other disadvantaged groups they often do not have the purchasing power to access abortion services.

7. The incidence of abortion recorded in Maharastra and Tamil Nadu household studies showed the difference of abortion rated across the rural and urban areas as well as across classes and social groups in both stated were significantly different. Abortion rates were nearly twice in urban areas compared to rural areas.
Therefore the better off had much higher rates than those economically and socially disadvantaged.

8. **Utilisation of Services:** The access of public health services in urban areas was twice better than in rural areas in both states, But the poorer section were large users of public facilities for abortion services wherever they were available. Thus there is a need to strengthen the public sector to support abortion care.

9. A reason for seeking abortion among married women was to limit family size. The disturbing fact was non-use of contraceptives. Though many reported knowledge of sterilization as well as about contraceptives such as condoms, IUD, pills for spacing birth did not use this knowledge into practice due to fear of side effects, pain and discomfort with irregular supply and problem with obtaining permission from husband. Some considered abortion as safer method compared to others.

10. Though women knew sex selective abortion was illegal they approached different facilities to ascertain the sex of the foetus and for abortion, the new PNDT Act was much known greater among the service providers, women than the detail of MTP Act. Women resorted to sex selected abortion as it affected their status in family and very survival of their marriage depends on their ability to produce sons.

11. An overwhelming perception that Private facilities were better as it takes less time, one visit, less formalities. Pvt. Doctors have better facilities, equipment's and treat women better ensuring confidentiality.

12. **Cost of Services:** It is equal comparatively to Pvt. providers and Govt. hospitals. In govt. facilities they has to pay separately for the medicines, repeated visits and travel cost for herself and the accompanying person, also includes forgoing wages for poor families. Cost varied as to the type of providers and gestation period.

13. Informal providers handled women with delayed periods and very early abortions. Some used oral methods like herbs, tablets etc. Informal providers cater to unmarried women and they act as links between formal providers and abortion seekers especially in rural areas.

14. The AAP project a policy review was undertaken to focus on the dynamics of MPT legislation to identify lacunae and concerns on abortion policy. The review papers also bring out future challenges and issues for advocacy on the abortion policy front.
**Agenda Item 4:**

**Summary of Case Studies presentation by Staff of RUWSEC**

In both the cases the women were not aware of spacing methods which should have been given to them through counseling. Secondly, they have no right on their own body and are bound to follow the decisions taken by their respective male members of the family.

**Case Study 1:** Its about an adi-dravida, semi literate poor woman who had experienced four pregnancies out of which through caesarian section, two were still births and the other two were aborted in a private nursing home for which she spent about Rs.2000 and Rs.1000. She is physically and mentally upset to go in for another pregnancy.

**Case Study 2:** A poor woman belonging to the Christian community, married of an early age experienced five pregnancies, she had two abortions through an unregistered practitioner - experienced death during the abortion process, she is pregnant for the fifth time which is also to be aborted, her culture does not permit her to go in for a sterilization.

and thirdly, the extent of pain and trauma experienced by these poor women due to the various factors controlling them within the family and at the health set up which deliberately keeps them ignorant about safe maternal health.

**Conclusion and Recommendations**

The afternoon session was thrown open for discussions and recommendation. The participants agreed with the observations made on the abortion assessment project where it is very clear that abortion has to be a serious concern, private medical practitioners mint money utilizing the time to treat as many patients as possible than to give them advise and counseling on preventive measure. It is also true that from case studies presented by RUWSEC on abortion and its impact on maternal health show that women live in a patriarchal society where their decision to make choices and their right towards sexual and reproductive health is restricted, the cultural value systems and lack of ethics by the medical professional keeping them ignorant about preventive measures further aggravates their maternal health.

Utilising health education material e.g.: "Our body and its function prepared" by RUWSEC for life skill education to adolescent boys & girls out of schools mere of great use in other districts implemented by partner NGO's where shared during the session.

**Recommendation by the participants**

1. Certification to formal abortion providers should be made mandatory, we need to find out what are the difficulties regarding its rules and regulations, which restrict this procedure. Indian Medical Association can be pressurized to complete this task of registration of all abortion providers.

2. Create awareness at all levels targeting couple education and adolescent groups who are preparing for marriage, discuss issues about reproductive health needs and gender equity and sex education through preparation of a training module. This awareness can be imparted right form school level, which should be included in the curriculum & incorporated within the exiting bodies NCERT, UNICEF - SSA etc.
3. Education and awareness on the issue can be taken to women through Self Help Groups. Couples can be educated about the seriousness of abortion and not to supplement it as a Family Planning method.

4. Counseling services should be made available at all maternal health centers to help patients adopt a suitable spacing method so that abortions can be avoided.

5. Advocacy on the subject can be taken at different level from judiciary, federation and field publicity. Campaign against abortions should be treated at a war-footing equal to that of AIDS awareness programme.

6. The PNDT Act should be implemented carefully as there is a wide disparity on sex ratio through sex selective abortions, which is a crime.

7. There should not be fixed rates for abortion services rather the Government should fix a reasonable rate so that doctors should not use this service a money minting industry.

8. Undertake studies among abortion seekers to know more about the reasons for choosing this method. More emphasis should be given on training and improving the work condition of paramedical staff.

9. Primary Health Centers or public service sector should be well equipped to make abortion services cost effective. Reduce the cost of medicines or provide it free of cost.

10. The Government has to take the initiative to promote safe maternal health. District Health Monitoring committee is required to implement programmes at the Govt. level which was a very strong recommendation made by the participants.

11. An alternative forum is important to work with medical people e.g.: A forum for the promotion of women's health which should be a non conventional forum which will consciously handle issues related to the medical profession.

12. Mechanism developed to monitor and guide standardization of treatment information's gathering and quality of care both in private and public sector.

Rappoteur: Mrs. Vallery Patric, RUWSEC.