



India – Recent Developments Affecting Women’s Reproductive Rights

By Rupsa Mallik
December 2002

Rajya Sabha¹ Passes Pre-Natal Bill (Times of India, December 11, 2002)

Abortion Bill Gets Parliament Nod (Times of India, December 5, 2002)

The Parliament of India recently approved amendments to two existing laws, one amending legislation on abortion, and the other imposing a ban on sex selection and prenatal sex determination. Closer scrutiny of these amendments reveals mixed implications for women’s rights.

On December 5, the Parliament approved a bill to amend the Medical Termination of Pregnancy (MTP) Act, 1971.² This law guarantees the right of women in India to terminate an unintended pregnancy. Despite gains in women’s health realized by the MTP Act, the number of illegal and unsafe abortions in India continues to be high, with an estimated 6.7 million abortions per year performed by untrained persons in unhygienic conditions (Khan, et al; 1998). Complications of unsafe abortion remain a major factor in high rates of maternal mortality throughout the country.

The main objective of the recent amendment to the MTP is to reduce the rate of unsafe abortions by making legal abortion more widely accessible. Lack of access to MTP services at the primary health care level has been cited as an important reason for the high rate of unsafe and illegal abortions. One of the most important provisions of this amendment therefore is the decentralization of authority for approval and registration of MTP centers from the state- to the district level. This is a critically important first step in reducing the toll of unsafe abortion in India where, in states like Uttar Pradesh, there are fewer than 600 legally-approved MTP centers serving a population of close to 80 million females, a large share of which are in their reproductive years. The current system for approving such centers is extremely cumbersome and slow. For example, anecdotal evidence

indicates that in Delhi alone 250 centers are awaiting government approval. At the same time, however, efforts at decentralization need to be closely monitored to ensure that a speedier approval process does not compromise quality of care, and that adequate resources for both training and technology are made available.

On December 11, the Parliament approved a second bill, titled the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment, 2002.³ The issue of sex selection and sex determination has emerged as an important area of concern during the past year, in part in response to the release of 2001 Census data revealing a dramatic decline in the child sex ratio in India. Pre-natal sex determination and sex-selection abortion has spread rapidly throughout India as the pressure on women to have smaller families while still bearing sons continues to grow (See ‘A Less Valued Life –Population Policy and Sex Selection in India’ at www.genderhealth.org).

The main impetus to amend the existing law has been to broaden the existing ban on sex determination to include the use of pre-conception and pre-implantation genetic diagnosis for sex selection. Other new provisions include maintenance by doctors of *written* records of procedures carried out (not previously required), and the vesting in state, district and sub-district level authorities of powers equivalent to civil courts to ensure compliance with the law and to follow-up reports on of violation and misconduct.

The fact that these amendments were passed at the same time underscores the complexity of the abortion debate in India. On one hand, lawmakers have recognized the need to secure women’s choices and reduce the toll of unsafe abortions by ensuring universal access to safe, legal procedures. On the other hand, the issues of when and why women choose to terminate a

pregnancy have received even more attention as a result of the growing evidence in India of high rates of sex-selective abortion of female fetuses *because they are female*, a practice linked to deeply entrenched discrimination against women and girls in Indian society.

Data now reveal that many women in India seeking late-term abortion procedures are often doing so only because they have waited for the results of pre-natal sex determination tests indicating a female fetus. This situation illustrates the uneasy confluence of the need for access to legal procedures and the deeply distorting results of gender disparities. Access to second trimester abortions in India is highly limited both by the lack of certified practitioners and by the legal requirement that two doctors must approve the procedure. Many women, finding themselves simultaneously pregnant with a female fetus, under severe familial and social pressure to bear male children, and lacking access to information and services, end up seeking out untrained providers for second trimester abortions. As Johnson points out, “sex selective abortion mediates and increases the propensity and prevalence of unsafe abortion” (Johnston; 2002:7&11). Yet the issue of why women seek sex selective abortion in the first place cannot be resolved through legislative means.

Both these amendments represent positive steps in an effort to improve women’s health and rights in India. At the same time, none of these issues can be solved through legislation alone. The potential of either amendment to promote meaningful changes in reducing the incidence of either unsafe abortion or sex selection in India is limited unless the government makes a serious commitment to addressing social and cultural bias against women and girls and to resolving contradictions that arise within the government’s own policies.

For example, both national and state-level population policies continue to emphasize the achievement of replacement fertility as their main objective. Historically, the National Family Welfare Program (FWP) has focused narrowly on population control, resulting in a bias toward sterilization over spacing methods for contraception. Lacking choices, women who wanted to space births but not end childbearing began to rely heavily on abortion as a means of birth spacing. Reliance on abortion for birth spacing is perpetuated by current policies, as a number of states continue to emphasize both a two-child norm and reliance on female sterilization as the preferred means of attaining these goals. Some go even further: The Uttar Pradesh Population Policy, for example, includes a clause that makes provision of MTP services conditional on the acceptance of female sterilization.

Similarly, in order to ensure the effectiveness of laws that ban prenatal sex selection the government can ill-afford population policies that use incentives and disincentives to impose a two-child norm. In the absence of concerted efforts to address deeply embedded gender discrimination, the trend toward fewer children will not eliminate the desire for sons or alleviate the pressure on women to abort female fetuses. It is clear that imposing a two-child norm using coercive policies will further fuel sex determination.

The issues of sex selection versus safe abortion are increasingly intertwined. The MTP Act giving women in India the right to safe abortion has recently come under increasing scrutiny by some as the debate on sex determination and sex selective abortion heats up. During the parliamentary discussion on the bill to amend the MTP Act, for example, a number of members questioned the usefulness of the amendments in curbing female feticide. The tendency to conflate access to safe abortion with the need to curb sex selection abortion also became evident when one Member of Parliament asked whether “abortion is tantamount to feticide. What is the difference between the two?” Some have called for comprehensive legislation to tackle these varied yet inter-connected issues. Such a process must include consultations with and the active participation of women’s groups to ensure that the fundamental right of women to control their own fertility is in no way compromised by sincere efforts to curb the growing reliance on sex selection.

Laws play an important role in every society in regulating medical practice, however they need to be counter-balanced by effective programmatic measures. In this context the effective use of existing systems to register and monitor pregnancies as part of the reproductive and child health package can be a useful programmatic option to prevent unsafe abortions. To this end the government needs to make a commitment to increase the number of auxiliary nurse midwives (ANMs) at the community level and provide them with adequate training and resources. Government resources must also be committed to improve women’s access to non-surgical methods of abortion like manual vacuum aspiration (MVA) and emergency contraception. Surgical abortion (dilation and curettage) continues to be the most common method for abortion. Although the government recommends MVA for all abortion of less than 12 weeks, the technology is not widely available, particularly in rural areas. The government needs to allocate resources for the purchase of MVA equipment--which is considered safe and cost-effective and can be undertaken on an outpatient basis. Increasing access to this procedure will ultimately lower the costs to women and society of unsafe abortions in India.

Abortion in India continues to be shrouded in veils of stigma, secrecy and taboo. Numerous organizations have sought to create greater awareness of the toll taken by unsafe abortion. Groups in India have in the past undertaken a number of important initiatives to create greater awareness on the issue. A recent example is the National Abortion Assessment Project by the Center for Enquiry into Health and Allied Themes (CEHAT) and Healthwatch India Trust. This effort includes a review of the government’s policy on abortion; an assessment of abortion services in the public and private sectors; and a study of both women’s perceptions as well as socio-cultural factors influencing decision-making on abortion. Findings from this project will be disseminated widely through various advocacy efforts.

It is clear that the Parliament’s approval of bills to amend the existing laws on abortion and banning sex determination represent largely positive but limited steps to improve women’s rights and health. Real progress will rest as much or more on a sustained commitment by the government to address the root causes of these problems as it will on effective implementation of these laws.

Reference:

- Johnston, H.B. 2002. *Abortion Practice in India: A Review of Literature*. Mumbai: CEHAT & Healthwatch. May.
- Khan, M.E.; Barge, Sandhya; Philip, George. 1998. ‘Abortion in India: An Overview’. *Social Change*. Sept-Dec 1998. 26(3 & 4). pp.208-225.

Links:

CEHAT - Abortion Assessment Project in India - CEHAT
<http://www.cehat.org/aap.html>

¹ Upper House of Parliament.

² The Medical Termination of Pregnancy (Amendment) Bill, 2002 is available online: <http://rajyasabha.nic.in/bills-ls-rs/XXXV-2002.pdf>

³ The Pre-Conception and Pre-Natal Sex Selection/Determination (Prohibition and Regulation) Act, 2001 is available online: <http://mohfw.nic.in/PNDT%20Amendments.htm>

Rupsa Mallik is a Program Associate at the Center for Health and Gender Equity. Correspondence about the paper should be directed to Rupsa Mallik <rmallik@genderhealth.org> or Jodi Jacobson <jacobson@genderhealth.org>. For additional copies, send an email to <info@genderhealth.org>.

All rights reserved by the Center for Health and Gender Equity. No part of this document may be reproduced, disseminated, published, or transferred, except with prior permission and appropriate acknowledgment of the Center for Health and Gender Equity. Suggested citation: Mallik, Rupsa. *India – Recent developments Affecting Women’s Reproductive Rights*. (Takoma Park, MD: Center for Health and Gender Equity, December 2002).