IJERLAS
International Journal of Educational Review, Law And Social Sciences

LEGAL FEMINIST APPROACH TO ABORTION IN TAMIL NADU - A STUDY

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Abstract

Induced abortion has been legal in India on a broad range of grounds since the Medical Termination of Pregnancy (MTP) Act was passed in 1971. An estimated 707,900 abortions are performed in Tamil Nadu annually. For 2015, this translates to 33 abortions per 1,000 women of reproductive age Thirty-two per cent of abortions occurring annually in the state an estimated 228,600 are provided in health facilities. More than half (56%) of these are surgical, and the remaining 44% are performed using medical methods of abortion (MMA). Eighty-two per cent of facility-based abortions are provided in private facilities, nearly 17% in public facilities and about 2% in NGO facilities. The majority of abortions in Tamil Nadu (63%) are done using MMA obtained in settings other than health facilities. Five per cent are performed outside of health facilities using other, typically unsafe methods. An estimated 43% of all pregnancies in the state 945,900 in 2015 are unintended. Three-quarters (75%) of these unintended pregnancies end in abortion. Each year in Tamil Nadu, roughly 183,300 women obtain facility-based post abortion care for complications resulting from induced abortion or miscarriage.

Key Words: Post abortion, Unintended Pregnancy, Feminist, Tamil Nadu

Introduction

Tamil Nadu is one of the states with the highest number of abortions in India. Abortion pills have been sold in large numbers in Tamil Nadu in the last two years. We are now forced to realize that many statistics point to the background of this shock. Through this study, we can Realize that there are many shocking and mysterious sociological criminal backgrounds behind the rhetoric of abortion. Many of these abortion-related statistics also indicate that a great deal of injustice against women is taking place implicitly in society. A woman goes through a lot of pain until the fetus is formed in the womb and the fetus grows for 10 months and gives birth to a child. We see many crimes against women in the daily

news. Amidst these miseries, we can point out that injustice is indirectly being done to women. In the background of this, we have explained many reasons and reasons that have led to a high crime rate. In that way, what are the reasons for women to have an abortion, what are the regulations and to what extent are they observed in Tamil Nadu. [i]

Abortion

Abortion is a procedure to end a pregnancy. It can be done in two different ways: Medication abortion, which uses medicines to end the pregnancy. It is sometimes called a "medical abortion" or "abortion with pills." Procedural abortion is a procedure to remove the pregnancy from the uterus. It is the removal of a pregnant woman from her uterus before it is viable outside the uterus and destroyed. In some cases, the embryo or embryo will die on its own while still inside the uterus. If this happens, it is usually called miscarriage or spontaneous abortion. Abortions that are performed on purpose rather than automatically are called induced abortions. In general, the term abortion refers to an induced abortion that is done intentionally. In induced abortion, an abortion performed for any medical reason (for the health of the mother) is called a therapeutic abortion.[ii]

Abortions performed for other reasons are called elective abortions. Abortion is usually performed to delay or stop childbearing. Confusions at work, disruptions in studies, unstable financial status, and instability in relationships are the common causes of this type of induced abortion. This type of abortion is performed even if a woman has become pregnant during sexual intercourse. With legal approval, abortion is one of the safest medical procedures in developed countries. Abortion is done by some drugs or surgery in the modern way. When abortions are done legally and safely, long-term mental and health consequences can be avoided.

However, 5 million women are admitted to hospitals and 47,000 die every year due to unsafe abortions performed by unskilled people, in unsanitary environments, and using dangerous equipment. The *World Health Organization* recommends that all women have access to safe, legal abortion,

Abortion has a long history. In the past, abortion was performed through various methods. These include the use of abortifacient herbs, use of sharp weapons, infliction of physical injuries, and many other traditional methods. In modern medicine, abortions are performed through medication and surgery. Laws and cultural attitudes regarding abortion

vary widely around the world. Debates between pro- and anti-abortion are taking place all over the world. Opponents of abortion argue that a foetus, young or adult is equal to human life, and destroying it is equal to murder. Proponents of abortion say that it is the woman's right to let the fetus grow and destroy it. Nowadays, in developed countries, abortions are usually carried out under the legal procedure of each country, using medically safe methods. However, around 70,000 pregnant women worldwide die from unsafe abortions every year. Globally, about 45% of the approximately 56 million abortions performed annually are unsafe abortions.[iii]

There was no significant change in this rate between 2003 and 2008, but there had been a decline in the previous few decades due to years of education about family planning and contraception. As of 2008, 40% of women were not legally restricted from obtaining an abortion of their choice. However, among countries that do allow abortion, different countries have different time limits on how early in the labour period an abortion must be. Abortion refers to the use of certain medicinal substances that can terminate the fetus. If medical abortion is not successful, surgical procedures are used and completed early or mid-term. An early abortion is usually safe. But late-gestational abortions can cause complications In Canada, many European countries, China, India, and other countries, mid-gestational abortions are usually the medical procedure. But in the United States, 96% of midterm abortions are surgical. France, Switzerland, and the Nordic countries have the highest rates of abortions performed within 9 weeks of conception. But early-term abortions in the U.S. are very low.[iv] During the three seasons of conception, the first trimester, and the following three months, the second trimester, mifepristone and prostaglandin are combined to perform an abortion through them, which is as safe as surgery. Contraceptive pills and devices can be used following an abortion. Absorption abortions are usually performed surgically within 12 weeks of conception.

In this type of suction, the umbilical cord is removed using electric or non-electrical equipment. The method of doing this will vary depending on the stage of germination. In the very early stages of conception, abortion can be performed by simple suction without dilatation of the cervix. Dilation of the cervix is necessary in the posterior stage. The second most common surgical procedure is Dilation and Curettage (D&C). This method is a method of abortion performed for various reasons. It is used to check for diseases such as cancer, to check for causes of abnormal bleeding, and to scrape and clean

the lining of the uterus after a miscarriage or spontaneous abortion. An instrument called a curette is used for scraping. The World Health Organization recommends using this method only when easier suction methods are unable to induce an abortion. If the fatal development goes beyond 15 weeks, up to 26 weeks, the abortion is usually done in a procedure called Dilation and Evacuation (D&E).[v]

In that case, the cervix is dilated, all the contents inside the uterus are removed with some surgical instruments and suction tools, and the uterus is emptied. Premature labour is induced with Prostaglandin, and ice water is injected into a concentrated, hypertonic solution containing saline, urea, etc. After the 16th day of conception, a method called intact dilation and extraction (IDX) is used. Here the mature head is decompressed and expelled. This method is banned in some places. In the last trimester of pregnancy, abortion is performed by this method, induced labour or hysterectomy. In this type of abortion, general anaesthesia is given. It is similar to cesarean delivery. Procedures in the first trimester are performed using local anaesthesia, followed by general anaesthesia for the abortionist.[vi]

Legal Feminist Approach

Western feminism has traditionally taken the position that the right to abortion is a fundamental and non-negotiable demand. However, the debate in India illustrates the problematic nature of liberal rights discourse in feminist politics. The women's movement in India has consistently campaigned for legislation to curb the practice of selective abortion of female fetus. However, it is clear that, given the imperatives of the Indian government, particularly in the area of reproduction, little if any possibility exists for achieving truly feminist and transformative legislation. In addition, it is philosophically incoherent to argue for abortion in terms of the rights of women to control our bodies and at the same time demanding that women be prevented by law from choosing specifically to abort female fetuses. Partly as a result of this incoherence, India's feminist movement is both using the rhetoric of women's choice to enhance access to abortion while demanding that women be prevented from aborting female fetuses. Therefore, the women's movement must rethink both the role and the conceptualization of rights. Section 312 of the Indian Penal Code, 1860, makes it an offense to voluntarily cause an abortion, even if the abortion is with the consent of the pregnant woman, unless the abortion is to save the life of the

woman. The woman has also challenged Section 3B of the Medical Fertility Act, 2003. This law allows termination of pregnancy between 20 and 24 weeks only for certain categories of women. This case raises very important questions about reproductive rights and recognition of female autonomy and female agency in India. This case raises very important questions about reproductive rights and recognition of female autonomy and female agency in India. Raised.[vii]

MTP Act

In 1971, the Medical Fertility Act (MTP Act) was introduced to liberalize access to abortion. Because this prohibitive criminal law has led to the use of unsafe and dangerous methods of abortion. Survivors of sexual assault or rape or sexual assault, or those who become pregnant through illicit relationships are eligible for termination of pregnancy. Girls below 18 years of age are eligible for termination of pregnancy Change of marital status (widow and divorce) during pregnancy; Women with physical disabilities [are eligible for termination of pregnancy if they have a major disability as per the criteria specified under the Rights of Persons with Disabilities Act, 2016. Mentally challenged women, including those with mental retardation; Women who are pregnant in humanitarian situations or in disaster or emergency situations declared by the government to have a fetus with a significant risk of being incompatible with the woman's life, or a child whose birth may be severely handicapped by such physical or mental abnormalities. The law recognizes a change in the circumstances of the relationship status between a pregnant woman and her partner – in the case of divorce and widowhood but it does not envisage the situation for unmarried women. It is this lacuna in the law that the petitioner in the Supreme Court claims.[viii]

Abortion-related rates in Tamil Nadu

Reports say that sales of abortion pills have increased in Tamil Nadu recently. Abortion pills can be used to terminate unwanted pregnancies in women. Drug Control Board has said that the sale of this pill this has recently increased prostol and mifepristone are two types of drugs being sold for abortion. Women's health can be affected to a great extent when these drugs are used continuously. Therefore, these abortion pills are not allowed to be sold without a doctor's prescription. However, some drug stores are desperate for money and sell it thinking that they are helping the victims. To prevent this,

the Drug Control Board is taking many measures to prevent it. They also said that action has been taken against 30 drug shops in Anmai for providing abortion pills without doctor's advice. Apart from that, it is also said that the sale of such pills in hospitals other than hospitals can be reduced.[ix]

In India, a woman dies every two hours from an unsafe abortion. According to a study, India sacrifices 48 girls every day to unsafe abortions. According to the World Health Organization, more than half of all unsafe abortions worldwide occur in Asia, particularly in South Asia and Central Asia. This means that most of the unsafe abortions are happening in India. Tragically, abortion is not illegal in India. Abortion. It is a medical procedure permitted by Indian law. Abortion law in India is not today. India has had a safe abortion law for over 50 years. The Act brought in 1971 was amended in 2002, 2003 and 2021. According to the amendments, abortion is legal for certain reasons. For women who do not have reasons, the law does not help. Activists say the confusion in this list of reasons causes pregnant women seeking abortions to resort to unsafe abortions. That is why in the effort to 'eradicate unsafe abortion in India' they are prioritizing awareness of the causes of the law as the first priority.[x]

Access to medical abortion in rural Tamil Nadu

A fundamental prerequisite for women's control over their own bodies and reproduction. Achievement of sexual and reproductive health and rights. A woman's ability to stop an unwanted pregnancy is considered an exercise of her reproductive rights. This study reports on interviews with 15 women who underwent a medical abortion in rural South India. It examines the circumstances their choice to have an abortion and their views on medical abortion. Women in this study, many factors such as the lack of a partner for child care contribute to the decision to have an abortion Contraception, hostile in-laws, economic hardship, ill health of women, wife violence, Lack of access to appropriate contraceptive methods, and social norms regarding reproduction and sexuality united to suppress them. Availability of easy and affordable methods like medical abortion although the pills were temporary, they helped women get out of difficult situations. Medical abortion also accomplished their special needs by ensuring confidentiality, minimal disruption to their domestic schedules, and providing for respite or caregiver needs. The study concludes that medical abortion can help Women in oppressive situations. However,

it does not provide gender equality or empowerment of women; Social conditions must change for that.[xi]

Characteristics of the women

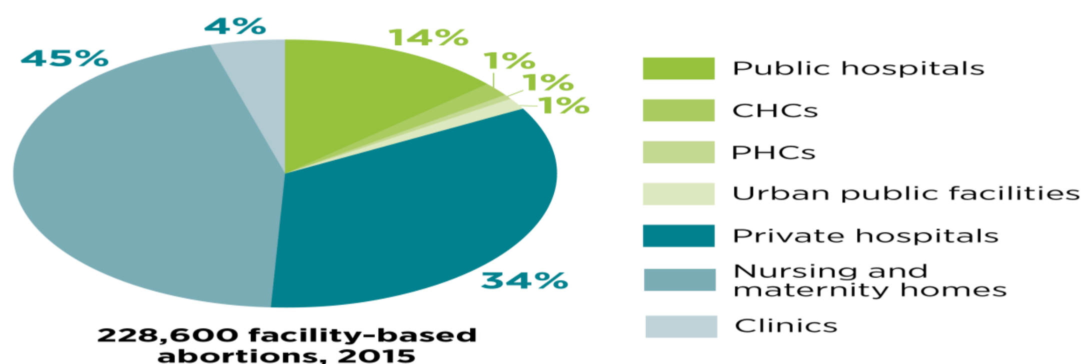
The 15 women interviewed, ten were aged 25–29 years, three were aged 20–24 and two were 36 and 37 years old. All the women had been to school; 11 had 8−10 years of schooling; three had post-secondary degrees or diplomas, while the oldest woman had had five years of schooling. In spite of significant education, nine of the women, including one who had qualified as a nurse, did not work outside the home. Three were agricultural wage labourers, one worked in a dress-making factory, one was a pharmacist and one was a church preacher alongside her husband. All the women were married and were co-residing with their husbands, except one, who had recently separated from her husband due to domestic violence.

The interviews did not probe into the circumstances of their marriages nor whether they could exercise any choice in the matter of when or who to marry. Women's descriptions of their marriage and family were dominated by the burden of their daily domestic routine with no time for themselves. This was a recurring theme in almost all interviews. This was compounded by the fact that even while living in large families *(11 of the women lived in joint families with one or both of their husbands' parents and sometimes their husbands' siblings and their families),* many of them reported that they were solely responsible for the majority of household chores and received little help from their husbands or other family members. This was especially true if the woman's relationship with her marital family members was not cordial.[xii]

Women's decision to have an abortion and Selection of provider

97 in most cases women Key decision makers in their own affairs Abortion, and 20 of them went on their own their pregnancy should be done away with counselling their husbands or other family members. This is contrary to popular interpretations Women's subordination and lack of decision-making power in Indian households. The women we interviewed generally felt that Husband should be consulted, his approval Obtained to have an abortion. However, many of them took the initiative to discuss Arrangement of pregnancy and abortion. 75 out of 97 women progressed to higher levels Qualified and safe (47) or intermediate (28) providers, 22 unqualified or insecure providers, four of them have

gone Traditional practitioners. One of these four Women are the wife of a very poor man Shoemaker; the other three appeared to be marginalized, illiterate women District health facilities



On Tamil Nadu, is part of a larger study titled Unintended Pregnancy and Abortion in India (UPAI), which was conducted to provide much-needed information on the incidence of induced abortion and pregnancy, as well as access to and quality of safe abortion services, in six Indian states. This report first provides detailed findings on facility-based abortion and postabortion services in the state; it then draws on these and other data to formulate estimates of the incidence of abortion and unintended pregnancy. The final section of the report offers recommendations to facilitate planning for improvements in the accessibility and provision of safe, high-quality abortion services.

- An estimated 707,900 abortions occurred in Tamil Nadu in 2015. These included safe and unsafe abortions, and those taking place both in health facilities and in other settings. The state's abortion rate was 33 terminations per 1,000 women of reproductive age.

- The majority of abortions (63%, or 442,900) took place in nonfacility settings using medical methods of abortion, and 5% (36,500) were performed outside of health facilities using other methods.

- About 32% of abortions (228,600) occurred in health facilities. Private facilities provided the large majority of facility-based terminations (82%).

- An estimated 3,235 facilities in Tamil Nadu provided abortion-related care (induced abortion, postabortion care or both types of services) in 2015; 14% were public and 86% were private. Eighty percent of public facilities reported offering no abortion-related care.
- The vast majority (92%) of health facility abortions took place in the first trimester of pregnancy (up to 12 weeks' gestation), and slightly fewer than half (45%) occurred at less than eight weeks' gestation. Most facility-based abortions were performed surgically using manual or electric vacuum aspiration (20%) or either dilatation and evacuation or dilatation and curettage (36%).
- Although nearly half of women of reproductive age in Tamil Nadu live in rural areas, only 5% of facilities that provide any abortion-related services were located in those areas. Among facilities that offered such services, only about 2% of public and private hospitals—the facilities best equipped to handle severe complications or later-term abortions—were located in rural areas.[xiii]
- About 43% of pregnancies occurring in Tamil Nadu in 2015 were unintended. The majority (75%) of these unintended pregnancies ended in an abortion.

All public facilities at the primary health centre (PHC) level or higher are approved to provide abortions, as long as they have a certified provider on staff. Facilities lacking the necessary equipment are expected to have referral linkages to higher-level sites. Private facilities, on the other hand, must become registered to provide legal abortion services, a process that entails meeting criteria specified by the MTP Act. Registration is difficult, in part because the District Level Committees responsible for approving private facilities do not exist in some areas and may meet infrequently in others. Several small-scale studies have found that many private facilities providing abortion services are not approved to do so.10-13 However; lack of registration does not imply that the abortions provided in those facilities are unsafe, as unregistered facilities may have qualified, trained staff performing safe abortions.

Conclusion

This study has concentrated on rural women because they are often described as having less access to safe abortion services, compared with their urban counterparts. It also focused entirely on married women. The proportion of unmarried women among abortion seekers in India is relatively small, but they are particularly vulnerable to dangerous abortions from unqualified providers because of their concerns about cost and secrecy, the tendency to delay seeking services and the unwillingness of qualified providers to help them. more attention needs to be paid to their situation. The data from our study show that, contrary to many pessimistic portrayals, rural married Women in this district of Tamil Nadu have access to relatively safe abortions from a variety of qualified providers. In about half of the cases, the providers were women gynaecologists with well-equipped

private facilities. Both VHNs and the women gave high ratings to these providers in matters of safety and quality of care. However, more than half of private abortion providers were not registered for abortion services with the Tamil Nadu government. Our data are in line with those from the Abortion Assessment Project–India, which also found that large numbers of abortions take place in facilities that are not registered with the government, and that there were only small differences in the technical and infrastructural aspects between certified and non-certified facilities. These data, taken together, strongly suggest that a considerable proportion of illegal, unreported abortions are conducted by qualified, relatively safe providers who are nonetheless still widely using D&C, an outdated abortion technique, thus perpetuating higher than necessary rates of post-abortion complications. The numbers of private doctors, clinics and hospitals in the district rose from 148 at the end of the 1980s to 287 in 2001 Forty of those private facilities were medium to large hospitals, all of which provided abortion services. This increase in the number of private doctors is part of a broader trend of increased medical services in Tamil Nadu

Number and percentage distributions of facilities offering induced abortion, postabortion care or both, by services offered and location, Tamil Nadu, 2015

	No. offering any abortion-related services		% distribution by type of service offered				% distribution by location		
Facilities	Unweighted	Weighted	Abortion only	Postabortion care only	Both	Total	Urban	Rural	Total
All	417	3,235	18.1	10.9	71.0	100.0	95.0	5.0	100.0
Public	125	459	22.2	18.6	59.3	100.0	72.1	27.9	100.0
Hospitals	79	220	16.3	5.5	78.2	100.0	93.8	6.2	100.0
CHCs	25	112	36.0	16.0	48.0	100.0	52.0	48.0	100.0
PHCs	14	88	29.1	43.6	27.3	100.0	31.3	68.7	100.0
Urban public	7	39	0.0	43.1	56.9	100.0	100.0	0.0	100.0
Private	292	2,776	17.5	9.6	72.9	100.0	98.8	1.2	100.0
Hospitals	129	1,062	12.9	10.1	77.0	100.0	98.5	1.5	100.0
Nursing and maternity homes	138	1,480	16.2	9.4	74.4	100.0	98.8	1.2	100.0
Clinics	25	234	46.1	8.8	45.1	100.0	100.0	0.0	100.0

NOTES: Postabortion care refers to care for complications resulting from either induced abortion or miscarriage. CHC=community health centre. PHC=primary health centre. Proportions presented in the text, figures and tables may differ slightly because of rounding. SOURCE: Health Facilities Survey.

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