

Applying a Human Rights Framework to the Provision of Abortion Care and Related Reproductive Health Services in India

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The international consensus on reproductive rights and enabling mechanisms provides a framework for evaluating reproductive health programs and policies. One such application examines unsafe abortion, a significant global cause of illness and death. India is a valuable context for such application — abortion was legalized in 1971 — but abortion-related mortality and morbidity remain common. This paper identifies key rights issues in abortion care in India and outlines possible remedial mechanisms, derived from the reproductive rights framework.

Key words :India; abortion; human rights; reproductive health

Introduction

The international consensus on reproductive rights is generally considered to be derived from rights documents signed by the member States of the United Nations. Over the last fifty years, an increasingly specific definition of reproductive rights has developed from these documents. The goal of such articulations of reproductive rights (and of all human rights) is to turn the consensus into practice by the modification of laws, practices, and resource allocations to promote the ability of individuals to enjoy their human rights. Reproductive rights are very closely tied to the promotion of health, particularly women's health. The framework of reproductive rights created by these documents, through its international origins, advocacy power, and connection to other human rights, may provide a useful tool to evaluate and develop reproductive health systems. The framework may also be a means to address the growing inequities between and within countries in an important facet of reproductive health — maternal health.

By providing a normative and international standard of basic rights and enabling actions required to guarantee these rights, the framework may also point to key steps in remedying inequities and promoting reproductive health.

Maternal mortality represents one of the most glaring disparities in health between developed and developing countries.¹ Abortion-related mortality, often due to unsafe abortion, is a significant component of maternal mortality. Unsafe abortion is a problem in nearly all developing countries (and several developed ones) and has been recognized by the World Health Organization (WHO) as a priority issue in women's health.² WHO defines unsafe abortion as "a procedure for terminating unwanted pregnancy either by persons lacking minimum skills or in an environment lacking minimum medical standards".²

India is a country where unsafe abortion causes a significant portion of maternal mortality and where reliance on unsafe abortion represents unmet need in contraception, social pressures such as son preference, and a failure of the public health system to provide equitable access to acceptable

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equipment and providers. These problems exist despite India's long history of a national family planning program and relatively early commitment to the provision of legal induced abortion. However, this emphasis on providing certain reproductive health services has often been informed by demographic goals rather than holistic health or empowerment goals. Consequently, India's difficulties in providing safe and accessible abortion services are due to resource scarcity, provider practices, discriminatory policies and social norms, and a long-standing tension between achieving numeric goals and providing quality services. This context makes India a useful environment for the application of the reproductive rights framework. The Indian model provides an example of how such country-specific application of a global framework identifies specific causes of barriers to and inequities in access, and provides guidance for creating a more rights-oriented, efficient, and effective system of abortion and post-abortion care. For the purposes of this paper, the term "abortion care" refers to the provision of induced abortion. "Post-abortion care" refers to the treatment of complications from induced abortion and the provision of related health services.

This paper first details the origins and components of the reproductive rights framework, arising from international agreements on general and specific categories of human rights. The delivery of abortion care services in India is then outlined. Key rights issues in abortion care are identified by applying the international rights framework to the Indian context. The social and health contexts of these issues are examined. Finally, the paper presents recommendations for addressing these situations and building rights-oriented interventions. Appendices present UN document sources for each rights issue discussed in the paper as well as recommendations for remedial mechanisms to promote rights and health.

The Reproductive Rights Framework

Reproductive rights constitute one of the most hotly debated but most often affirmed categories of rights addressed by United Nations consensus documents. Reproductive rights are situated at the convergence of women's rights, the right to health, and issues of population and development. The degree to which a government protects and affirms these rights through its policies and programs is an important indicator of progress in many arenas. The weak (or non-

existent) enforcement powers of most statements of, or based on, reproductive rights mean that compliance is largely the consequence of internal belief in these rights and the benefits of honoring them.

Before considering reproductive rights specifically, the definitions of the different categories of human rights used here should be noted. Human rights are those that all people are entitled to by virtue of their personhood without any distinction such as race, sex, or nationality. There are specific ways in which these rights apply to women that can be denoted as women's rights. Generally, women's rights are thus labeled because women are more vulnerable to the violation of certain rights. Women's rights are a means of arguing for equal enjoyment of human rights by all people and are often referred to as equal rights.

Similarly, reproductive rights also derive from basic human rights, particularly those involving the right to life, security of person, privacy, and health.¹ Reproductive rights involve the important roles of sexuality and reproduction in people's lives and the risks associated with them. Often reproductive rights are articulated to address the potential violation of other human rights due to these risks (such as health risks from unwanted pregnancies). Specific reproductive rights statements, like specific women's rights statements, follow from broader rights noted in earlier consensus documents such as the Universal Declaration of Human Rights (UDHR). Thus, the right to choose the number and spacing of one's children is a reproductive right tied closely to the right to health and the right not to be deprived arbitrarily of life. Similarly, the right to information on family planning is linked to the right to benefit from technological progress and the right to information and education. Reproductive rights involve both sexes but are often linked to women's rights due to the higher health burden suffered by women from reproductive causes. Additionally, the heavily skewed focus of family planning and reproductive health programs thus far on women requires the specific application of reproductive rights to women's health.

These rights have been recognized and protected in order to uphold the central right of self-determination and are thus interdependent. The ability to exercise reproductive rights is integral to the ability to enjoy many other rights. Rights entirely outside the sphere of health, such as the

right to freedom of assembly or the right to information and education, may be essential to gain access to the means necessary to exercise the right to health. These three approaches - based on human rights, women's or equal rights, and reproductive rights - are all useful in creating and evaluating rights-based reproductive health policies and programs.³

The international consensus on human rights is codified in international law and in a series of documents that have been signed and ratified by many member states of the United Nations. These documents lead from the UDHR of 1948 to progressively specific documents denoting rights within different spheres of society (such as economic rights) and for different groups (such as children). These consensus documents define basic rights, which are usually concerned with individual liberty and social rights, and pertain to government obligations to citizens.⁴ Often, social rights are implied by basic rights and are codified in subsequent consensus documents. For instance, the recognition of the right to choose the number and spacing of children (a basic right) preceded the recognition of the obligation of governments to ensure the existence of family planning programs (a social right).⁴ Many of these documents are not legally binding, and even the legally binding covenants have fairly weak measurement, monitoring, and enforcement mechanisms. Some of these documents (the platforms of action), rather than articulating "new" rights, are consensus agreements on key actions necessary to promote basic human rights and broad social goals. However, together they all clearly define the principles that should be upheld by all public health activities, show the boundaries that should never be crossed by any programs (even in the interest of a laudable health goal), and provide proof of an international consensus on human rights. The framework created by these documents can thus serve as a mobilizing force for change to promote rights and equity, even if it cannot always act as a legal force. The following table briefly describes salient documents.

Table 1 United Nations Consensus Documents and Reproductive Rights

Consensus Document	Impact on Reproductive Rights
The Universal Declaration of Human Rights - 1948 [UDHR] ⁵	<ul style="list-style-type: none"> - bases human rights on the fundamental dignity and worth of the human person - recognizes first principles: entitlement of all people to all rights; fundamental rights to life, liberty, and security of person; equality of all persons under law - recognizes the right of people to found a family and share equal rights within marriage
Proclamation of the Teheran World Conference on Human Rights - 1968 [PTHR] ⁶	<ul style="list-style-type: none"> - establishes the right to family planning ["the right of parents to determine the number and spacing of their children"] - notes the right to benefit from scientific progress
International Covenant on Civil and Political Rights - 1976 [ICCPR] ⁷	<ul style="list-style-type: none"> - defines rights to self-determination, pursuit of development, and information and education - notes right not to be arbitrarily deprived of life and to have rights protected in a non-discriminatory fashion
International Covenant on Economic, Social, and Cultural Rights - 1976 [ICESCR] ⁸	<ul style="list-style-type: none"> - recognizes the right to the highest attainable standard of health, including access to medical services
Convention on the Elimination of All Forms of Discrimination against Women - 1981 [CEDAW] ⁹	<ul style="list-style-type: none"> - reflects the recognition that general rights instruments are not sufficient to protect the human rights of women - addresses the violation of human rights by private agents (non-systematic violations) - sanctions the modification of traditional practices, customs, and laws
Vienna Declaration of the World Conference on Human Rights - 1993 [WCHR] ¹⁰	<ul style="list-style-type: none"> - focuses on the empowerment of individuals through rights-oriented activities - mainstreams women's rights, including mechanisms for promotion as a key area of concern
Cairo Consensus of the Conference on Population and Development - 1994 [ICPD] ¹¹	<ul style="list-style-type: none"> - focuses on integrating reproductive rights and the rights to health and education into population policies and programs - notes individual empowerment as the primary goal of such programs
Platform for Action of the Fourth World Conference on Women - 1995 [FWCW] ¹²	<ul style="list-style-type: none"> - addresses importance of shared responsibility between sexes, inclusion of women's rights in human rights, and the broader context of economic and social development - notes specific objectives and mechanisms for promoting relevant rights

For those concerned with reproductive health, these UN documents reflect a set of internationally agreed upon values, goals, and actions shaped by human, women's, and reproductive rights. These agreements, therefore, are a legitimate basis for defining the reproductive rights

framework. Central to this framework is a concise set of reproductive rights that have been identified by prominent actors in the reproductive health field.¹³⁻¹⁴ These are:

- The right to life, liberty, and security of person
- The right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment
- The right to bodily integrity
- The right to be free from gender discrimination
- The right to modify customs that discriminate against women
- The right to health (or the highest attainable standard of health)
- The right to privacy
- The right to marry and found a family
- The right to family planning services and information
- The right to decide, freely and responsibly, the number and spacing of children
- The right to information and education
- The right to be free from sexual assault and exploitation
- The right to enjoy the benefits of scientific progress and consent to experimentation
- The right to freedom of assembly and political participation

The core reproductive rights that arise out of these various consensus documents are: the right to freely and responsibly decide the number and spacing of children, the right of access to family planning information and education, and the right of access to family planning services.¹⁵ The role of induced abortion services in implementing these rights varies according to the legal context because the UN agreements refer vaguely to "other means of fertility regulation, where legal".¹¹⁻¹² However, access to post-abortion care is required in all contexts by the ICPD and FWCW.¹¹⁻¹² Abortion as a backup to contraception has been interpreted by some as a corollary to the right to decide on the number and spacing of children.⁴

While these rights are recognized in the official context of an international consensus, clearly that consensus does not manifest itself in adherence to these rights by all governments. This can have several causes, including resource scarcity, conflict with traditional practices and legal codes, and a slow process of change to reflect recent

agreements. Applying the rights framework is, however, an effective way of evaluating the delivery of reproductive health services. Rights in documents ratified by governments can also become tools for advocating change in health services and the policies that shape them. In countries where the legal context supports human rights but provider practices undermine them, the framework can be an important part of the training process for improving services. The framework can also be used to promote broader social advocacy and change, outside the medical and legal systems.

There are certain caveats to keep in mind when applying the rights framework to a country's practices or policies. First, it is the culturally biased nature of the consensus. Most definitions of rights come from a Western, secular, humanist emphasis on individual freedoms. This may be a jarring contrast to the community-focused traditions of many countries.¹⁶ Even when representatives from such nations sign UN treaties, there may be internal perception of the treaties as a form of "ideological imperialism". Second, the use of the word "right" implies an undebatable moral imperative, a fixed truth. In reality, our definitions of rights reflect our own changing norms. "New" rights are recognized by each subsequent UN convention; this constant shifting may appear to undermine the power of rights language.¹⁷ Finally, to avoid discriminatory application of supposedly universal mandates, rights advocates must be careful to avoid selective application of consensus documents to developing countries. For instance, there is no restriction on the use of prenatal sex-determination technology for sex-selective abortion in the United States, as long as the abortion is done within a legal time frame.¹⁸ However, rights advocates rarely target such practices outside of "third-world" countries. Such selective application only promotes fears that rights language is a proxy for a Western cultural agenda and may stymie the empowerment of those victimized by rights violations.

Before applying the rights framework it is important to note two primary categories of rights violations: *De jure* violations occur where the laws and regulations of a country enshrine inequalities between men and women or deny women access to services or information considered rights by UN consensus documents. An example is a law that outlaws delivery of post-abortion care, even to save the life of a woman. Violations can also be *de facto*, such as

infrastructural lack of capacity that prevents access for large portions of a population (such as rural women). *De facto* violations can also be caused by practices at the provider level, such as the requirement of spousal consent for medical procedures.

Abortion Care in India

Reproductive health services in India form a useful context for applying the rights framework. In India, for decades, family planning was synonymous with population control.¹⁹ The family planning program placed heavy emphasis on numerical targets as the easiest way to monitor effectiveness and emphasized sterilization as the easiest method to promote.¹⁹ During the National Emergency period of the 1970s, this became overt coercion and resulted in abuses such as poor quality, mass vasectomy camps, sterilization of males under and over the reproductive age, harsh disincentives for government employees and others, and the use of teachers and a host of other “motivators” in pushing for higher levels of contraceptive use.²⁰⁻²² Not only did such practices constitute gross violations of human rights, but they alienated people from both family planning and the public health system. The coercive practices ignored the health goals of contraception and left persistent consequences such as the almost exclusive reliance today on female (vs. male) methods among those couples opting for sterilization.

This history makes the adoption of a human rights-based approach in India particularly important. In addition to being imperative from the rights perspective, change is essential for the Ministry of Health and Family Welfare to achieve its own goals. Such changes have begun to occur - the government has modified its policy strategy by adopting the rubric of integrated reproductive health rather than vertical, target-driven family planning programs in isolation from other health services or follow-up care.^{19,23} The government has formulated essential and comprehensive reproductive health services packages for implementation at the community and primary health center levels as well as through the system of district and teaching hospitals.²³ The official rejection in 1996 of targets in the national family planning policy reflects a growing recognition of the importance of a rights-based, client-oriented approach in achieving sustainable contraceptive use and long-term health and population goals.²³ Additionally, it demonstrates the

strategic effect of the ICPD consensus.¹⁹ The target-free approach can lead to an increase in the use of spacing methods and the ability of family planning workers to help lower parity couples rather than focusing on “easy” quota-filling high-parity couples.¹⁹ These changes are manifestations of policy-level support for the promotion of human rights. However, there are still numerous rights issues in the provision and regulation of reproductive health services in India. These issues are also concerns as they compromise the efficacy of public sector programs and prevent the realization of health goals across both the private and the public sectors.

Abortion care and post-abortion care serve as a useful microcosm for reproductive health services as a whole. India legalized abortion with the 1971 Medical Termination of Pregnancy (MTP) Act.²⁴ This act allows induced abortion under certain conditions: 1) MTP must be performed by a registered medical practitioner (RMP), meaning a physician, at a public site (intended to be primary health centers, comprehensive health centers, and district/teaching hospitals) or at a private site registered with the government; 2) MTP can be done with one RMP's approval up to 12 weeks and with two RMPs' approval up to 20 weeks; 3) MTP is allowed for danger to the mother's life, risk of serious physical or mental injury to the mother, or serious risk of physical or mental abnormality in the fetus.²⁵ These conditions must be determined “in good faith” by RMPs and have been interpreted broadly to include pregnancy due to contraceptive failure and rape.²⁶ Consent must be obtained from the woman if she is over 18 and not mentally handicapped.²⁵ Induced abortion done outside of these circumstances is illegal and both the woman and the provider can be prosecuted under the Indian Penal Code.²⁴

Several other laws passed by the Indian government have the potential to affect the provision of abortion care. The Prenatal Diagnostic Techniques Act of 1994 prohibits genetic counseling facilities from revealing fetal sex to prospective parents. It limits the use of prenatal diagnostic techniques to specific groups of women (e.g., those who have been exposed to teratogens).²⁴ However, the law has not had a significant impact on the practice of prenatal sex determination except to raise the cost of such services.²⁶ Another relevant law is the Consumer Protection Act of 1986, which protects consumers from faulty or hazardous

products. Private sector health services come under this act but public services do not.²⁷ Approximately 80 percent of health services in India are provided in the private sector²⁸; and this law provides the legal grounds to regulate these services.²⁹ The Act has not been effectively applied to standardizing care and quality in the private sector. Additionally, the exclusion of public services from this Act leaves many providers and sites of care, especially those on which poorer women rely, unaccountable.

The MTP law arose out of concern over maternal mortality and as a backup for population control strategies, rather than as an affirmation of women's rights.²⁹⁻³⁰ Another goal of the law was "medicalization" of abortion provision, restricting provision to registered physicians. Issues such as poor publicity, training limitations, and barriers to access have limited the impact of the law. The MTP program developed in the 1990s by the Ministry of Health and Family Welfare, attempted to address these issues and included the establishment of MTP "cells" at the state level, training programs, and distribution of manual vacuum aspiration (MVA) equipment.^{24,31}

For every abortion done within the confines of the MTP Act, it is estimated that 10-11 clandestine abortions are performed by traditional providers, unsafe providers, or safe private physicians who perceive few benefits in registering with the government.³² Additionally, only 10 percent of eligible sites actually perform MTPs.³³ The primary reasons for this are lack of trained physicians and appropriate equipment.³³ Despite government policy to promote MVA, at least as many MTPs are done using dilation and curettage (D&C) as using any kind of vacuum aspiration.³² Among traditional providers' methods to induce abortion are the use of herbs, other abortifacients, and the insertion of sharp treated objects into the vagina.^{32,34} Pharmacists also dispense a variety of drugs to induce miscarriage.^{32,34} Traditional health providers are the largest group among untrained providers. However, approximately half of unregistered providers are medically trained individuals.³³ Despite this training, the lack of universal standards remains a health concern. A study in Uttar Pradesh revealed that nearly half of unauthorized providers of all types took no steps to treat prolonged or heavy bleeding or abdominal pain in their patients.³³

MTP acceptors are typically married women in their 20s and 30s with several children.³² The majority of MTPs are performed in the first trimester. However, over the last decade, the proportion of women seeking second trimester abortions has increased. The concurrent increases in out-of-wedlock pregnancies and in the popularity of sex-selective abortions have been postulated as factors in the growing reliance on late term MTPs.³⁵ These abortions are riskier, carrying significant death rates, even when performed at teaching hospitals.³³

Unsafe abortion is estimated to account for approximately 20-30 percent of maternal mortality in India³⁶ and an unknown level of morbidity. The most common complications of induced abortion are pelvic infection, incomplete abortion, hemorrhage, uterine injury, and cervical injury.³³ Legality has not significantly reduced abortion-related mortality.³⁵ Inability to access abortion services adds to the health burden of numerous, early, and unspaced pregnancies. Reliance on ineffective abortifacients and other dangerous techniques may lead to significant levels of fetal damage and subsequent child morbidity. These health issues are tangibly linked to the rights issues that are also manifested in the provision of abortion care and family planning in India. Addressing the rights issues may be an effective way to improve the health of women of reproductive age.

Applying the Rights Framework to the Delivery of Abortion Services

Certain inequities in access to abortion and post-abortion care common to many countries also exist in India. Some are caused by resource and capacity limitations, whereas others are more insidious, reflecting discrimination at the level of law and/or practice. Following are the most important issues in service provision that can be viewed as rights violations according to the framework developed above :

1. Sex-selective abortion
2. Coercive or contingent linkage of abortion or post-abortion care to acceptance of family planning
3. Unequal treatment of and sources of abortion care for unmarried vs. married women
4. Use of incentives or disincentives (e.g., monetary compensation for sterilization, but not for other medical procedures)

5. Lack of shared responsibility between sexes for prevention of unwanted pregnancy (e.g., government and/or provider focus on female-only methods such as tubal ligation and IUD, which may be riskier than certain male methods)
6. Spousal consent requirement/veto power
7. Inequity of distribution of care among rural and urban populations
8. Lack of publicity/awareness of legal status of abortion or sources of abortion/post-abortion care
9. Marginalization of abortion among health services
10. Charging for public services that should be free, for instance under the guise of fees for drugs
11. Medicalization of abortion without implementation capacity
12. Reluctance of providers to treat post-abortion complications

These issues represent distinct, identifiable conflicts with the rights framework outlined above. These conflicts can be seen by applying that framework and the individual human rights and action documents that India has signed to each issue. Such application highlights two mutually reinforcing points: 1) the direct utility of the reproductive rights framework in uncovering points of intervention to promote reproductive health and 2) the significant overlap in issues that are areas of concern from a health perspective and those that are concerns from a rights perspective. The primary article addressing the area of abortion care is Article 8.25 of the ICPD platform: "Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling.... In circumstances in which abortion is not against the law, such abortion should be safe".¹¹ However, the other consensus documents comprising the rights framework also provide a foundation for viewing these issues as fundamental conflicts.

Key principles with which these practices and patterns of discrimination conflict include: directives against discrimination based on gender; the core reproductive rights, especially those proscribing coercion; and the rights to health, health services, information and education. The declarations of human rights which reveal problems in the provision of abortion care in the Indian context include the UDHR, ICESR, and CEDAW. The programs of action which detail necessary steps in enabling these rights and

consequent social progress are the ICPD and FWCW documents.

Thus, spousal consent requirements are problematic because they violate rights of equality in marriage, constitute (in their application only to women) discrimination based on gender, and compromise the rights to health and to the best attainable standard of health services. Appendix A applies the rights framework to each of the issues identified above, showing how it violates precepts from either the rights documents, or the directives from rights-based programs of action, or both. For certain issues (sex-selective abortion and medicalization of abortion without implementation capacity), the rights framework provides arguments for and against intervention. In these cases, both perspectives are presented.

The Social and Health Context

Based on the treaties and consensus agreements (whether legally binding or not) that India has signed, these issues represent direct or indirect violations of concrete human rights. However, they are also concerns from a health perspective. They arise out of a complex social context, reflect gaps between law and practice, and are the causes of major health burdens for women of reproductive age in India. These factors must be understood in order to identify affordable and appropriate remedial mechanisms.

Sex-selective abortions : The social context of sex-selective abortions includes a tremendous pressure to produce sons. This pressure and fear of the consequences of failure (e.g., abandonment) leads to avoidance of contraception and sterilization and clandestine abortion. Additionally, a reason given by women for sex-selective abortions is not to bring a daughter into the discriminatory environment they themselves face.³⁷

This son preference can manifest itself in a range of behaviors, from neglect or malnourishment of female children to infanticide. Many researchers have found that higher proportions of neonatal mortality occur among girls. However, studies have found that in communities where sex-selective abortion has increased the gender gap at birth, the gap between age-specific infant and child mortality rates for boys and girls has decreased.²⁶ Nielsen et al, studying rural Tamil Nadu, found suggestive patterns in female infant

mortality.³⁸ They found that the daughters of multiparous women with no sons had a relative risk of neonatal death of 15.48. In contrast, daughters of multiparous women with at least one son had only a 1.87 relative risk. These figures indicate that allowing couples to regulate the sex of their children may improve the health of the girls that are born - they will, at least, be wanted.

The power of this norm for son-preference is also demonstrated through the use of sex-determination technology, despite its nominal illegality. A Punjab study of recent mothers found that prenatal sex determination (PSD) had been done on less than 2 percent of infants with no older sibling, but on 60 percent of infants with two or more sisters and no brothers.³⁹ Sex selection is believed to be a leading cause of the increase in late abortions.³⁵ Ultrasonography (the most commonly used PSD technology) is generally done at 14-18 weeks.³² This often forces second-trimester MTP, which is less safe and far more likely to be illegal. Additionally, the cost of PSD can be a significant cause of debt for rural families - particularly troubling, given the lack of resources (or perhaps willingness) to pay for prenatal care. Many studies find that the use of PSD increases with income.^{26,40} Khanna notes that in communities where affluence has increased without parallel changes in social norms, women are encouraged to wait as long as possible so that PSD may be accurate — indicating greater regard for son production than for women's health.²⁶ This can also be seen in the far greater awareness of rural women about PSD than about the legality of abortion.^{40,41} In a rural study, nearly none of the women who knew of PSD technologies knew about the health-related purposes of these techniques.⁴⁰ That girls are nearly never selected for was demonstrated by a retrospective study in Bombay (done before the PSD ban) which found that of 8000 sex-selective abortions, 7,999 fetuses had been female.⁴²

Coercive or contingent linkage of abortion or post-abortion care to acceptance of family planning :

Numerous studies and reports from women's groups in India have found coercive promotion of family planning for MTP acceptors.^{37,43-45} This is not part of official family planning or MTP policy.^{24-25,46} Some providers "pretend" to be coercive, telling women that they will not receive MTP unless they agree to accept sterilization or IUD.⁴⁶ Qualitative studies have found contingent linkage of contraception to abortion

to be a cause of reliance on unsafe providers who are not influenced by official or unofficial targets.³⁷ The "obsession" of public providers with family planning (and perceived indifference to other health issues) has discredited it in rural areas.⁴⁷ An obstacle to the expansion of utilization of public abortion services may be promotion of sterilization for abortion acceptors. With public awareness of this promotion, there may be unwillingness to use services, even if logistical barriers to access are removed.³³

Bordering on coercion is withholding of information from MTP acceptors on their options for family planning.⁴⁵ Women are often informed of only one method (usually sterilization or IUD), thus prevented from making a free and informed choice.⁴⁸ Often, public sector providers choose a method for women based on a rapid judgement of the woman's needs (or on tacit population goals).³³ A situation analysis of contraceptive counseling and abortion services in regions of Uttar Pradesh found that only 12 percent of patients were informed about more than one method and less than 1 percent were told about possible side effects.⁴⁹⁻⁵⁰ Only 4 percent of sterilization acceptors were told about IUDs, indicating provider control of information.⁵⁰

Unequal treatment of and sources of abortion care for unmarried women vs. married women :

Women face different pressures and barriers to service access based on their marital status. Married women may be discouraged from aborting unwanted pregnancies and unmarried women may be pressured into abortions even while they are denied access to other reproductive health services and education.^{45,51} There is provider bias against providing MTP to married women for early pregnancies, which can especially jeopardize the health of married adolescents.⁴⁵ The health burden of early childbearing is perpetuated by the social norms to prove fertility rapidly after marriage. Over half of the 15-19 year old women have been pregnant and reproductive mortality is the second leading cause of death for young women.⁵¹

This also indicates the importance of honest response to adolescent sexuality, whether the youth in question are married or unmarried. The sexuality of unmarried adolescents is ignored - there is little access for young women to education about sexuality and reproduction.⁵¹⁻⁵² About half of the unmarried women seeking abortions are

adolescents; they are more likely to delay seeking services,⁵¹ which means that MTP will be more dangerous and more likely to be illegal. The rise in out-of-wedlock pregnancy among young women is a cause of late abortions.⁵⁵ While there is social pressure for unmarried women to have abortions, they may have difficulty accessing safe services and the reproductive health services that should be part of post-abortion care.⁵³

Use of incentives or disincentives : The negative consequences of the Family Welfare Program as it functioned during the 1970s were partly attributed to the use of incentives and disincentives both for patients and family planning workers. Despite this, India's population policy has continued to use such schemes. The 8th Five Year Plan included incentives (priority consideration for social services and improvement projects) for high-sterilization rate communities, cash incentives for sterilization/IUD acceptors, and cash incentives for providers.^{31,54} Incentives and disincentives are discriminatory by default in a context where there is grossly unequal distribution of resources.¹⁵

Lack of shared responsibility between sexes for prevention of unwanted pregnancy : Sharing responsibility means addressing 1) the behavior of male and female partners regarding sexuality and reproduction and 2) the priorities and actions of family planning and reproductive health providers. While the first cannot be enforced or mandated through policy, the second is certainly amenable to such influence. First, however, lack of shared responsibility is a cause of many of women's health problems before they encounter the medical system. Gupta and colleagues, through case studies and focus groups, identified several obstacles to women's open discussion of their health needs, most linked to gender relations.³⁷ They cited poor communication about sexual health with the spouse and the extended family's utilitarian attitude regarding female members.³⁷ They also noted that the lack of responsibility among husbands in terms of reproductive behavior was a major cause of repeated and unsafe abortions. Focus groups with rural women found that women often feel unable to refuse sex, even on account of reproductive illness.²⁸ The Indian Penal Code does not recognize rape within marriage.⁵⁵ In such a context, it is important to educate men about the consequences of sexual behavior and reproductive options, rather than merely targeting women for contraceptive

services. Pressure on MTP patients to accept contraception reflects this disregard of the male component of family planning. This lack of attention to both sexes also compromises the success of family planning programs; giving women contraceptives is futile if they are not allowed to use them or are under pressure to have children. This programmatic focus on women is a manifestation of lingering views of women as the root of the population problem.²⁸

Spousal consent requirement/veto power : The MTP Act requires the consent of women for induced abortion. The practice of requiring spousal consent before performing MTP is not legally protected but is ubiquitous at public sites.^{41,37,53} Studies have found delays in women's receipt of care due to problems in obtaining spousal consent.³⁷ This *de facto* requirement of spousal consent has even been applied to women after separation from their spouses.³⁷ Providers claim that this practice is maintained to avoid liability. Entrapment between fear of a husband's disapproval or even abandonment and the fear of unwanted pregnancy may be a significant cause of reliance on unsafe providers. Case studies from rural Uttar Pradesh showed that women with legal reasons for MTP used traditional providers or dangerous abortifacients to keep their husbands from finding out.⁴⁴

Inequity of distribution of care among rural and urban populations : MTP centers are disproportionately located in cities.⁴¹ The hospital-based MTP acceptor is typically educated and from the urban middle class.³² For rural populations, primary health centers (PHCs) are intended to be an accessible source of abortion care. However, in many states, less than 20 percent of PHCs offer MTP services.⁵⁶ In Uttar Pradesh, the most populous state in India, less than 5 percent of PHCs provide MTP.⁵⁶ Only approximately 10 percent of rural health facilities are equipped to provide MTP.⁴⁹ Of public sector medical services, the great majority are located in urban areas, and two-thirds of private providers are in urban practice.⁵⁷ Part of this rural/urban gap involves providers: despite the vast physical infrastructure of PHCs, comprehensive health centers, sub-centers, district hospitals, etc., there are not nearly enough trained providers of MTP in rural areas. Of the 6200 providers trained in MTP in India in the early 1990s, only 1600 worked in rural areas.⁴⁹ In a country that is 70 percent rural, this is a gross mis-allocation of resources. The location of centers

does not reflect either need or population. Maharashtra, which has less than 10 percent of India's population, has 23% of its MTP sites; Bihar, with 10 percent of the population, has 2 percent of MTP sites.⁵⁶ Inequities in distribution mean that rural women, especially those who must maintain confidentiality, face numerous barriers to access. A 1998 study of women with complications from unsafe abortion found that 75 percent of the women traveled between 10 and 50 kms to get to treatment.³⁴ This distance is especially dangerous if delayed complications develop.

Lack of publicity/awareness of legal status of abortion or sources of abortion/post-abortion care: Numerous studies have shown low levels of awareness among women about the legality of abortion, the risks of unsafe or repeated abortion, and the locations of safe providers. A recent five-state study showed that 63 percent of rural women did not know that induced abortion is legal.⁴⁹ A 1993 all-India survey showed that 57 percent of women lack awareness about the legal status of abortion.⁵⁸ Even where women are aware of the legality of abortion, knowledge of safe sites of care is low. A rural study showed that while nearly all women in the sample knew some source of induced abortion (often traditional providers), only 14 percent knew that doctors provide MTP.⁵⁹ This is augmented by the refusal of some media outlets to run MTP advertisements.⁴⁵ Even women's groups have been less willing to publicize MTP relative to other health services and issues.³² This situation is worsened at the provider level by the lingering bias against induced abortion. For instance, a 1991 study showed that the majority of female health supervisors and multipurpose workers did not advise women to go in for MTPs because they believed induced abortion to be bad for women's health.³³ Such practices in the absence of mandatory referral to amenable providers may be a cause of the widespread lack of knowledge about safe providers.

Marginalization of abortion: The marginalization of abortion by public health programs is a major obstacle in expanding access at lower levels of the health care system. Certain government practices that single out MTP promote a "ghettoization" of induced abortion. These have included the lower remuneration for abortion relative to other reproductive health services, the time required to register as a legal provider of MTP (up to three years), the excessive paperwork required in documenting MTP, and the tax on

provision of induced abortion services.^{56,60}

Charging for nominally free services: Studies show that public sector MTPs, though nominally free, usually cost women a significant fee.^{56,73} This is a consequence of provider practices and can delay care for poor women. A recent study found that this practice made abortions at public clinics almost as expensive as abortions at private sites.³⁴

Medicalization of abortion without implementation capacity: The medicalization of illegal abortion was intended to reduce maternal mortality. However, it can only do so for the small minority of women who can reach and afford competent providers.³ Studies discussed elsewhere show limited awareness of the legal categories of abortion providers and limited provider capacity. In this context, the requirement of RMPs for abortion provision limits women's access to safe abortion. Additionally, the requirement criminalizes many local abortion providers⁴¹ who, with proper training initiatives, could be a more accessible group.^{32,45} The provider requirements are especially pernicious when they criminalize the provision of post-abortion care by non-RMPs.^{20,41} The limited number of treatment sites for post-abortion complications is aggravated by limitations on legal providers.

Reluctance of providers to treat post-abortion complications: The weakness of the referral system in treating women with post-abortion complications may be a major cause of abortion-related deaths.³³ The first providers women reach with complications are often reluctant, unequipped, or not allowed to treat them. The lack of regulation of the private sector makes such gaps difficult to address. For instance, private clinics have been known to refer patients who developed complications to public hospitals to avoid liability.²⁹

In a rural sample of women with post-abortion complications, Maitra found that 33 percent had to travel 100 km to get treatment.³¹ The mean time to reach the treatment center was nine days. Only three of the women in this study came to treatment centers with direct referrals. The others needed up to seven consultations before receiving a useful referral.³⁴ Patients had to rely on multiple modes of transportation, including public buses, carts, and even bicycles to reach care. There is also no consistent

policy or system for referral and transitional services. Comprehensive post-abortion care is mostly available only in big cities.³² This lack of willingness or capacity to treat complications, incomplete abortions, and emergencies is a cause of mortality.

Consequences of Rights Issues

A major consequence of these rights issues and the structure of the health system is that at least 90 percent of induced abortions in India are done in illegal settings.³² This is certainly a major cause of the contribution of MTP to maternal mortality in India - the majority of abortion-related deaths are due to sepsis following illegal abortion.³⁵ Women are often reluctant to use public sector providers, who are relatively competent medically.⁵⁶ Identified reasons include the perceived lack of anonymity or privacy⁵⁶; the longer post-MTP stay often required by public-sector providers (which may also jeopardize secrecy)⁵⁶; the public provider practice of requiring spousal consent; pressure to accept long-term contraception or sterilization; the fact that the majority of officers at primary health centers are male; as well as overcrowding, longer waiting times, and poor interpersonal relations with providers.³²⁻³³ As a result of these factors, women often do not receive care in the desired or safest sector. Poor care in the public sector leads to private sector care. High costs in the private sector lead to dangerous sources of care.³⁷ Often, the consequence of these pressures is reliance on unsafe, illegal providers.⁴³

Causes of reliance on illegal providers for abortion include the rights issues identified above: lack of access in rural areas, lack of knowledge about MTP services, lack of credibility of public services, and social reasons mandating confidentiality. For women who do know about safe services, the reasons for relying on unsafe providers include distance of the safe site, unaffordable charges, lack of privacy, and ignorance of the lack of certification of traditional providers.³⁴ Additionally, nearly all surveys uncover the fact that public hospitals charge for some aspects of MTP provision. These pressures and service weaknesses deter women from safe and legal services.

Recommendations and Conclusions

As the studies cited above show, many of these rights issues have direct roots in the regulation or structure of services. "Holes" in the MTP Act lead to inconsistent application,

illegal abortions, and insignificant reduction in abortion-related deaths.³⁰ Inadequate training facilities lead to gaps in practical training and providers who are hesitant to provide MTP.⁶⁰ Inadequate supervision leads to difficulty in implementing a target-free approach and makes the consistent introduction of informed consent practices difficult.^{28,30} Poor quality public-sector provision leads to the use of unregistered facilities and unsafe providers. Inadequate distribution of education and publicity materials leads to a lack of legal literacy and use of unsafe providers. The linking of MTP with overzealous promotion of family planning deters women from using the public sector.

These issues are problematic from both a health and a rights perspective. However, the rights framework must be used not merely to identify violations but to construct remedies and build "an affirmative program of reproductive health".⁶¹ Mechanisms to address these gaps in abortion care need to affect providers, women, and the broader society that influences sexual and reproductive behaviors and health. These mechanisms can work at the population level through national policy or public health campaigns, and at the provider level, through training and supply improvements. Some of these mechanisms are identified in the programs of action of the ICPD and the FWCW. Others can be derived from directives in the rights documents. The rights framework can also be useful beyond indicating policy or legislative actions. Advocates can employ human rights language and principles to generate change in public opinion and to promote discussion around issues that cannot be legislated on, such as personal responsibility for sexual behavior. In fact, in many contexts, such social advocacy may work more quickly than legislative implementation of international agreements.

Key recommendations that directly address abortion services, awareness, and access are detailed in Appendix B. Policy changes must emphasize consistent systems of referral, informed choice and consent, and provider registration. Population level changes should address the necessity of broad public education, particularly of adolescents and women regarding their human rights and legal entitlements. The education of providers regarding their patients' rights, safer low-cost technologies, and the processes of informed consent and counseling is also crucial. These changes are necessary to maximize the potential of the infrastructure

for abortion care and of the providers who are often women's primary contact with the health system. Many of these recommendations require the recognition of the tremendous involvement of illegal providers in abortion care. However, addressing these issues solely in the arena of abortion care is short-sighted. Underlying social factors, such as pressures to marry girls young and lack of female access to other basic needs (such as primary education), as well as women's decision-making power and inter-gender relations must also be tackled.^{52,62} Just as reproductive rights are linked to other human rights, "fixing" reproductive health care must be linked to other initiatives. One critical obstacle to be overcome is government reluctance to address customs and practices within the private sphere (identified by CEDAW and other consensus documents as a primary location of women's rights violations). This reluctance is manifested in India's reservations to CEDAW, which include a "policy of non-interference in the personal affairs of any Community without its initiative and consent" and a reluctance to register all marriages.⁹

The overlap between obstacles to achieving equity in enjoyment of human rights and obstacles to achieving public health goals is significant. Similarly, many of the same key actions that promote equal enjoyment of human rights also promote the public's health. The ideological value of the international consensus on reproductive rights and the envelopment of reproductive rights in the broader notion of human rights make the reproductive rights framework a powerful tool in advocacy for more equitable and effective health services. Where abortion continues to be illegal the framework has less strength, due to equivocation over the "right" to other means of fertility regulation beyond family planning. But, in countries such as India where induced abortion is legal and part of official maternal and child health policy, the intersection of public health and human rights goals provides concrete mechanisms for the improvement of reproductive health services.

Appendix A: UN Document Sources for Rights/ Equity Issues

The following is an examination of each issue identified in the text as a rights/equity violation or pattern of discrimination. For each issue, the specific document of international agreement whose principles are violated is cited. When the issue is clearly a rights/equity problem, but the language of international consensus provides conflicting interpretations regarding interference or non-interference, both sides are presented.

Sex-selective abortion:

Interference-

1. Violation of directives to address discrimination from the earliest stages of life [CEDAW, WCHR, FWCW].^{9-10,12}
2. ICPD (Chapter 4) and FWCW (Actions to be Taken/Women & Health) refer to prenatal sex selection as a type of gender discrimination to eliminate.¹¹⁻¹²

Non-interference-

1. If the procedure represents the decision of the woman, then it is part of the core right to decide "freely and responsibly on the number and spacing of children" [PTHR, ICPD, FWCW].^{6,11-12}

Coercive or contingent linkage of abortion or post-abortion care to acceptance of family planning:

1. The central tenet of reproductive rights is that people have the right to decide on the number/spacing of their children "free from coercion, discrimination, and violence" [PTHR, CEDAW, WCHR, ICPD, FWCW].^{6,9-12}
2. ICPD: "The principle of informed free choice is essential to... family planning programs... coercion has no part to play." ICPD notes that reproductive health programs should provide the widest range of services without any form of coercion.¹¹
3. CEDAW recommendations 19 + 21: "Elimination of all forms of coercion [in family planning programs]".⁹
4. Coercion will be disproportionately directed at women (especially when abortion services are contingent upon acceptance of family planning). This undermines the mandate to promote shared responsibility between genders in family planning, educate men to take responsibility, and share the health burden of family planning between sexes [CEDAW, WCHR, ICPD, FWCW].⁹⁻¹² It also constitutes discrimination based on gender [CEDAW and WCHR].⁹⁻¹⁰

Unequal treatment of and sources of abortion care for unmarried women vs. married women:

1. ICPD (7.19) notes the responsibility of governments, providers, and NGOs to remove all programmatic barriers to care; unequal access for women according to marital status constitutes a programmatic barrier.¹¹
2. Often unmarried women seeking abortion or post-abortion care are adolescents:
 - a. ICPD (7.45) notes the vulnerable status of adolescents and that "countries must ensure that the programs and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need".¹¹
 - b. FWCW (para 93): "Adolescent girls need, but often do not have access to necessary... services; counseling and access... (which) are still inadequate and lacking." (para 95): "Full attention should be given to... meeting the education and service needs of adolescents [who are]... particularly vulnerable".¹²

Use of incentives or disincentives:

1. ICPD (7.12) discourages incentive schemes, noting their marginal effect and their negative impact on free and informed choice.¹¹
2. ICPD (7.23) encourages governments to focus efforts on educational/voluntary measures rather than schemes involving incentives and disincentives.¹¹
3. Disincentives, particularly, amount to coercion in low-resource settings. They may be especially coercive when applied by employers, as in India. They also amount to discrimination when applied selectively to certain populations or sub-groups within a country. The basic statement of reproductive rights in all consensus documents forbids coercion, discrimination, or violence.^{6,9-12}

Lack of shared responsibility between sexes for prevention of unwanted pregnancy:

1. The FWCW mission statement and specific paragraphs speak of the importance of cooperation and partnership with men and devoting of attention to the promotion of mutually equitable and respectful gender relations.¹²
2. FWCW includes, in actions to be taken, the development of programs to educate men on sexual and reproductive health and family planning.¹²
3. Programs that focus only on services for women prevent the development of joint decision-making on a basis of equality of information and power between men and women [a goal in CEDAW, WHCR, ICPD, and FWCW].⁹⁻¹²

Spousal consent requirement/veto power:

1. Spousal consent is made a requirement exclusively for women. This violates the ICCPR (23.5) directive that states ensure equality of rights and responsibilities of spouses during marriage.⁷
2. Such consent requirement constitutes discrimination solely on the basis of sex, and as such is forbidden by CEDAW (Article 12) and WCHR.⁹⁻¹⁰
3. FWCW explicitly notes the negative consequences on women's health of policies that promote and perpetuate gender stereotypes.¹²
4. FWCW (para 92): "Women's rights to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality to men." Spousal consent requirements are a clear violation of this mandate.¹²

Inequity of distribution among rural and urban populations:

1. ICPD and ICESCR note that all couples and individuals have the right to the highest attainable standard of health services. Most other documents note the universal right of access to, at the very least, information and education.^{8,11}
2. CEDAW (Article 14) notes the particular problems faced by rural women and mandates appropriate actions by states to eliminate discrimination against women in rural areas and to ensure to such women "the right to access adequate health care facilities, including information, counseling, and services in family planning".⁹

Lack of publicity/education/awareness of legal status of abortion or sources of care:

1. When governments suppress information about services or legality, they limit the right of couples and individuals to benefit from technological progress [PTHR].⁶
2. Expansion of the availability of information is one of the means prescribed by ICPD (7.19, 7.20) for eliminating barriers to care.¹¹
3. All major consensus documents list access to information as equal in importance to access to services.¹⁻¹²
4. FWCW (para 219): "Insufficient information on existing rights... perpetuate[s] women's *de facto* inequality".¹²
5. Women cannot implement their right to make reproductive decisions without information and education.
6. Discrimination in provision of information about abortion (vs. other reproductive health services) when abortion is legal violates the right of access to information about the full range of services and creates a *de facto* access barrier [ICPD].¹¹

Marginalization of abortion among other health services:

1. FWCW (para 94) also recognizes the importance of access to abortion services in reproductive health packages and the "rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of... regulation of fertility which are not against the law".¹²

Charging for public services that should be free:

1. Most documents note that services that are a "right" should be affordable and free where necessary in order to maintain access to that right [ICPD, FWCW].¹¹⁻¹²
2. The rights to enjoy scientific progress [ICESCR, PTHR] and legal means of fertility regulation [ICPD, FWCW] cannot be enjoyed when unaffordable fees are levied.^{6,8,11-12}

Medicalization of abortion without implementation capacity:

Non-interference -

1. Promotes the enjoyment of the right to the best attainable standard of care [ICESCR, CEDAW, WCHR, ICPD, FWCW], discouraging services by unqualified, unsafe, or unregulated providers.⁸⁻¹²
2. Requiring high quality, high-tech care promotes the right to enjoy scientific progress [PTHR] (UN 1968).

Interference -

1. When there are not enough providers of required caliber to guarantee access for all who need it:
 - a. The basic right to decide upon the number/ spacing of children [PTHR and all others] is limited.⁶⁻¹²
 - b. The actual right to health [CEDAW, WCHR] is undermined.⁹⁻¹⁰
 - c. Women are differentially affected through the consequences of unwanted pregnancy and through the

greater restrictions on their access to care; this violates mandates to prevent discrimination in access to health services on the basis of gender [WCHR 41, CEDAW 12.1].^{9,10}

- d. Such restrictions on the provision of services will differentially affect rural women, who will face far greater barriers to access than urban women; they violate CEDAW (14.2) provisions.⁹
- e. Such restrictions may be considered programmatic barriers to care [ICPD 7.19].¹¹

Reluctance of providers to treat post-abortion complications:

1. ICPD (7.24): "[States need to] in all cases [to] provide for the humane treatment and counseling of women" who have had abortions, regardless of the legal status of induced abortion.¹¹
2. ICPD (8.25): "In all cases women should have access to quality services for the management of complications".¹¹
3. FWCW (para 90): "Lack of emergency OB services is of particular concern".¹²

Appendix B: Rights-based Policy and Practice Recommendations

Policy Changes:

1. Expand the categories of legal abortion providers, particularly for emergency care.^{32,33}
2. Reduce the paperwork and time required to become registered as a legal private provider.
3. Increase training capacity. There is a tremendous physical infrastructure for abortion services but the current training system does not create enough competent providers.
4. Streamline the referral process for post-abortion care by creating consistent policies (within both private and public sectors) for the treatment of incomplete or septic abortions. WHO considers such treatment an essential part of first-level referral services.³
5. Enforce "paper laws," such as the 1929 ban on child marriages. The government needs to address its reluctance to interfere in "communal matters".⁹
6. Maintain at least current levels of funding for maternal and child health services. Cutbacks in the VII Five Year Plan are believed to have hurt service delivery.³² In 1995, the only provision for women's health was in MCH services which got 2 percent of the health budget [which, itself, has been receiving a declining percentage of GDP].⁵⁷
7. Remove all salary-related incentives for family planning workers, as they may encourage coercive practices or infringement upon informed choice.⁶³
8. Regulate health care in the private sector. Studies document the widespread existence of poor conditions at sites of care, poor training of providers, and the misuse of drugs.²⁹

Public Health Campaigns:

1. Educate adolescents about sexual and reproductive health.^{43,61-65} Sex education (and, of course, education in general) is recognized

as one of the most basic ways to promote women's rights and health.⁶⁶⁻⁶⁷

2. Raise awareness of abortion legality and safe sites of care,^{2,30,43,61,68} especially at the community level.

Provider-Level Interventions:

1. Increase awareness of and distribution of MVA in the private sector. Promote medical abortion in both public and private sectors.
2. Train providers in counseling and the process of informed choice.^{43,49,68} This involves creating a two-way flow of information between patient and provider, emphasizing confidentiality and privacy, and training providers in interpersonal relations.
3. Train traditional providers to recognize signs of complications and refer patients to the nearest treatment centers. This requires acknowledgment of the high involvement of untrained providers, especially in rural areas, in abortion care.
4. Enforce consequences for levying fees that create barriers to access for public services.⁴³
5. Make public and private sector providers aware of the legal status of abortion and service protocols (i.e., their duties to patients).²

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