

ABORTION LEGISLATION AND ACCESS TO SAFE ABORTION CARE SERVICES: THE INDIAN EXPERIENCE

Sunita Bandewar¹

CEHAT: Centre for Enquiry into Health and Allie Themes

Population size	846.3 million
Women of reproductive age (15-44)	47%
% population living in urban area	26%
Gross domestic product per capita	US\$ 1,670
Human development index	0.545
Literacy rate of women aged 15+	39%
% hospital births	34%
Maternal mortality rate	459 per 100,000 live births
Religious affiliation	82% Hindu
Abortion legal status	Legal since 1972 through the Medical Termination of Pregnancy Act decriminalised abortion

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Introduction

The Medical Termination of Pregnancy (MTP) Act was passed in India in 1971. The Act, implemented in 1972, decriminalised abortion. The manner in which the Act is implemented remains inadequate, however, and the quality of care available to women seeking abortion care at institutions and elsewhere is very poor. This chapter presents a critique of the legislation, examines the process through which the Act came into being, provides information about current access and documents advocacy efforts aimed at improving access to safe, legal and affordable abortion care services.

The chapter is primarily a documentation of the abortion advocacy initiative of the group to which the author belongs and so relies considerably on personal knowledge and experience. Earlier writings on the MTP legislation and women's movement provided background material. Additional information on the role of the women's movement was obtained through interviews with representatives of women's organisations.

The MTP act

The content and the critique

Two aspects of the Act are particularly noteworthy. Firstly, the Indian legislation represented the first time in the world that abortion was made legal in cases of the failure of contraception. Secondly, the legislation did not require the husband's consent for abortion. Despite these strengths, the Act can be criticised for the power it gives medical practitioners. Other weaknesses are described below:

The Act stated that a termination up to twelve weeks had to be approved by a single registered medical practitioner, while it

needed the approval of two medical practitioners between twelve and twenty weeks. The practitioners had to testify that continuing the pregnancy would place the life or physical or mental health of the woman at risk, or that there was significant risk that the child would suffer from serious physical or mental abnormalities. Within these definitions, a pregnancy caused by rape was considered to pose a serious threat to the mental health of the woman, as was the failure of contraception.

While the Act was relatively liberal in its clauses, it established medical practitioners as the ultimate gatekeepers. Further, the fact that failure of contraception was only considered a just cause for married women was evidence of a moralistic position concerning women's sexuality which links the use of contraception with her marital status. This linkage precludes all other situations in which a woman may express her sexuality leading to an unwanted or unintended pregnancy.

The Act is open to differing interpretations by medical providers engaged in abortion care services. To date the interpretation of the law has been liberal. This could partly reflect the government's preoccupation with population control or the medical profession's commercial motivation. Nevertheless, the possibility remains that the Act could be interpreted restrictively without a singleword of the text being altered (Jesani and Iyer, 1993).

Few abortion care facilities are 'stand-alone'. Most are situated either in the general health care service facilities or in maternity care centres. The MTP Act specifies the need for abortion-specific instruments. The standards do not cover the other minimum physical standards at the health care facilities at which abortion care services are situated.

The only medical legislation which covers general minimum standards is the Bombay Nursing Home Act of 1949 which covers the urban area of the state of Maharashtra and other provincial legislation, such as the Tamil Nadu Private Clinical Establishments Regulation Act of 1997. In the absence of any

monitoring system, research suggests that these laws mean little. They are also not applicable in all parts of the country.

The Act lays down the necessary qualifications and experience required of a medical practitioner to perform an abortion, but does not clarify the meaning of the concept ‘assistance’ when it states that the practitioner must have assisted in at least 25 cases. This could be interpreted as not requiring hands-on experience.

Further, the stipulated experience and training requirements focus exclusively on medical skills. Non-medical aspects, such as provider-client interactions, quality of information exchange and counselling, do not feature at all. These ‘soft’ aspects of service delivery have a special significance in abortion care services where the service provider must be in a position to interact with clients in a sensitive and humane manner.

The Act does not lay down any mechanism for those who aspire to learn MTP procedures.

Implementation of the Act

The MTP Act details the reporting mechanism to be followed by heads of abortion care facilities, but does not delineate the responsibilities of government in terms of periodic inspection of institutions registered to provide abortion care services. It also does not provide mechanisms for monitoring illegal providers. The absence of these mechanisms could allow illegal abortion services to function with impunity.

This is not to suggest that the Act should be more strictly formulated, possibly restricting access to safe, legal and affordable abortion care services. Rather, the concern is that while a woman may not be denied abortion care, she will usually have no control over the quality of the care that she receives.

Perhaps the biggest problem is that basic health care services – leave alone abortion services – are inaccessible and unavailable to many in India. The MTP Act fails to make the right to access to abortion services a justiciable right. In reality, no law

can automatically create easy access and utilisation of the abortion services or automatically improve the quality of services until general health care services are easily accessed in India.

The process of abortion legislation

In India, unlike in many other countries, the MTP abortion legislation was passed without much controversy or opposition. Liberalisation of abortion through the MTP Act occurred in India without it ever having been on the agenda of the women's movement. This section looks at how and why the Indian government played the initiating role.

The Shah Committee

In 1964, the government's Central Family Planning Board expressed anxiety concerning the increasing number of induced abortions occurring under unsanitary conditions, which affected the health and life of the mother. On the recommendation of the board, the Ministry of Health constituted a committee to study the question of the legalisation of abortion. The committee was chaired by Shantital Shah, the then Minister for Health, Law and Judiciary in Maharashtra. Other members represented the Indian Medical Association, the Association of Medical Women in India, the Federation of Gynaecologists and Obstetricians, the Family Planning Association of India, the All India Women's Conference (AIWC), the Central Social Welfare Board, the Indian Council of Child Welfare and the Central Family Planning Institute. The mandate of the committee was to examine the legalisation of abortion in all its aspects – medical, social, legal and moral – and to make recommendations.

The Committee issued a questionnaire to all government ministries, state governments, members of the Planning Commission, members of parliament and state assemblies, central and state family planning boards and medical, social, legal, political and religious organisations throughout the country. A total of 570 questionnaires were returned. Of these, 64% came from

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members of the medical community and about 25% from welfare organisations, including family planning associations and women's organisations. Of the 570, only eight were from religious leaders.

- The broad areas covered in the questionnaire included:
- Estimates of induced and spontaneous abortion;
- Reasons for, and nature of, illegal abortions;
- Conditions under which abortion should be permitted;
- Whether and when mandatory sterilisation should be considered;
- Possible safeguard mechanisms in cases of legalised abortion;
- Whether unmarried women and widows should have access to abortion care services;
- Penalties to be imposed on unqualified abortion providers; and
- Religious and cultural issues.

The committee was established as a result of concern around public health, morbidity and mortality. The issue of women's right to abortion was not reflected in appointing the committee. It was also not reflected in its recommendations. The areas covered in the questionnaire show that committee members were concerned about (a) abortion procedures by 'unqualified' people under unhygienic conditions, (b) unsafe abortion-related mortality and morbidity and (c) the rate of population growth.

The committee was dominated by bureaucrats and medical professionals, with the exception of the AIWC – one of the early initiatives in support of women's issues. The AIWC was ideologically close to what was then the largest nationalist political party, which had emerged out of the struggle for independence. Beyond the AIWC, it seems that family planning

associations and other welfare organisations were considered adequate to speak on women's behalf. Further, the committee did not seek the participation of civil society in its deliberations. It sought out the opinions of a few selected people only through the mailed questionnaire and no efforts were made to engage in open debate and discussions nor to seek the opinions of ordinary women and men. It was a top-down approach.

The fact that religious leaders did not create an uproar suggests that the issue was not of great interest to them.

The committee made recommendations and formulated legislation based upon the British abortion law .

The role of the women's movement

As noted, the women's movement did not play a role in the passing of India's liberal abortion law. It has also shown limited interest in later advocacy around access to safe abortion services. This section describes the development of the women's movement and reasons for its stance on abortion.

Analysts have identified three 'waves' in the women's movement from pre-independence to date. The pre-independence movement constituted the first wave and was characterised by the organisation of women by men to provide active support for men in the freedom struggle. It was part of the larger social reform movement that attracted large numbers of the oppressed and disadvantaged and was concerned with the gross violation of basic human rights through anti-women traditions such as *sati* (burning of widows). During this period, women were encouraged to enrol in schools and participate in public activities beyond the boundaries of household chores.

The second wave occurred immediately after independence and was a reaction to the prevailing models of development, economic planning and organisational functioning. The period was characterised by mass struggles around land rights, minimum wages, price increases, corruption, and the rights of tribal people and peasants. Middle and working class women participated in the alternative development activities, mass

struggles and agitation in great numbers and with militancy, although men and political parties led and initiated the action.

It was during the third phase, beginning in the early 1980s, that issues such as sexual harassment and violence within the family came into the public domain and were opened up to debate. During this phase the movement was more fragmented as there was no longer a common cause as there had been during the freedom struggle. Nonetheless, this fragmentation allowed different parts of the movement to pursue issues related to their own interests, concerns and convictions. At times these fragmented groups left their differences aside when the issues demanded strong lobbying and active support.

One such coming together occurred in the mid-eighties, when there was nationwide mobilisation around the abuse of pre-natal diagnostics for sex-discriminatory, selective abortion. Other people's movements joined women's groups in this struggle, which opened up many controversial issues and differences of opinion among those who advocated for women's right to abortion. Some of the more important rifts included:

- Those supporting abortion as a right were faced with a 'pro-choice' lobby in favour of choice in respect of sex-selective abortions;
- Those who opposed sex-selective abortion were challenged by those who supported abortion because of eugenics.

The strong feeling in certain areas of the women's movement for the need to accommodate differences of opinion worked against the development of a common position on the issue. Some of those associated with the women's movement today still do not feel able to place abortion and related issues on their agenda at all.

Firstly, some groups are not willing to accept international funding to support their activities. They fear that they may lose autonomy and that dependence on donors will limit their free-

dom to critique the imperialist policies of the developed nations.

Secondly, the fact that liberal abortion legislation is in place means that, theoretically at least, women have legal access to abortion care services. And in practice women are rarely denied abortion. The outstanding issues are about the quality of services and measures to reduce women's abortion needs. Ensuring proper implementation generally requires more sustained effort than simply changing legislation.

Thirdly, there are many other issues that the women's movement considers as priorities, both within and beyond the health field. In the health arena, considerable energy has been spent on addressing India's coercive population policy and fighting the use of hazardous contraceptives, such as injectables and implants. By choosing different foci, the limited resources can be used for a greater range of issues. Meanwhile, the solidarity shown on a number of occasions between different women's groups and women-centred organisations demonstrates their respect for each other's ideologies, priorities, means and methods of achieving common goals and principles.

The role of research

In the absence of a strong interest in abortion from the women's movement, it has been researchers who have been most active in promoting more liberal ideas around abortion. In 1998, after about three years of struggle, the Maharashtra state government enacted legislation banning sex-selective abortions. In 1994, the central government followed suit. Having won this battle, some of those who had participated through health and human rights research, felt the need for further research and advocacy work on abortion-related issues. These individuals eventually formed the Centre for Enquiry into Health and Allied Themes (CEHAT). This Centre sees its role as conducting socially relevant and rigorous academic health research, promoting the well-being of disadvantaged people, strengthening the people's health movement and realising the right to health care.

When CEHAT was formed, most of the existing research on abortion had focused on the extent to which the legislation had contributed to fertility reduction and to understanding the socio-economic and demographic profile of women seeking abortion care services. There was little or no attention paid in research to improving the quality of services or the extent to which the legislation safeguarded women's health by preventing exposure to unsafe abortion services.

Indications that the legislation was not being properly implemented prompted CEHAT to start with a scenario analysis of induced abortions in India and of the health care system more generally. The second focus was a critical examination of the content of the legislation to ascertain why it was not providing the hoped-for benefits for women.

CEHAT's examination of the health care system exposed:

- the inadequacy of services provided to the rural population by both the public and private health care sectors;
- the inadequate equipping in terms of staff and infrastructure of the primary health centres which constitute the lowest level of the state health care delivery system in India;
- the fact that, in the absence of adequate public health services, many people were seeking health care from private providers who were charging exorbitant fees;
- the lack of regulation of private sector provision.

The research into abortion services found that the number of MTP institutions increased about fivefold between 1972 and 1997. The number of MTPs performed at these institutions over the same period increased by only about 40%, suggesting more widespread access, but fewer abortions performed per institution.

Despite the increase, there is still far less provision than there could be. There were over 22,010 primary health centres, 2,662 community health centres, and 13,692 hospitals in India in 1997 (Ministry of Health and Family Welfare (MOHFW)), all

of which were eligible under the MTP Act to offer MTP facilities. Yet only 8,891, or 23%, of these were approved MTP institutions. The institutions each conducted, on average, 61 legal induced abortions every year. If these institutions were to conduct all the estimated 4.7 million induced abortions (Jesani & Iyer, 1993) in the country, they would be required to perform an average of 529 abortions each year. Such a nine-fold increase in work would seriously compromise the quality of care unless something is done to increase the number of registered institutions. To make matters worse, the available services are distributed unequally within the states, between private and public sectors, and between rural and urban.

The findings of CEHAT's examination of the legislation are summarised in the critique of the legislation above.

As CEHAT took forward its abortion research and advocacy agenda in the 1990s, other groups also pursued research that contributed to understanding the abortion issue. The initiatives included a national level study on illegal abortion conducted by the governmental Indian Council for Medical Research, a community-based study of induced abortion conducted by King Edward Memorial Hospital Research Centre in Pune and an assessment of the quality of institutional-based abortion care conducted by the Centre for Operation Research and Training.

Combining research and advocacy

The research process helped CEHAT identify the constituencies which could be influenced by the proposed advocacy initiative. The most important constituencies were the state machinery, the medical community and ordinary women and men. Given limited resources, CEHAT decided to limit its advocacy efforts to the state or provincial level. The discussion which follows describes, chronologically, what CEHAT studied and how it embarked on advocacy in respect of each.

Women's needs

CEHAT utilised a community-based, qualitative approach. The research was woman-centred, and removed from the popula-

tion control perspective that dominated abortion research for the two decades after legalisation. The research revealed that women were largely unaware of the fact that abortion is legal and provided free of charge at public health care facilities, including PHCs. When the legislation and situation was explained to them, most were in favour of universal access to abortion care services.

Their concerns in seeking abortion care were not identical to concerns in other health-seeking situations. While women opted for abortion in a range of situations, they were not free of moral dilemmas and feelings of guilt about doing so. As even talking about abortion remained taboo, CEHAT found that women attached considerable importance to confidentiality, speed of service and the husband's signature not being compulsory (Gupte et al, 1999). The fact that many women appeared willing to trade safety and quality of care considerations for assured confidentiality helps explain why the private sector is often the preferred source for abortion care services.

Advocacy: Issues and strategies

CEHAT chose as its advocacy goals the development of a mechanism for building awareness in society about abortion legislation and for changing attitudes. The organisation prepared a booklet and slideshow in the local language, which covered the medical, legal, socio-cultural and political aspects of abortion. The materials were prepared with the participation of the women from the community and drew heavily on the insights gained in the research. To date, about 3,000 copies of the booklet have been disseminated.

While 3,000 is a small number for dissemination to the population, the materials have reached larger numbers through the use of networks. For example, the materials have been used in a 'Women and Health' initiative, which brings together a state-wide network of NGOs working on women's health and related issues. Middle-level health workers in these NGOs underwent a year-long training programme on gender-sensitive women's health care. The workers are members of the com-

munities in which they work and thus ideally placed to take the message further.

The booklet was launched at a public function that was opened by the Deputy Director of Health Services in the state and to which CEHAT invited NGOs and women's groups, activists, people's organisations, office-holders of medical associations, leading gynaecologists and the press. A gynaecologist, women's activists, and the Deputy Director shared the platform to express their views about women's health and women's abortion needs. The public function served as an expression of solidarity among the groups and a collective commitment to the cause.

CEHAT also attempted to provide the resource material to service providers constituting the upper cadre of the state's public health sector. These were the civil surgeons who are the chief medical officers in districts and officials at the state-run district hospital who are responsible for overseeing MTP performance and approval of centres in their districts. There was also some outreach to grassroots health workers from the public health care sector. Unfortunately, despite their attempts, CEHAT was unable to use the official Information, Education and Communication (IEC) Bureau to disseminate the booklet. It seemed that CEHAT would have to pay for this facility and perhaps also contribute in terms of labour. The organisation chose instead to devote its energies to disseminating the material through the NGO networks.

The slideshow was designed for illiterate and newly literate people and contained visuals as well as text. It was primarily used in training programmes, especially to train trainers. Dissemination was constrained by the need for a slide-projector, basic training for animators and the costs involved in these. It was thus comparatively less accessible than the booklet despite its tremendous educational potential. The NGOs which served as anchors for large networks of smaller grassroots groups were able to use the slideshow in combination with the booklets.

The above efforts to disseminate the booklet and slideshow were geared to the large rural population. For the urban population, CEHAT made use of the mass media, especially the local press. The organisation wrote articles for daily and weekly newspapers and received some positive response from readers.

Expansion of abortion services

Given the inadequacy of current service provision, CEHAT's research:

- Explored ways of accommodating medical professionals other than the practitioners of allopathy who are currently the only ones legally allowed to provide abortion care services;
- Explored the feasibility of introducing abortion methods such as manual vacuum aspiration (MVA) and misoprostol (RU486); and
- Explored the feasibility of involving paramedics in abortion service provision.

The research looked at both legal and medical feasibility and drew on the experience of other countries, both with similar and contrasting health care systems and health status. The research also examined the capacities and skills that existing medical and nursing courses impart, particularly to students of Indian systems of medicines.

Advocacy: Issues and strategies

In conducting this research over a four-year period, CEHAT interacted with women's groups and grassroots organisations, health activists, the medical community, the nursing and paramedic community and state administrators. This interaction gave visibility to the issue and built awareness.

CEHAT organised a state level consultation in 1998 for which it prepared background discussion papers. The organisation also invited representatives of other constituencies to share their perspectives on alternative methods for expanding abortion

care services. Invitees included medical officers from the public health care sector, office-holders of the medical and nursing association, women's groups involved in running training programmes for grassroots level health workers and middle-level health workers engaged in service provision. CEHAT decided not to invite state representatives as they feared it might hinder open dialogue among the other representatives.

As anticipated, many of the issues were not resolved as participants held often divergent views about them. The allopaths were against any expansion on the grounds that MVA is not a method with acceptable efficacy. The allopaths also did not approve of the idea of accommodating medical practitioners from other systems of medicine for abortion service provision.

As regards paramedics, CEHAT had thought that imparting skills would help to change the power relationship between them and those with more formal qualifications. Paramedics were not willing to take on any additional duties, however, given their responsibility for all the work in the state's Family Welfare Programme.

Only the women's health activists were prepared to explore the involvement of paramedics in MVA. They were also in favour of promoting other medical methods of menstrual regulation such as misoprostol. However, they emphasised that improving the existing public health care system was essential. They cautioned that, in the absence of an improved and accountable health care system, introducing such methods would only add to women's suffering.

The different opinions highlighted the conflicting interests of the constituencies. The consultation also gave CEHAT, as advocates, greater clarity as to which issues to tackle in the short, medium and longer term. For example, expansion of services seems to present a tougher challenge for advocacy purposes, especially as it is still in the conception phase. It is perhaps easier to concentrate on those issues related to improvement of the quality of existing abortion services.

Providers and state administrators

CEHAT's research in respect of providers focused, firstly, on their knowledge and opinions on abortion-related issues. A second research focus in this area involved an institution-based assessment of the nature and quality of abortion care services. Among state administrators, CEHAT enquired about knowledge of abortion-related laws and procedures, as well as problems encountered in providing services. The investigation covered rural and urban areas, private and public, and registered and non-registered facilities. It also covered all systems of medicine, not only allopathy.

The research revealed that providers, like women, were not adequately informed about abortion law. The immediate need, therefore, was to inform and educate the medical community. The quality of both general health care and abortion care was found to be abysmal on almost all the indicators, both medical and non-medical. Abortion care services were, if anything, worse than other areas because women needing abortion services are generally vulnerable and unable to negotiate for quality care. The situation is aggravated if the woman is having a repeat abortion, or has conceived outside of marriage. The research also revealed that some of the state requirements for registration as a provider of abortion were stringent and impractical given the status of the health care system.

Advocacy: Issues and strategies

CEHAT feared a backlash and withdrawal of support from the medical community because the research painted such a negative picture of the existing situation. It chose instead to appeal to the medical community on the basis of the risks that women are exposed to because of the poor quality of services.

The organisation focused on two issues. Firstly, on the information needs of providers about the legislation and about the administrative and technical details of approval procedure for MTP facilities. CEHAT used the information needs of the providers in the semi-urban and rural areas to make alliances with this powerful community. Secondly, CEHAT focused on inter-

action with state administrators to change the restrictive rules that were obstructing MTP approval for many. In India, as in many other countries, interacting with the state machinery means patience, sustained effort and a readiness to make frequent trips to the Directorate of Health Services and Ministry.

With this strategic conceptualisation in mind, CEHAT organised a meeting-cum-consultation to communicate the research findings. Representatives of the medical community (both respondents and others), office holders of medical associations and Federation of Obstetrician and Gynaecologists Society of India and state administrators were invited. In particular, CEHAT ensured that the Deputy Director, MTP Cell, State participated in the meeting. The agenda included the tabling of a draft booklet containing a guideline for MTP registration and other relevant information. CEHAT also tabled a draft recommendation for relaxing state-specific requirements in respect of registration.

The information about the existing situation was presented as resulting from systemic problems rather than holding individuals responsible. The documents tabled included both information and well-reasoned arguments as to why alternatives were preferable. Information obtained through interviews with the state administrators responsible for implementation of the act contributed to make the documents useful. Consultation with experts was also important in explaining the alternatives and in drawing up arguments to counter possible resistance. CEHAT's primary agenda in organising this event was to consolidate alliances with concerned constituencies by strategising on the weak links in the existing service delivery system. The organisation hoped that building alliances and facilitating the processes required for improving access to safe and legal abortion care services would complement each other and achieve a better advocacy outcome, both in terms of quality and multiplier effect.

The booklet on MTP registration guidelines was subsequently finalised after a consultative meeting with representatives of the medical community, including non-allopaths and the state

administrators. The consultative meeting helped to develop a positive attitude towards the initiative among medical professionals. The group also entrusted the responsibility for pursuing the draft recommendations with the Directorate and the Ministry to CEHAT. The organisation has since persuaded the state machinery to accept certain of the recommendations of the state-level consultation. One recommendation that was not entertained was that of allowing non-allopaths to be assistant abortion service providers.

The combination of agendas in a single meeting proved to be a fruitful strategy in earning the confidence of both service providers and state administrators. It also served several other purposes. It provided an opportunity for representatives of all parts of the medical community to share their problems with the most senior person from the Directorate of Health Services in the state. The state administrators were able to share their financial, personnel and other constraints with the providers and both constituencies were forced not only to understand each others' constraints, but also to develop tolerance toward each other.

CEHAT has since been invited by the state to design a training module and conduct a training programme for civil surgeons. Civil surgeons constitute only a small fraction of the entire health care sector, but, because they are in charge of the public health care sector for the entire district, successfully educating and sensitising them would have a snowball effect.

The challenges ahead for advocacy

The first challenge is to improve women's access to safe, legal and affordable abortion under the current law. This implies addressing the bureaucratic hurdles by informing all those concerned about the details of the registration procedure. It implies sensitising and educating medical professionals in the public and private health care service sector and putting pressure on the state to increase the health budget.

The second advocacy issue is the need to articulate the right to abortion without compromising on a position that opposes 'selective abortion' on the grounds of commitment to human rights.

The third advocacy issue is to find ways to reduce women's abortion needs. This necessitates an improved and assured supply of safe contraception without coercion and education on how to use it. It also requires advocacy for women's right to reproductive decision-making and the separation of this from the population control ideology.

Access to abortion care services cannot be attained outside of the context of general health services. India will never provide adequate abortion care services until there is comprehensive health care for all the population. Advocates for abortion thus need to join up with advocates promoting universal health insurance and those who promote regulation of the private health care sector. Abortion advocates also need to network with women's groups and mass organisations. In particular, it is important to interact with health groups and initiatives such as the People's Health Assembly and women's health networks such as the Women and Health Network.

Advocacy for safe, legal and accessible abortion services faces a range of challenges. These include:

- Limited financial, human and other resources;
- The country's geographical spread and cultural diversity;
- The sometimes conflicting interests of women as users of services and medical professionals as providers;
- Ideological differences and differing priorities between the different groups who need to form part of the lobby; and
- The danger that, with a fundamentalist state, too hard a push for reform of the existing abortion legislation without mass support could spark efforts to remove the opportunities available at present.

Lessons learnt

- It remains a challenge to fight for quality abortion services even once seemingly liberal abortion legislation is in place.
- It is difficult to mobilise the masses around the single issue of abortion when the majority of the population lacks access to the means to satisfy their basic needs.
- As a consequence, it is difficult to motivate people's organisations to participate actively and in a sustained way in abortion advocacy campaigns. Their efforts and priorities are concentrated around people's basic needs for survival.
- Because the potential of enactment of liberal abortion legislation is viewed too optimistically and because of limited resources in terms of human energy and finances, abortion advocacy has a low priority on the agenda of the women's movement.
- Liberal legislation, if not complemented by an adequate implementation plan, will not achieve what it is meant to achieve. The plan must include strategies for awareness building among the concerned constituencies, such as service providers, women and their families, implementers and bureaucrats.
- CEHAT's abortion advocacy initiative, although dominated by non-medical people, earned credibility through rigorous research and by giving due weight to the problems faced by both service providers and state administrators.
- The unregulated and dominant private health sector is difficult to target with conventional methods of advocacy given the power and monopoly they enjoy in health care service provision in India.
- A broad-based advocacy campaign is an appropriate strategy in the initial phase to make the issue visible at

different levels and among different constituencies, but CEHAT still has to find strategies to sustain the initiative, to extend it geographically, and to develop mechanisms to assess its usefulness to women.

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Author

Sunita Bandewar is an anthropologist by training and has a doctorate in development communication. She currently works as a senior research officer at CEHAT. She has been engaged in abortion research and advocacy work since 1994 and headed a three-year project aimed at improving women's access to safe and legal abortion. She is currently responsible for a large-scale, community-based abortion research project that is part of the national abortion assessment initiative being jointly co-ordinated by CEHAT and Health-Watch.