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"CHANGING DIMENSIONS OF ABORTION IN INDIA: A CASE STUDY (W.R.T ILLEGAL ABORTIONS)"

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CHAPTER 1

INTRODUCTION

Abortion in India is legal in certain circumstances. It can be performed on various grounds until 20 weeks of pregnancy. In exceptional cases, a court may allow a termination after 24 weeks.[1]

When a woman gets a pregnancy terminated voluntarily from a service provider, it is called induced abortion.[2]Spontaneous abortion[3] is the loss of a woman's pregnancy before the 20th week that can be both physically and emotionally painful. In common language, it is called a miscarriage.

Till 2017, there was a dichotomous classification of abortion as safe and unsafe. Unsafe abortion[3] was defined by WHO as "a procedure for termination of a pregnancy done by an individual who does not have the necessary training or in an environment not conforming to minimal medical standards." However, with abortion technology now becoming safer, this has been replaced by a three tier classification of safe, less safe, and least safe permitting a more

[1]"India rape victim, 13, allowed to abort". *BBC News*. 6 September 2017.

[2]*Pratigya – Campaign for Gender Equality and Safe Abortion*. 20 June 2018. Archived from the original (PDF) on 20 June 2018. Retrieved 20 June2018.

[3]*Pratigya – Campaign for Gender Equality and Safe Abortion*. 20 June 2018. Archived from the original (PDF) on 20 June 2018. Retrieved 20 June2018.

nuanced description of the spectrum of varying situations that constitute unsafe abortion and the increasingly widespread substitution of dangerous, invasive methods with use of misoprostoloutside the formal health system.

- Safe abortion: provided by health-care workers and with methods recommended by WHO.
- Less-safe abortion: one by trained providers using non-recommended methods or using a safe method (e.g. misoprostol) but without adequate information or support from a trained individual.
- Least-safe abortion: done by a trained provider using dangerous, invasive methods.

Comprehensive Abortion Care (CAC), a term "rooted in the belief that women must be able to access high-quality, affordable abortion care in the communities where they live and work", was first introduced in India by Ipas [4]in 2000. The concept of CAC encompasses care through the entire period from conception to post abortion care and includes pain management.

BARRIERS TO ACCESIBLE SAFE AND LEGAL ABORTION:

The Indian state's approach to reproductive rights historically has focused on population control rather than enhancing individual autonomy and removing structural barriers to reproductive health services, which is reflected in the barriers to provision of services. As a consequence of the early adoption of family planning and population control measures in the 1950s, India was one of the first countries to legislate on abortion and legalise conditional abortion. While contraception was also made available, the focus was on meeting targets for sterilisation rather than temporary spacing methods. This has shifted focus away from universal provision of abortion and contraception to meeting top-down targets for population control.

CHAPTER 2

[4]"Ipas Development Foundation". *ipasdevelopmentfoundation.org*. Retrieved 20 June2018.

JURISPRUDENCE ON ABORTION IN INDIA

2.1 ABORTION LAW, POLICY AND SERVICES IN INDIA

The Indian Penal Code 1862 and the Code of Criminal Procedure 1898, with their origins in the British Offences against the Person Act 1861, made abortion a crime punishable for both the woman and the abortionist except to save the life of the woman. The 1960s and 70s saw liberalisation of abortion laws across Europe and the Americas which continued in many other parts of the world through the 1980s[56]. The liberalisation of abortion law in India began in 1964 in the context of high maternal mortality due to unsafe abortion. Doctors frequently came across gravely ill or dying women who had taken recourse to unsafe abortions carried out by unskilled practitioners. They realised that the majority of women seeking abortions were married and under no socio-cultural pressure to conceal their pregnancies and that decriminalising abortion would encourage women to seek abortion services in legal and safe settings.[7]

The Shah Committee, appointed by the Government of India, carried out a comprehensive review of socio-cultural, legal and medical aspects of abortion, and in 1966 recommended legalising abortion to prevent wastage of women's health and lives on both compassionate and medical grounds. Although some States looked upon the proposed legislation as a strategy for reducing population growth,the Shah Committee specifically denied that this was its purpose. The term ''Medical Termination of Pregnancy'' (MTP) was used to reduce opposition from

[5]Berer M. Making abortions safe: a matter of good public health policy and practice. Bulletin of World Health Organization 2000;78:580–92.

[6]Rahman A, Katzive L, Henshaw S. A global review of laws on induced abortion, 1985–1997. International Family Planning Perspectives 1998;24:56–64.

[7]Chhabra R, Nuna SC. Abortion in India: An Overview. New Delhi7 Veerendra Printers, 1994.

socio-religious groups averse to liberalisation of abortion law. The MTP Act, passed by Parliament in 1971, legalised abortion in all of India except the states of Jammu and Kashmir.

Despite more than 30 years of liberal legislation, however, the majority of women in India still lack access to safe abortion care. This paper critically reviews the history of abortion law and policy reform in India (Box 1), and epidemiological and quality of care studies since the 1960s. It identifies barriers to good practice and recommends policy and programme changes necessary to improve access to safe abortion care.

2.2 JOURNEY OF ABORTION LAWS IN INDIA

October 6, 1860: Section 312 of Indian Penal Code, 1860 criminalised abortions, dubbing it as intentionally "causing miscarriage."

December 30, 1966: The Shantilal Shah Committee report came out, which recommended that abortion and reproductive laws need to be regulated in India. The committee was set up in 1964 after 15 countries legalised abortions in the 1960s.

August 10, 1971: The Medical Termination of Pregnancy (MTP) Act was passed which legalised abortion.

December 18, 2002: The MTP Act was amended. The law of abortion was decentralised and penal sanctions were added for unapproved abortions that led to the formulation of MTP rules in 2003. These rules increase access for women, especially in the private health sector.

October 29, 2014: The Union Ministry of Health and Family Welfare proposed a draft bill to amend the existing MTP bill. This came after the National Commission for Women had recommended that the 20-week gestation limit for abortion be raised to 24 weeks and urged that women, irrespective of their marital status should be given abortion rights. The bill was never placed in Parliament.

Major amendments proposed included:

- Raising the gestation limit for terminating abortions to 24 weeks

- Increasing the provider base of abortion services by including registered health practitioners to conduct abortions after specified training
- It also eliminated the pre-condition of the opinion required of a registered medical practitioner, whether to abort or not, in case of pregnancies not exceeding 12 weeks
- In case of pregnancies exceeding 12 weeks but not 24 weeks, it reduced the number of opinions required by a medical practitioner from two to one, extending more rights to women over their pregnancies
- Replaced "married women" to "all women" under the contraceptive failure clause which would help unmarried women to access safe abortion in cases of contraceptive failure

November 6, 2014: The Indian Medical Association (IMA) opposed the bill, questioning the amendment which increased the provider base of abortion services.

August 4, 2017: MTP Amendment bill, 2017, was introduced in the Rajya Sabha which intended to raise the pregnancy period of abortions to 24 weeks.

January 22, 2018: MTP Amendment bill, 2018, was introduced in the Lok Sabha with the same demand to substitute the 20 week duration with 24 weeks and added that it should be raised to 27 weeks in case of a rape survivor.

December 28, 2018: Shashi Tharoor introduced the Women's Sexual, Reproductive and Menstrual Rights Bill which also sought to do away with the pre-condition of a medical practitioner's opinion in case of pregnancies not exceeding 12 weeks. But the proposed bill did not tamper with the gestation period limit of 20 weeks.

May 29, 2019: Petition filed at the Supreme court by Swati Agarwal, Garima Sekseria and Prachi Vats also challenged the 20-week gestation limit saying that advancements in science and technology has made it possible to terminate pregnancies at later stages. It also asked for amendments in Section 3(2)(a) of the MTP Act on grounds that they violate Article 14 and 21 of the Constitution.

It cited a report by Guttamacher Institute and a few others which suggested that a first trimester abortion carries less than 0.5 per cent risk of major complications during hospital care. Section 3(2) of MTP Amendment bill, 2014, had also done away with the requirement of the opinion of a medical practitioner in case of pregnancies not exceeding 12 weeks.

May 26, 2019: PIL filed by Amit Sahni in the Delhi High Court asking to raise the 20 week limit to 24 weeks.

May 28, 2019: Delhi High Court issues a notice in plea to the Centre asking to extend the duration of termination of pregnancy by 4-6 more weeks in case health risks to mother or foetus.

April 24, 2019: Madras High Court issues notices to the Centre and state governments seeking their response in extending the period for termination of pregnancy, stating that it is a matter of urgency.

August 2, 2019: Affidavit submitted by the Union Health Ministry in response to the PIL filed by Amit Sahni. The affidavit stated that draft MTP Amendment bill, 2019 has been sent for inter-ministerial discussion.

August 6, 2019: Supreme Court issues a notice to the Centre seeking its response to the PIL filed by Swati Agarwal, Garima Sekseria and Prachi Vats.[8]

2.3 MEDICAL TERMINATION OF PREGNANCY (MTP) IN INDIA [9]

A. Legal Status of Abortion

The Medical Termination of Pregnancy Act, approved in India in 1971 and enacted in 1972, permits abortion (or MTP) for a broad range of social and medical reasons, including: to save the life of the woman; to preserve physical health; to preserve mental health; to terminate a pregnancy resulting from rape or incest and in cases of fetal impairment. Contraceptive failure also is sufficient ground for legal abortion (United Nations 1993).

[8] https://www.downtoearth.org.in/news/health/abortion-in-india-experts-call-for-changes-66369

[9] Shryock, Henry S. and Jacob S. Siegel. 1976. The Methods and Materials of Demo- graphy. San Diego, California: Academic Press.

Barring medical emergencies, legal abortions must be performed within the first 20 weeks of pregnancy and must be performed by a registered physician in a hospital established or maintained by the government or in a facility approved for the purpose by the government (Mathai 1998). For abortions taking place between twelve and twenty weeks of pregnancy, a second opinion is required except in urgent cases. Women must grant consent prior to the performance of the abortion. In the case of minors (defined as under age 18) and mentally retarded women, written consent of guardian is necessary (United Nations 1993).

Critics of the abortion law admit that when it was introduced it was a great achievement for women's health. Nearly 30 years later, the law and associated rules and regulations are considered overly medicalised and bureaucratic, and as such, not oriented torward women's right to access safe and legal abortion services. The law offers substantial protection for medical providers. Chhabra and Nuna (1947) note that "doctors . . . receive blanket indemnity under the MTP Act – instead of functioning as for other surgical procedures and taking the consequences of any default or neglect". Jesani and Iyer (1995) state "Clearly the MTP Act does NOT encompass a fundamental right to induced abortion but is limited to the liberalisation of the conditions under which women may have access to abortion services provided by approved medical practitioners". The law constrains women's access to legal abortion services by requiring providers receive a level of training that is difficult to achieve given the shortage of training facilities in the country and the absence of incentives to receive formal training (Khan et al. 1999).

Bureaucracy associated with registering MTP facilities with the government and with reporting and recording MTP procedures, further contributes to the end result that many physicians provide abortion illegally (Chhabra and Nuna 1994). When a physician performs abortion without registering the

procedure, the physician can avoid the extensive paperwork associated with re- porting MTP (Barge et al. 1994; Chhabra and Nuna 1994; Kerrigan et al. 1995).

B. Inadequate Legal Abortion Service Pro- Vision

Despite the broad range of indications for legal abortion, illegal and unsafe abortions are common in India for many reasons. Women access care from uncertified providers because certified providers are geographically inconvenient; staff at certified facilities tend to not respect women's confidentiality; because women are unaware of certified facilities; because registered facilities often do not have a trained provider and/or the necessary equipment to provide safe abortion services; and many women are unaware that abortion is legal and publicly available. Cost, coercion, moral dilemma, late knowledge of pregnancy and unmarried status are additional reasons women seek abortion from illegal providers. Some providers do not approve of elective abortion and scold the client as they provide treatment; the pressure to accept sterilization or other long-term contraception after an abortion discourages women from using registered facilities. When the reason a woman elects to abort a pregnancy is not legally sanctioned, for example for a sex-selective procedure; or when the procedure is highly socially stigmatized, for example to terminate an extramarital pregnancy, women must access the more confidential services of uncertified abortion providers (Barge et al. 1997; Barge, et al. 1994; Chhabra and Nuna 1994; Gupte 1997; Kerrigan et al. 1995; Khan et al. 1999; Khan et al. 1998; Ravindran and Sen 1994; World Bank 1996).

Government facilities are acknowledged to be inadequate providers of abortion services. MTP facilities are most often located in urban areas while the vast majority of Indian women live in rural areas. Only about ten percent of the clinics that are registered to provide MTP actually have a trained provider and the necessary equipment to provide safe abortion services. Many doctors who are authorized to provide MTP feel inadequately trained to provide the service safely. In addition, many women do not know MTP is legally available at government facilities. Unfortunately, many government facilities that are supposed to provide MTP services free of charge actually charge clients for MTP services, placing another barrier to women's access of safe abortion from the formal health care system (Khan et al. 1999; Khan et al. 1998). Furthermore, evidence suggests that contraceptive acceptance can be a precondition to the abortion (Ganatra et al., 2000; Lakshmi and Pelto, 1999; Gupte et al. 1997, as cited in Ganatra 2001).

Table 5 shows that on an average, MTP facilities do not perform high numbers of MTPs annually. Still, there is significant variation among the states in terms of average number of

MTPs performed per MTP facility. Assam has the highest number of MTP per- formed per institution, followed by West Ben- gal, Orissa, Madhya Pradesh, and Haryana. Gujarat and Karnataka have the fewest number of MTP performed per facility. It is not clear whether states with higher levels of MTP per facilities better meet women's needs and thus attract more clientele or have in- sufficient number of clinics and thus a heavier client load. Likewise states with fewer MTP per facility may have more ad- equate number of facilities or may run in- adequate facilities that prevent clients from presenting.

More telling statistics are the number of MTPs per 1000 people and the number of MTP facilities per population by state in Table 5. Uttar Pradesh and Bihar have the lowest ratios of MTP per 1000 person yet are ranked to have among the highest levels of total abortion (see Table 1). This combination indicates that more abortions are performed outside certified facilities in Uttar Pradesh and Bihar than in any other Indian states and suggests that the level of unsafe abortion may be higher in Uttar Pradesh and Bihar than elsewhere in India.

The population per MTP facility ratios in Table 5 show that Bihar has one MTP center for every 445,000 people. In Uttar Pradesh, Madhya Pradesh, Assam and Orissa MTP facilities are more prevalent but still each facility serves an average of over 200,000 people. The six states that have the highest number of abortions (Assam, Bihar, Madhya Pradesh, Orissa, Uttar Pradesh and West Bengal according to results of three indirect estimation techniques presented in Table 1) mirror the states with fewest facilities per population. This suggests the population most needing access to MTP facilities are also the population least likely to have ac- cess to MTP facilities.

2.3.1 INADEQUATE LEGAL ABORTION SERVICE PROVISION

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reasons women seek abortion from illegal providers. Some providers do not approve of elective abortion and scold the client as they provide treatment; the pressure to accept sterilization or other long-term contraception after an abortion discourages women from using registered facilities. When the reason a woman elects to abort a pregnancy is not legally sanctioned, for example for a sex-selective procedure; or when the procedure is highly socially stigmatized, for example to terminate an extramarital pregnancy, women must access the more confidential services of uncertified abortion providers (Barge et al. 1997; Barge, et al. 1994; Chhabra and Nuna 1994; Gupte 1997; Kerrigan et al. 1995; Khan et al. 1999; Khan et al. 1998; Ravindran and Sen 1994; World Bank 1996).

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2.3.2 ILLEGAL ABORTION – PROVIDERS AND

Methods

Because of the barriers preventing women from accessing MTP, women access abortion from unregistered, uncertified providers. Abortion services from unregistered providers range from completely safe – provided by trained medical doctors in appropriate facilities – to life-threatening – provided by a range of providers in various settings (Mathai 1998; Kerrigan et al. 1995; Johnston et al. 2001). Uncertified abortion providers can include trained medical doctors

and nurses in hospitals, Auxiliary Nurse Midwives (ANM), ayurvedics, homeopaths, dais or traditional birth attendants, family health workers, village health practitioners, pharmacy shop-keepers and village women (Bandewar n.d.; Mathai 1998; Johnston et al. 2001).

Common methods of inducing abortion include vaginal and oral methods. Dais use methods such as inserting sticks, herbs, roots, and foreign bodies into the uterus to induce abortion. Other vaginal methods include pins, laminaria tents, and Fetex Paste[3] . Rural Medical Providers (RMPs or "quacks") sell medicines for oral use to induce abortion. ANMs (Auxiliary Nurse/ Midwives) and ISMPs (Indian System of Medical Practitioners) use intramniotic injections such as intramniotic saline and intramniotic glycerine with iodine to induce abortion. Orally ingested abortificants include indigenous and homeopathic medicines, chloroquine tablets, prostoglandins, high dose progesterones and estrogens, papaya seeds with high dose progesterones and estrogens, liquor before distillation, seeds of custard apple and carrots, etc. (Mathai 1998; Johnston et al. 2001). Chloroquine is applied intramuscularly as an abortificant. Abdo- minal massage, witchcraft, dilation and curettage, vacuum aspiration and heat appli-cations are also used to induce abortion (Indian Council of Medical Research 1989; Kamalajayaram and Parameswari 1988; Maitra 1998; Meenakshi, et al 1995; Rani et al. 1996; Sood 1995, as found in Mathai 1998).[10][11]

CHAPTER 3

CASE REPORT

[10] Shah, S. L. 1966. Report of the Committee to Study the Question of the Legalization of Abortion.

[11] Sharma, V., U. Sharma, and B. Jain. 1992. Study of Maternal Mortality over a Ten- Year Period (1976-1995) at Umaid Hospital, Jodhpur. Journal of Obstetrics and Gyne- cology (46):73-76.

"This country case-study was informed by research authored by Tasneem Mewa, and edited by Ambika Tandon and Aayush Rathi at the centre for internet and society."

Body of a 40 year old woman was brought to the mortuary of our hospital with alleged history of death following a gynecological operation. External examination revealed multiple confluent, sub-cutaneous and submucosal hemorrhagic patches all over the body (Fig 1). She had a pale and dehydrated look. A vertical laparotomy stapled wound surrounded by in-situ drainage wounds was found over the anterior abdomen (Fig 1). Examination of perineum revealed dry blood stains with surgical gauge packing in and around the vaginal canal. On removing the gauge pack, foul smelling serosanguinous discharge mixed in clot and gauge piece was oozing out of the vaginal orifice. Exploration of abdomino-pelvic cavity revealed generalised peritonitis. Peritoneal cavity contained about 350 ml of blood tinged transudate. A part of omentum was surgically resected. Stomach contained about 20 ml of mucoid fluid without any specific odour. Multiple, confluent patches of sub-mucosal hemorrhages were found almost all over the gastric mucosa.

Fig I: (i) Multiple confluent patches of subcutaneous hemorrhage (thin arrows) (ii) surgically stapled wound (15.7cm long) over anterior abdomen (thick arrow) (iii) peritoneal drainage wound (spearhead arrow)

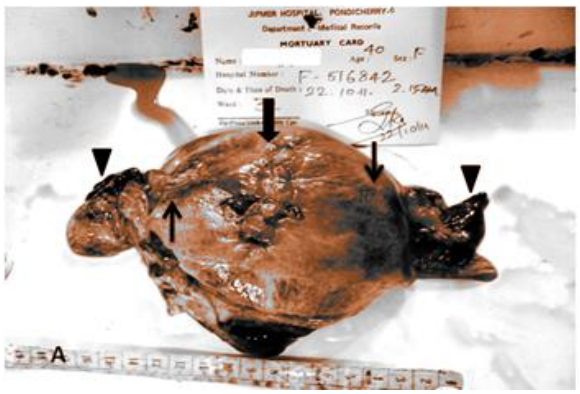

Fig IIA: posterior view of uterus &adenexa. Uterus bulky (size- 16cmX9.8cmX2cm, wt. 475 gm) (i) surgical repair wound (5cm) of uterine perforation on posterior wall of uterine fundus (thick arrow) (ii) ovaries enlarged, congested and hemorrhagic (spearhead arrows) (iv) multiple patches of sub-serosalhemorrhage (thin arrows)

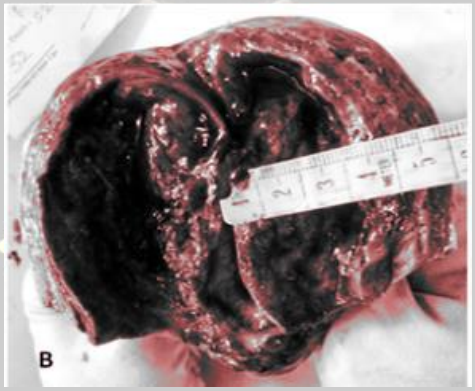

Fig IIB: showing uterine cavity- endometrium congested, thickened, hemorrhagic and necrosed with areas of sloughing

A dark-brown submucosal hemorrhagic patch of size 4.5 cm diameter, ulcerated at the center was found over the greater curvature close to the pylorus. A part of mesentery along the distal loops of ileum was surgically removed. The adjacent part of small intestine was hemorrhagic and edematous; multiple petechial hemorrhages were found on both serosal and mucosal surfaces. All major abdomino-pelvic blood vessels were intact. Liver was congested. Cut section revealed multiple patchy areas of hemorrhage. Hemorrhagic changes were noticed in adrenals and in

pancreas. Both kidneys were congested. Cut-sections revealed diffuse sub- cortical hemorrhages. Diffuse, mottled sub- capsular hemorrhage was seen over the surface of the spleen. Examination of pelvic viscera revealed enlarged, bulky , dusky brown appearing uterus (Fig 2A). A vertical sutured wound was found on the posterior wall of uterine fundus. Cervix was surgically repaired. Uterine adnexa were congested and had multiple confluent patches of sub-serosalhemorrhage. Both side ovaries were enlarged, hemorrhagic and congested (Fig 2A). Cut- sections revealed stromal hemorrhage and necrosis. On opening the uterine cavity, endometrium was congested, hemorrhagic and necrosed with multiple areas of sloughing (Fig 2B). Heart showed multiple patches of sub-epicardial and sub-endocardial hemorrhages. Both lungs showed multiple sub-pleural hemorrhagic patches and blood tinged edema fluid came out on cut section. Scalp, skull and membranes were intact. Brain was congested and edematous. A subcortical necrosed cavity (2 cm diameter) was found over the lateral surface of the left parietal lobe. On dissection, diffuse sub-cortical micro- hemorrhages were found within the substance of brain.

Perusal of hospital records revealed, the deceased was admitted in a critical condition with complaints of excessive vaginal bleeding, lower abdominal pain, fever and skin rashes for 1-2 days accompanied with chill and rigor, giddiness. Vitals were, pulse-122/min/ low volume, BP-90/50mm Hg, Respiratory rate- 34/min. Investigation reports revealed low hematocrit values (Hb-7gm% improved to 10.8gm%, Hematocrit- 38%). Blood urea level- 101 mg/dl, creatinine 2.2 mg/dl, total bilirubin 2.2 mg/dl, total protein 5.3g/dl, and albumin 2.5 g/dl. Arterial Blood Gas analysis showed- pH 6.97, pCO2 19 mmHg and $pO_2$130mmHg. Liver enzymes were within normal limits. Emergency explorative abdominal sonography was done and it showed enlarged uterus with thick, irregular endometrial echo-texture, and cavity contained disorganized mass of products of conception (POC). There was perforation of posterior wall of uterine fundus laceration of endocervix bowel loops. The provisional clinical diagnosis was ‘Septic abortion with co-morbid uterine- perforation, bowel necrosis, renal failure and DIC’. Therefore, she was shifted for emergency laparotomy after conservative stabilization and blood transfusion. Post-operative notes of gynaecologist recorded repair of perforation of posterior wall of fundus, and surgical resection of gangrenous cervix and mesentery of distal ileum. She was died on the first post-operative day.

Further history from the attendants and police disclosed the inherent cause of abortion. The deceased was from a remote village of Tamil Nadu. She was married for 21 years and had children. The husband was an alcoholic and used to abuse her physically. Allegedly, she became pregnant out of an illicit affair with a fellow villager and to have abortion surreptitiously, she approached a village quack. The quack gave her some pills of crude herbal extracts to eat, and a twig of some herb to keep inside the vaginal canal. However, in order to achieve rapid abortion, she vigorously manipulated the twig inside her vagina; and the very next day she had abdominal cramp and profuse vaginal bleeding. She was shifted to a nearby primary health centre, from where she was referred to our hospital.

Discussion

Illegal abortion is a major cause of maternal morbidity and mortality in India. Singh *et al* observed, about 98% of illegal abortions take place in developing countries like India.Data from 67 studies in 17 countries, indicate that, in some areas, up to 50% of maternal deaths occurring in hospital are due to complications of unsafely induced abortion. In many countries this proportion averages about one-quarter of all maternal deaths in hospital.Nevertheless, the practice of safety-less abortion is not uncommon in developed countries too. Practicing abortion in many catholic European countries is not legal, because of certain religious public sentiments against abortion. A recent incident of death from complicated abortion at Ireland kindled public ire and huge protest to legalise abortion. One in two people in India don't know that abortions are legal. The result: Mortality rate as high as 8% among women who are compulsively approach ill-trained clandestine practitioners for abortions. According some eminent Health economist of India 15,000-20,000 women die every year due to lack of access to safe abortion practices.

Safe abortion (MTP) services remains inaccessible to the rural underprivileged parts of India despite such services being provided free by the government. Most of the government and private MTP facilities exist in cities rather than in the underdeveloped rural areaA wide variety of uncertified and/or self-trained abortion service providers are available in the country side like the informal, alternate system of medicine (ayurvedic, homeopathic, unani etc.) practitioners, Auxillary Nurse Midwives (ANMs), nurses, pharmacists, Traditional Birth Attendants (TBA) and even medicine shopkeepersIn developing countries like India, most of the abortions are

performed by local unqualiûed quacks who use orthodox and unscientific methods like inserting foreign bodies into uterine cavities, oral administration of crude abortifacients, and sometimes inserting poisonous herbal products or substances into the uterus. Therefore, the chances of an induced abortion getting septic is very high in these proceduresA retrospective study on septic abortion cases revealed that about 58% percent of the complicated abortions were done by self-trained quacks or clandestine service providers; only 9.7% were attended by trained doctors. A study by Singh *et al* (2011), in 62% cases the untrained local quacks were involved in committing the abortion; and midwifery, nurses were involved in 26% of cases, while the patient herself tried in 8% cases. The commonest method employed for inducing abortion was local trauma, i.e. insertion of foreign body into the uterus (70%), followed by ingestion of poisonous substance (14%). Unknown poisonous substances were introduced into the uterine cavity in 12% of cases. Similar results were recorded by other authors, where 60% of the cases of abortion were dealt by clandestine, unqualified service- providers and, the methods used were oral medications e.g. ayurvedic preparations, chloroquine tablets, high-dose progesterone, high dose estrogen plus progesterone etc, with or without intra-vaginal interventions like use of sticks, roots, iodine-benzoin paste, decoctions of papaya and custard apple seeds etc. Injections (Carboprost or A yurvedic preparations) used in 36%, and surgical methods (D&C, catheters, intra-amniotic saline or glycerin)were adopted in rest 4% of the cases.[3,4] In the present case the deceased had taken service from a village quack and was treated with a combined method of ayurvedic pills and intra-vaginal insertion of some herb-twig.

Confidentiality and rapid service are two major priorities for most women who seek abortion. Local providers, though uncertified or unqualified are preferred for several reasons. Because, they are familiar and stay close to the community; secondly, they are believed to be trustworthy as regard to the professional secrecy. Nevertheless, most often they lure by waiving-off of their fee amount. The major concern for most women seeking abortion is to get in and out of the clinic as quickly as possible, preferably on the same day, before any neighbour or acquaintance find out the truth. The burden of domestic work and family responsibilities often restrain them to have a longer hospital stay (which may be required for a safe abortion). Therefore, they tend to resort to trusted providers despite their ineligibility. Abortion in adolescents are more likely to be performed by the uncertified, clandestine-service providers and contribute to 20% of all

abortion-related deaths among adolescents. The reasons Indian women terminate unwanted pregnancies are many and varied; and it may be due to financial burden, pregnancy related health hazards, old age pregnancy , pregnant out of illicit relationship or rape etc. Nevertheless, not so commonly reported reasons for seeking abortion are pregnancy occurring outside marriage or adolescent pregnancies. However,

female feticide has taken the front among surreptitious abortions. Not only the untrained/self-trained service providers but also the trained doctors are providing service to this group of women; because, now it is a lucrative gray-business in India. Government sponsored MTP-centers or certified MTP centers have low caseloads due to their apathy to maintain confidentiality , may incur high costs due to compulsive bribing practice by the workers in government centers, cringing formalities and pressure to accept sterilization or IUD etc. In many government MTP-centers, especially in rural areas, the services are not available due to lack of doctors, functional equipments and other infra- structures. The MTP training facilities in those areas are also sparingly available. Given such a situation, where safe abortion services are not easily accessible, the problem of abortion is of great magnitude and makes a major contribution to maternal deaths.[16] In the present case, deceased had pregnancy out of extra-marital sexual contact with a fellow villager. Hence, she sought a secret way of procuring abortion from a known village quack, so that she can get an immediate, hassle free and confidential service at door step. The disadvantages with the unqualified service providers are, their inability to attend the complications of abortion or ancillary medical needs and failure to do a timely referral etc. Hence, illegal ways of abortion practices are prone to land up in to complications e.g. shock, uterine perforation, cervical laceration, bowel injuries, peritonitis, septicemia, septic shock, acute renal failure and DIC etc. However, commonly encountered complications include incomplete abortion, haemorrhage and uterine or cervical injury. Study by Agrawal et al.(2008), it revealed that about 63% cases of complicated abortion brought to the hospital are subjected to emergency explorative laporatomy. Out of those uterine perforation were seen in 40% of cases, bowel injury in 34% of cases, blood/pus or faecal peritonitis in 18% cases, and death in 8% cases.[18] The major killers among the complicated abortion, in descending order are hemorrhagic shock, septicemia (together accounts 58%), disseminated intravascular coagulation (28%), acute renal failure (9%) and adult respiratory distress syndrome (5%).[19,20] In present case, the deceased

had suffered from uterine perforation, cervical laceration and multiple bowel injuries. She was died of complications of incomplete abortion i.e. refractory shock, disseminated intravascular coagulation and acute renal failure.

Conclusion

This case report legibly projects a clear picture of the prevailing abortion practice in India. Therefore, it requires a considerable attention in order to transform the theoretical right to a practically feasible safe abortion practice into service. The current situation warrant reforms in the trend of abortion practice; and need to initiate a campaign to raise public awareness with a special attention to the unreachable, rural sectors. Appropriate redistribution of resources in critical sectors, and reduction of the extraneous paperwork that discourages proper reporting by the service providers should be considered. Legal stakeholders should contemplate for reforms in existing MTP Act in order to educate, train the uncertified or unqualified abortion service-providers; so that the clandestine practice of unsafe abortion may be prevented and simultaneously, they can be mobilized as a resource at unreachable rural areas.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATION

4.1 CONCLUSION

Policy review recommendations based on the literature review are made. Any movement toward revising policy needs to be made collectively involving Members of the Ministry of Health and Family Welfare, public and private abortion providers and key non-governmental organizations.

This review of literature shows that a great deal is known about provision of and access to safe and unsafe abortion services in India and the need to improve safe abortion and contraceptive choices to more adequately meet the needs of women experiencing unwanted pregnancies. Still, a great deal more needs to be known before programs are implemented to ensure low- resource Indian women can readily access safe abortion services. The cost in terms of women's health and

lives emphasizes the need to efficiently and effectively pursue efforts to make abortion safer and more accessible for Indian women.

4.2 IMPROVING KNOWLEDGE OF ABORTION INCIDENCE

There is an identified absence of verifiable abortion incidence data in India. Suggested rates of abortion and unsafe abortion vary widely. Methods of collecting acceptable abortion incidence data are intensive, use multiple methods of data collection and instruments must be designed based on local cultural norms (Anderson et al. 1994; Huntington et al. 1996). These fundamental requirements necessitate medium-scale studies (several districts or statewide). Intensive studies of the incidence of abortion and abortion complications would be informative and would yield valuable information particularly as baseline measures and guides for intervention studies.

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