



Abortion in India: Impact on gender health and sustainable development with regard to gender equality

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Abstract

Gender refers to the social relationships between males and females in terms of their roles, behaviours, activities, attributes and opportunities, and which are based on different levels of power. Gender interacts with, but is distinct from, the binary categories of biological sex. In this paper we consider how gender interacts with the 2030 agenda for sustainable development, including sustainable development goal (SDG) 3 and its targets for health and well-being, and the impact on health equity. We propose a conceptual framework for understanding the interactions between gender (SDG 5) and health (SDG 3) and 13 other SDGs, which influence health outcomes. We explore the empirical evidence for these interactions in relation to three domains of gender and health: gender as a social determinant of health; gender as a driver of health behaviours; and the gendered response of health systems. The paper highlights the complex relationship between health and gender, and how these domains interact with the broad 2030 agenda. Across all three domains (social determinants, health behaviours and health system), we find evidence of the links between gender, health and other SDGs. For example, education (SDG 4) has a measurable impact on health outcomes of women and children, while decent work (SDG 8) affects the rates of occupation-related morbidity and mortality, for both men and women. We propose concerted and collaborative actions across the interlinked SDGs to deliver health equity, health and well-being for all, as well as to enhance gender equality and women's empowerment. These proposals are summarized in an agenda for action. The recent judgement of Supreme Court provides an immense opportunity for gender equality reflecting the spirit of the Indian Constitution mentioned in fundamental rights and directive principle of state policies as SC has extended the right to safe and legal abortion up to 24 weeks to unmarried and single women, saying it is the right of every woman to make reproductive choices without interference from the state.

Keywords: abortion, India, impact, sustainable development

Introduction

Presented research comes under the study area of the sociology of gender and health. In sociology gender and health is part of sociological study under which the study of woman health has been done as abortion. An abortion is a medical or surgical procedure to deliberately end a pregnancy before an embryo or fetus is born. It is also sometimes known as a termination of pregnancy. The pregnancy is ended either by taking medicines or having a surgical procedure.

Complications of unsafe abortion are a major public health issue facing women in developing countries. In India, abortion is legal for a broad range of medical and social reasons. Officially, women can access safe abortion services by trained medical personnel in registered facilities, and minors need consent from their husband or father. In practice, limited access to authorized abortion providers, the threat of forced contraceptive acceptance, the financial costs associated with legal abortion, the stigma associated with induced abortion, and low levels of awareness regarding the legality of the procedure bar women from safe abortion services. As a result, women often resort to untrained clandestine practitioners operating under unsafe conditions. The consequences of abortions performed under such circumstances range from life-threatening to chronic reproductive tract morbidity such as infections, chronic disability and infertility.

In India each year an estimated 453 women die due to maternal causes for every 100,000 live births (UNFPA 1997). This statistic masks the vast variation among states. While national and state estimates are imprecise, they are able to represent certain trends. Orissa and Madhya Pradesh had approximately 738 and 711 maternal deaths per 100,000 births in 1992. Among the large states, Kerala has a singularly low ratio of 87 maternal deaths reported per 100,000 births. On an average, roughly fifteen percent of maternal deaths in India are thought to result from unsafe abortion. In what conditions are these abortions provided? What impact do these unwanted pregnancies.

A reproductive health service that is part of the lives of women, couples and communities in both developed and developing countries. When faced with unintended pregnancies, especially in contexts in which women lack access to effective family planning, induced abortion is an important part of women's reproductive health care.

Ensuring the safety and availability of abortion services is critical to women's health, and creating a supportive legal environment is one step in that process. In India, the second most populous country in the world, abortion has been legal on a broad range of grounds since 1971. More than 1.2 billion people live in India, approximately 26% (328 million) of whom are women of reproductive age (15–49).¹ According to Sample Registration System data for 2012, women in India have an average of 2.4 births in their lifetime.⁶ This key indicator of reproductive health, known as the total fertility rate, has declined from 3.6 in 1991. Women living in urban areas have fewer children (1.8) than their rural counterparts (2.6). Reproductive outcomes vary widely throughout India, reflecting the social, demographic and economic diversity of its states and differential access to health services across the country.

Medical Termination of Pregnancy Act

The Indian Parliament passed the Medical Termination of Pregnancy (MTP) Act in 1971 with the goal of regulating and ensuring access to safe abortion.² As of this writing, this law permits only registered allopathic medical practitioners at certified abortion facilities to perform abortions to save a woman's life or to preserve her physical or mental health; it also permits abortion in cases of economic or social necessity, rape, incest, fatal impairment or the failure of a contraceptive method used by a married woman or her husband. Consent for the abortion is not required from the woman's husband or from other family members, however a guardian's consent is required if the woman seeking an abortion is either younger than 18 or mentally ill. The act allows an unintended pregnancy to be terminated up to 20 weeks' gestation; however, if the pregnancy is beyond twelve weeks, a second doctor's approval is required. The Medical Termination of Pregnancy Act of 1971 greatly liberalised the indications for which abortion is legal in India. The Government intended for this Act to reduce the incidence of illegal abortion and consequent maternal morbidity and mortality. However, 30 years after the groundbreaking legislation, the majority of women seeking abortion still turn to uncertified providers for abortion services because of the barriers to legal abortion. While some uncertified providers offer safe services, many provide unsafe abortions that result in complications or death. Women with access to fewer resources, for example low-income rural women and adolescents, are among those most likely to turn to unsafe abortion and have complications. Studies suggest that the choice of specific provider is most often not made by the woman inducing abortion but with or by her husband or other family members.

While the incidence of abortion in India is unknown, the most widely cited figure suggests that around 6.7 million abortions take place annually. According to government data, only about one million of these are performed legally. The remaining abortions are performed by medical and non-medical practitioners. Levels of unsafe abortion are very high in India, especially given that abortion is legal for a broad range of indications, and available in the public and private health sector. In the current situation abortion services are not adequately decentralized, and regulatory reform will have to take place before decentralization of legal services will happen in a meaningful way. To reduce morbidity and mortality from unsafe abortion in this context, several broad activities require strengthening: decreasing unwanted pregnancies; increasing access to safe abortion services; and increasing the quality of abortion care, including post abortion care.

Table 1: Ratios of MTPs, Government Approved MTP Facilities and Population by State

State	No. of MTPs (1993-94)	No. of facilities (1993-94)	State Population (1996)	MTP: Facility ratio	MTP: Population ratio	1000 Population Facilityratio
Andhra Pradesh	13719	373	72,155,000	37	0.19	193,445
Assam	21372	100	24,726,000	214	0.86	247,260
Bihar	11060	209	93,005,000	53	0.12	445,000
Gujarat	10263	700	45,548,000	15	0.23	65,069
Haryana	22438	228	18,553,000	98	1.21	81,373
Karnataka	9077	471	49,344,000	19	0.18	104,764
Kerala	34433	559	30,965,000	62	1.11	55,394
Madhya Pradesh	33086	295	74,185,000	112	0.45	251,475
Maharashtra	97079	1775	86,587,000	55	1.12	48,781
Orissa	19510	169	34,440,000	115	0.57	203,787
Punjab	19436	242	22,367,000	80	0.87	92,426
Rajasthan	29023	316	49,724,000	92	0.58	157,354
Tamil Nadu	42364	623	59,452,000	68	0.71	95,429
Uttar Pradesh	12103	425	156,692,000	29	0.08	368,687
West Bengal	64273	452	74,601,000	142	0.86	165,047
India	609915	9271	934,218,000	63	0.65	100,768

Amendments to the MTP Act

Since 1971, the government of India has taken steps to increase access to legal and safe abortion services by implementing policies designed to expand the number of legal abortion providers. Despite the legality of

abortion provision in the public sector, actual provision at lower-level public facilities (such as primary health centers) was scarce prior to 2000. In 2000, the National Population Policy officially recommended expanding the provision of abortion up to eight weeks' gestation to all public facilities, including primary health centers.²¹ A decade later, community health centers continue to be the main providers of abortions up to eight weeks' gestation, and provision at the lower level remains a challenge because most primary health centers are not staffed with certified abortion providers.²³

Proposed 2014 Amendment to the MTP Act

For several years, sections of India's medical community, advocacy groups and government officials have been discussing an amendment to the MTP Act, which was officially proposed by the Ministries of Health and Law in 2014 and is now pending approval by Parliament.^{30,31} The 2014 draft amendment, which includes changes that would potentially improve access to legal abortion, proposes

- expanding abortion provision to nurses, auxiliary nurse midwives and practitioners trained in the Indian System of Medicine with recognized qualifications in Ayurveda, Unani, Siddha or homeopathy;
- allowing abortion at a woman's request up to 12 weeks' gestation and increasing the gestational

Medical Termination of pregnancy act (2020)

The Rajya Sabha passed The medical termination of pregnancy (amendment) Bill, 2020. The bill was passed in the Lok Sabha in March 2020

The Bill seeks to amend the Medical Termination of Pregnancy Act (1971)

Provisions

- **Termination due to Failure of Contraceptive Method or Device:** Under the Act, a pregnancy may be terminated up to 20 weeks by married woman in the case of failure of contraceptive method or device. The Bill allows unmarried women to also terminate a pregnancy for this reason.
- **Opinion Needed for Termination of Pregnancy:** Opinion of one registered medical practitioner (instead of two or more) for termination of pregnancy up to 20 weeks of gestation.
- **Gestation is the foetal development period from the time Opinion of two registered medical practitioners for termination of pregnancy of 20-24 weeks of gestation.**
- **Opinion of the State-level medical board is essential for a pregnancy to be terminated after 24 weeks in case of substantial foetal abnormalitie.** Every state government is required to constitute a Medical board.
- **These Medical Boards will consist of the following members:** (i) a gynaecologist, (ii) a paediatrician, (iii) a radiologist or sonologist, and (iv) any other number of members, as may be notified by the state government.
- **Upper Gestation Limit for Special Categories:** It enhances the upper gestation limit from 20 to 24 weeks for special categories of women which will be defined in the amendments to the MTP Rules and would include survivors of rape, victims of incest and other vulnerable women (like differently-abled women, minors) etc.
- **Confidentiality**
The "name and other particulars of a woman whose pregnancy has been terminated shall not be revealed", except to a person authorised in any law that is currently in force.

Abortion, contraception and gender

In India, the need for abortion is related to the availability and use of contraceptives and to the social, cultural, familial and gender dynamics around whether and when contraception is acceptable. In fact, in qualitative studies conducted as part of the Abortion Assessment Project across multiple states in 2002, the majority of unintended pregnancies that were resolved through abortion occurred during periods when women were not using any form of contraception; few were reportedly due to contraceptive failure.⁶²

Abortion among unmarried adolescents

In India, considerable stigma is attached to having a nonmarital pregnancy or birth, especially during adolescence. Among 549 unmarried adolescents obtaining abortions who were included in a 2007–2008 study in Bihar and Jharkhand, nearly all (92%) chose to terminate their pregnancy because they were unmarried or did not want to raise a child alone.⁶⁶ A large minority of respondents reported that the pregnancy resulted from nonconsensual sex (18%), most often perpetrated by a family member (9%) or neighbor (6%). Similar findings came from in-depth interviews conducted in Maharashtra in 1996–1998. Among 16 unmarried adolescents obtaining abortions, a majority reported that they were seeking an abortion because their pregnancy was the result of nonconsensual sex with their employer (6) or a family member (4).

Son preference and sex-selective abortions

Numerous social, cultural and economic factors contribute to son preference, including patrilineal kinship and inheritance practices, a patrilocal marriage system, the expectation that sons will help with farming or a family business and provide security to their parents in old age, and religious traditions that require sons to perform last

rites for their parents.68,77,78 On the other hand, daughters traditionally incur *dowry and marriage costs and leave after marriage, rarely providing support to their aging parents.*

Litratue Review

(Khan *et al.* 1999; Mathai 1998) ^[19] Increase awareness among women and men of reproductive age of the availability of safe abortion services and the dangers of unsafe abortion. Household decision-makers are often husbands and mothers-in-law as well as pregnant women. All could be the focus of campaigns that educate about the availability of safe abortion facilities and methods and the dangers of unsafe abortion services. Safe abortion services need to become a priority for women accessing abortion and those who decide from whom women will access abortion care. The stage of gestation at which a woman can safely abort a fetus is an important component of any campaign to increase awareness.

Ganatra, (1998) The care a woman receives when a complication is first recognised is crucial. Typically, the woman is first cared for in her own home by the female head of household (Potts *et al.* 1998). Women with complications tend to play a peripheral role in making the decision of whether or not they should obtain care (Ganatra, *et al.* 1998).

(Anderson (1994) ^[9] Huntington (1996) 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

1. Christopher Kaczor wrote a book with the name of *The Ethics of Abortion Woman's Rights, Human Life, And the Question of Justice*. The main moto of this book is The Ethics of Abortion.

2. Detal Navin '*Improving Comprehensive Abortion Care Services in Meghalaya* in his book a comprehensive study has been done in Meghalaya.

Potte (1998) Johnston (2001) If obtaining care is determined necessary, the woman may go to a traditional birth attendant, trained midwife, a range of community level providers or a qualified allopathic doctor. There is a general lack of information in rural community about the type of treatment and the providers accused by women for abortion care. If the women who require emergency care following an abortion complication are not obtaining it in the health care system, this serivce-delivery gap needs to be better understood and addressed (Potts *et al.* 1998; Johnston *et al.* 2001).

3. SK Banerjee '*Accreditation of Private Sector Health Facilities for Provision of Comprehensive Abortion Care Services* 'in this article health facilities has been shown on the abortion facilities.

Barge (1997) Potts (1998) The third critical aspect of abortion care, linking women to other reproductive health services suffers from a lack of information and appropriate facilities in most countries including India. Several studies conducted in Uttar Pradesh have documented a lack of awareness among medical providers of the risk of sexually transmitted diseases (STDs) or reproductive tract infections (RTIs) contributing to the spread of HIV or morbidity such as secondary infertility and thus a lack of concern for post abortion reproductive health care such as screening for and treating STDs and RTIs.

SK Banerjee '*Evaluation of a network of medical abortion providers in two districts of Maharashtra* '. As a condition of medical abortion is the main concern of the ethical issues.

Rickie Solinger (2015) However, amongst members of the AMA, it was known that the criminalization of abortion would work to correct declining white birth rates.

Mathai (1999) Bandewar (2000) ^[12] Upgrade facilities that currently offer abortion services. Monitoring of safe abortion service providers may be necessary to ensure that providers are at their sites during clinic hours, that charges do not exceed a set standard, that high quality care is provided from the patient's entry into the clinic throughout service provision and contraceptive counseling. Public and private medical officers could provide monitoring services

Objectives of the Research

1. To understand the socio-ethical condition of pregnancy termination.
2. To know the expectation of the woman regarding termination.
3. To study about the interrelationship between the woman and their family members.
4. Raising Awareness of welfare Action Plan regarding to woman health.
5. To understand the psycho-socio condition of woman.

Research Methodology and Area of Study

After finding the research objective and analysing the introduction to the sociology of health and gender, it is necessary to clear that which methods tools have been used during the completing our research Proposed research work will be depend on the termination of pregnancy and their impact on the health of woman Prayagraj.

In research 15 to 49 age group woman will be involved so this will be tough to study on the huge area so choose the sample from the whole will be indispensable here I will use these steps of method to collect the material.

1. Sampling
2. Interview-schedule
3. Observations
4. primary and secondary sources

Conclusion

This review of literature shows that morbidity and mortality from unsafe abortion remains a serious problem for Indian women; 30 years after the indications for legal abortion were greatly liberalized in India. Research results show that unsafe abortions are common; adolescents and unmarried women are most at risk of morbidity and mortality from unsafe abortion. Furthermore, studies show that for a number of reasons current legal abortion services are not meeting the needs of Indian women, particularly rural women. In four states, a large sample of registered facilities and certified providers have been intensively studied and from those four state studies means of improving services have been identified. In addition, facility-based studies of abortion provision have identified means of improving clinical services. A number of qualitative studies have described the needs of women at the community level. 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 lowresource 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.

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