Denial of Safe Abortion to Survivors of Rape in India

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Abstract

Access to abortion is desperately needed when pregnancy is the result of rape, both within and outside marriage, and especially when a girl has been raped. The availability of services remains highly restricted because of the way abortion providers interpret the law. This paper presents the experiences of 40 rape survivors, including two children, denied an abortion following rape. The cases were recorded by CEHAT (Centre for Enquiry into Health and Allied Themes) in the course of building capacities of public hospitals to respond to violence against women in Mumbai, India, since 2000. We found that enormous damage is inflicted on women and girls by misinterpretation of the laws on abortion and rape, combined with a lack of understanding of the serious damage rape does, particularly repeated rape, and alongside other forms of assault and abuse. Domestic laws in India place a clear legal responsibility on health professionals to offer immediate care and treatment to rape survivors, including timely access to abortion. It is past due time for both the government and the courts to begin to hold themselves and health professionals accountable for ensuring this care is provided.

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Introduction

India has passed several laws that recognize the right to health care for survivors of domestic and sexual violence. These include the Protection of Women from Domestic Violence Act (PWDVA) 2005, the Protection of Children from Sexual Offences Act (POCSO) 2012, and relevant clauses on sexual violence in the Criminal Law Amendment Act 2013.[1] As a response to overwhelming evidence showing that India's health systems mistreat rape survivors, the latter two laws mandate that public and private hospitals provide immediate treatment for survivors of sexual violence. They also mandate punishment for failure to do so.[2]

The POCSO 2012 requires that all registered medical practitioners render emergency medical care to attend to the needs of children who have been raped, including access to abortion. That the immediate treatment for survivors of rape must include emergency contraception and abortion services has also been clearly mentioned in policy guidelines issued by the Ministry of Health and Family Welfare in Guidelines and Protocols for medico-legal care for survivors/victims of sexual violence.[3] In reality, however, rape survivors who become pregnant, both girls and women, face procedural gaps and a range of barriers in accessing abortion services.

This paper presents the experiences of 74 people (72 women and 2 children) who had been raped and who sought an abortion. Fifty-five of the women sought an abortion before 20 weeks of pregnancy, and 19 women and the two children did so after 20 weeks. None of those who sought an abortion after 20 weeks of pregnancy was able to have an abortion, not even the two children, even though they followed the procedure for seeking permission from a high court to do so. Of those who sought an abortion before 20 weeks, which should have been granted without delay or question, only 36 of the 55 were able to have an abortion.

The paper concludes by suggesting ways of ensuring easier access to abortion for rape survivors.

Barriers preventing rape survivors from accessing abortions

CEHAT (Centre for Enquiry into Health and Allied Themes) is a Mumbai-based research institute that has been working on health and human rights since 1994. As part of our program on violence and health, we have worked closely with hospitals in Mumbai since 2000 to improve their responses to violence against women and help them build their capacity to provide psychosocial support to survivors and their families. This entails ongoing training of health providers, counselors, and direct intervention services for women who have experienced violence. This work puts us in close contact with other parts of the public health system, including abortion service providers, and gives us the opportunity to understand the barriers women face when they seek abortions after rape.

Experiences described in this paper come from three sources of data gathered by CEHAT during the course of our work:

- A study conducted by CEHAT in two antenatal departments of public hospitals where we asked all the women about their experience of domestic violence and offered counseling services.[4] Of the 142 women who disclosed abuse in their marriages and consented to the counseling intervention, 31 reported that their current pregnancy was the result of rape by their husbands. All 31 sought abortions. Of these, 24 women were less than 20 weeks' gestation but only five of them were able to have an abortion. Of the rest, the 19 women who were less than 20 weeks and the seven who beyond 20 weeks were all forced to continue their pregnancies.
- The service records of crisis intervention services provided by CEHAT to survivors of sexual violence at three public hospitals from April 2008 to March 2015.[5] Of the 728 women who received these services, 43 reported becoming pregnant as a consequence of rape. Of them, 31 were within 20 weeks of gestation and received abortions, while 12 who had sought abortions after 20

weeks of pregnancy were refused.

- Legal interventions initiated by CEHAT in two cases of child rape where pregnancies were discovered only after 20 weeks of gestation. An appeal was made to the High Court and the Supreme Court for permission to terminate the pregnancies.[6]

The women in the public hospitals who had disclosed rape by their husbands reported that health care providers imposed the following barriers, which in many cases led to the denial of abortion services in the hospital.

1. Abortion refused because it was their first pregnancy

These women were told that abortion may cause secondary infertility, and that it may be a threat to their lives. Even though CEHAT provided factual details that contradicted their claims of such risks, the health care providers insisted on what they said and reiterated that abortion was a risk they would not allow.

2. Misinformation about medical abortion pills

Women who reported in an early stage of pregnancy and requested medical abortion pills were turned away. Providers said the pills may cause life-threatening bleeding, and that excessive bleeding would necessitate a surgical intervention anyway. In fact the mifepristone-misoprostol combi-pack is approved by Drug Controller General of India for use up to 63 days of gestation.[7]

3. Abortion offered only if woman agreed to contraception or sterilization

Women with two or more children were told that abortion would be provided only if they consented to sterilization to prevent future pregnancies or accepted a Copper-T IUD after the abortion. The abortion law does not mention such conditions, though contraception is provided if the woman herself wishes it. These conditions are a form of medical abuse, however, with a long history in India. They arise from the country's population control policies, which were and often still are enforced with little regard to human rights.[8]

4. Insistence on spousal consent

Spousal consent for abortion is the greatest barrier for women seeking abortion services. Despite the fact that the law clearly states that the providers need only have the consent of the adult (married) woman, several providers insisted on the husband's consent or authorization. It is only in the case of a minor (less than 18 years of age) that parental or guardian consent must be obtained. This is a critical issue for survivors of marital rape because the husband may well want to exercise control over whether the woman can have an abortion.[9] Several of the women in the antenatal clinic reported having disclosed spousal abuse to their doctors, who continued to insist on the husband's consent, ignoring the woman's difficult situation. This is rooted in patriarchal notions about a husband's role as decision maker, as well as a defensive practice by doctors, who claim that a husband may challenge them for proceeding with a termination without his permission. Two women in the antenatal clinic reported the following experiences.

> *N., age 25, was eight weeks pregnant. Her husband had been physically and emotionally abusing her throughout their four-year marriage. She did not want to continue with the pregnancy, but the doctor insisted on her husband's signature, even after she disclosed the abuse. Having got the husband's permission, the doctor went on to ask her to get a no-objection certificate from the police, that is, permission from the police to allow the abortion.*

The doctor's demand was totally baseless.

> *M. had filed for divorce after having endured her husband's violence for over 15 years. She was living separately from him and had her child with her. The husband would barge into her house and rape her. When she discovered that she was pregnant, she sought an abortion. The doctor insisted that she either get her husband to consent or produce a divorce decree. She was able to have an abortion only after reporting the matter to the higher*

authorities at the hospital.

5. Insistence on D&C for abortion, requiring an overnight hospital stay

Many Indian abortion providers continue to use dilation and curettage (D&C) as the method of abortion no matter the length of pregnancy. This method is no longer recommended by the World Health Organization or the Indian Ministry of Health and Family Welfare guidelines because it requires general anesthesia and an overnight stay, and far safer and less invasive methods are available.[10] Indian doctors continue to recommend it and also insist on using it; D&C may be the only method they know, and they consider it to be the most reliable and safe method. This is more than just an issue of abortion method; it has an important bearing on women's access to abortion. Any method that requires a hospital admission makes it difficult for women to conceal that they are having an abortion; extended family may come to know about it, thereby threatening loss of privacy and confidentiality. These are both critical for women accessing abortion care, especially if they do not want an abusive husband to know they are having an abortion.

The following two case histories are among the worst that the CEHAT team has encountered in its interaction with women in one of the public hospitals.

Insistence on delaying abortion to do a D&C despite negative social consequences for the woman. A young woman survivor of spousal violence who was 11 to 12 weeks pregnant asked for an abortion at the earliest possible time. She had come to the hospital after she had missed her periods for two months and discovered that she was pregnant. As she was experiencing severe physical and sexual abuse from her partner, she did not want to proceed with the pregnancy. No one in the family knew about the pregnancy and she therefore wanted to end it as soon as possible. She managed to get her mother to come to the hospital with her, as a relative was required to give consent for a surgical procedure. However, the doctor told her to come back four weeks later for the abortion. The woman went to the counselor at the hospital-based crisis center and told her this. She was afraid that in four weeks her baby bump would be visible, and everyone would know she was pregnant. The counselor intervened and was told by the doctor that the "surgical procedure" was easier and safer after 16 weeks (this is often said about D&C), that she was only trained to do abortions after 16 weeks, and that the fetus was very small prior to 16 weeks so it was harder to carry out the procedure.

The counselor intervened by speaking not only to the treating doctor but to other more senior doctors. The woman was only able to have an early abortion when the senior doctors overruled the treating doctor.

Delaying an abortion on medical grounds and jeopardizing the woman's health and life. A 31-year-old woman in an increasingly abusive marriage sought help from the hospital-based crisis center in filing a case for maintenance and divorce. She also wanted to file a police report so that her husband could be arrested immediately. However, the police did not record the complaint, but called her husband into the police station, where they threatened him and sent both of them home. A month later, the woman came back to the crisis center following a visit to the hospital gynecology department for an abortion. She told the counselor that she did not want the child at all, but the doctor told her she did not have "enough blood" (she was anemic), so an abortion could not be done. The doctor advised her to take iron tablets for a week and then come back for the abortion. She went back 10 days later, but the doctor still refused to do the abortion because she was still too anemic. At that point she was between six and eight weeks pregnant. The counselor spoke to the doctor about the urgency of the abortion. The doctor told the counselor that if after she had taken iron tablets once more, the hemoglobin levels still did not increase, they would give her a local anesthetic, and do the abortion with no further delay. She came back after two weeks and told the counselor that her community had found out that she was pregnant, as

she was by then visibly pregnant. The hospital was willing to carry out the abortion at this stage, but her family and neighbors were pressuring her to continue the pregnancy. She was completely distraught and felt forced to continue the pregnancy. She had a premature labor in her eighth month, resulting in a stillbirth. She had become very weak; her situation had worsened in the last three months and she could not go to work due to pregnancy and exhaustion. She continues to live with her abusive husband. Thus, a woman who had made up her mind to leave an abusive husband, despite all the pressures, felt forced to stay in the relationship and continue an unwanted pregnancy, while the delay in receiving an abortion had severe consequences for her health and life. The treating doctors in her case were simply unable to understand her social reality and why they needed to provide an abortion urgently.

Doctors may not provide abortions because the criminal law does not require abortion to be provided in cases of marital rape. Our findings show that many women who experience marital rape, both those living with their partners and those who are separated or divorced (who may still be raped by their partners), may be refused access to safe and legal abortion in spite of the law.

Yet there is global evidence of a strong positive association between women seeking an abortion, and violence and physical abuse (defined as slapping or beating) by husbands in the year previous to the abortion. Evidence reported from India in this multi-country study also indicated that women in violent relationships were more likely to have an abortion, as well as to experience violence after (and possibly because of) the abortion.[11]

Qualitative studies among women in several states of India found similar associations.[12] For example, in Tamil Nadu, qualitative interviews with 66 women and 44 of their husbands living in rural hamlets showed that non-consensual sex and sexual violence were strongly associated with the women having had an abortion and with their inability to use contraception effectively or to get their husbands' cooperation to abstain from sex as a way to space or prevent pregnancies. Both the women and the men in this study reported that it was the right of the husband to demand sex, regardless of what the wife wanted. Several respondents noted that especially if the husband was drunk, he might demand sex and refuse to use contraception. Women who objected to having sex or who wanted to use contraception were sometimes accused of sexual infidelity and were often beaten.[13]

Given this evidence, doctors need to recognize marital rape as a compelling reason for providing abortion services. Yet the law as it stands today only treats rape as a condition for which an abortion should be provided unconditionally if the rapist is not the woman's husband or former husband. Marital rape continues to be an exception under the criminal law, even though it has been recognized as a form of violence under the civil law since 2005 in the Protection of Women from Domestic Violence Act.

Barriers to abortion

Refusal of abortion in the public sector

The various barriers that women experience in seeking an abortion in the public health sector often push them to the private sector, if they can afford it, or to resort to unsafe abortions, which continue to be common in India. Data show that the majority of Indian women who have had an abortion report doing so at a private facility.[14] The only other option is to continue with an unwanted pregnancy. This makes them more vulnerable and unsafe if they are in an already abusive home situation.

Seeking abortion beyond the 20-week time limit

Seven women disclosed marital rape when we interviewed them at the time of their first antenatal registration at the public hospital, which was at 20 weeks of pregnancy. They did not attend the health facility earlier because their husbands were controlling their movement and forbid them to access the health service. None of the seven women wished to continue their pregnancy, but all of them were denied an abortion because the pregnancy was beyond the legal 20-week limit.

We additionally received 31 rape survivors at the crisis intervention centers located in three public hospitals. These women were raped by ac-

quaintances. Twelve of them were able to disclose rape only after the pregnancy had advanced to a stage when it was visible. Most of the perpetrators had threatened to harm their families and repeat the abuse if they told anyone about the attacks. All 12 women said their pregnancy was an outcome of the rape and pleaded for a termination. They too were denied abortion due to advanced gestational age, without any concern shown by the health professionals about the social consequences of continuing the pregnancy. When the CEHAT team engaged with the health care providers, they suggested the women could give the babies up for adoption once they were born, with no apparent awareness of the multiple impacts on the lives of women facing this situation.

Child survivors of sexual violence seeking abortion

Two cases of child rape survivors, one age 10 and the other age 13, received a lot of public attention in India recently.[15] In each case, the pregnancy was well beyond the 20-week legal limit when the child sought access to an abortion. The CEHAT team proactively intervened in both these cases at the level of the providers as well as in the courts. In the case of the 10-year-old, expert opinion from gynecologists, as well as a statement signed by three US gynecologists with expertise in third-trimester abortion—published by the International Campaign for Women's Right to Safe Abortion—were submitted to the Supreme Court. The opinions and statements underscored the need to terminate the pregnancy in the best interests of the child and to emphasize that a third-trimester abortion was not less safe than the alternatives.[16]

In the case of the 13-year-old, CEHAT's first intervention was an appeal to the provider to terminate the pregnancy under Section 5 of the MTP Act, which allows abortion when the life of the woman or girl is at risk. To authorize this, two medical opinions were required, but the provider referred the matter to the court. The 13-year-old child was initially taken to a private practitioner, as her parents were concerned that their daughter had gained so much weight. An ultrasound indicated that the child was 28 weeks pregnant. Due to the advanced gestational age, the medical provider sought the intervention of the Supreme Court as to whether to carry out a termination. The Supreme Court directed the state to set up a medical board and provide its opinion on a termination of pregnancy. The pregnancy was at 32 weeks when the Supreme Court ruled in favor of carrying out a procedure to terminate the pregnancy, citing grave mental trauma as the justification. But within a day or two of this verdict the child was already in labor and ended up delivering a live fetus.

The 10-year-old had been raped by her uncle. When her family realized she was pregnant, they immediately sought medical assistance so she could have a safe abortion. The hospital dated the pregnancy at 26 weeks. She and her family were referred to the district court to seek permission to undergo a termination. The district court directed the medical institute to set up a medical board to examine the child and provide an opinion on whether or not she could undergo an induced abortion. The opinion of the board was not made public except to confirm that the pregnancy was 26 weeks. The district court rejected the plea for abortion. The matter was taken to the Supreme Court of India, which requested a new medical board to provide a second assessment and an opinion. Re-examination of the child dated the pregnancy at 32 weeks. The board opined that carrying out a termination at that stage could be life threatening. The Supreme Court denied a termination of pregnancy. The child went on to deliver in a medical institution.

Obstacles in ensuring access to abortion for child survivors of rape

There are several reasons why pregnancies are already at an advanced stage when they are discovered; these became clear during our interactions with the girls and their families. To begin with, a child is very unlikely to realize that she is pregnant or that being raped could lead to a pregnancy. Hence, by the time one or more family members realize that something is not right, or that the child

is pregnant, there has already been a delay of several months; that is, until the pregnancy is visible. Slightly older children, who may recognize that they are pregnant, may fear that their family members will not believe them. This too may contribute to delay in going to a health facility. Other factors, such as fear from a threat by the abuser to her life or to her loved ones can also keep the child from disclosing the violence and its outcome. Thus, in many cases, a pregnancy is detected only when the child complains of nausea or abdominal pain, or when it is visible.

Role of the courts vis-à-vis authorizing abortions after 20 weeks

As is evident from the two narratives and similar reports that are appearing regularly in the media, the courts are being inundated with pleas from women and girls seeking their authorization for abortions after 20 weeks of pregnancy. But the courts find themselves in a difficult situation.17 This is because determining whether or not an abortion after 20 weeks should be allowed for a child or a woman is a matter of medical rather than legal judgment and hence not within their purview. Therefore, the courts have invariably ordered a medical board to be established to make the medical judgment. It is important to clarify here that the MTP Act makes no mention of the need or requirement of a medical board. This has been initiated by the courts and has now become the standard. These boards are expected to evaluate the physical and mental health condition of the pregnant child or woman, advise whether or not to provide a termination of pregnancy, and submit a written report to the court. Taking cognizance of several such cases that had reached the Supreme Court, the court directed the Ministry of Health and Family Welfare to instruct all the states in India to establish a permanent medical board in all tertiary medical institutes.[18] However, the medical boards in many cases appear to restrict their role to the interpretation of the MTP Act, instead of lending their expertise to assessing the extent of the physical and psychological trauma caused by the act of rape that led to the pregnancy.[19] Moreover, the members of any one medical board may or may not have expertise on or experience of abortion after 20 weeks of pregnancy, let alone at 28 or 32 weeks.

Hence, the opinions provided by medical boards in a number of cases in the past were well within the scope of the treating doctor's expertise, yet they took an average of four weeks to be assembled, examine the patient, and debate and return an opinion. Moreover, none of the medical boards' opinions that we have studied has raised concerns about the denial of abortion by the treating doctors despite the existence of Section 5 of the MTP Act. In fact, they did not even raise concerns about the mental trauma and anguish that survivors endure due to the delay in receiving a decision, let alone an abortion itself.

In an effort to garner support for access to safe abortion in these child pregnancies, medical opinions were sought from senior US-based gynecologists with expertise in carrying out third-trimester abortions.[20] In their letter of support, these doctors provided a comprehensive body of evidence suggesting how to safely perform a third-trimester abortion in a young child. Their letter outlines several safe procedures including use of a feticidal injection of digoxin or potassium chloride, followed by one or two days of gradual osmotic cervical dilation, and then induction of labor with misoprostol and/or oxytocin as the safest and most common way of carrying out the intervention. The letter also draws attention to the risks of continuing a pregnancy to term in children under the age of 18, citing a range of reasons, such as an under-developed uterus, narrow pelvic bones, cervix, and birth canal, and the increased risk of serious obstructed labor in a vaginal delivery, which could lead to maternal death. This evidence was made available to the medical board and was also placed on the record at the Supreme Court.

Yet, in the case of the 10-year-old, the medical board did not substantiate its claim that the continuation of pregnancy was safer for this child, who also suffers from a congenital heart condition and whose pelvic bones were under-developed compared to those of an adult woman. Despite being

doctors, they did not comment on the psychological impact of a pregnancy on the child in the aftermath of rape. It is therefore critical to stress that doctors appointed to these boards may have no expertise in provision of abortions beyond 20 weeks. Nor have we heard of any training for those who may serve on these boards, to acquaint them with safe abortion guidelines for late abortions and evidence of the negative impact rape has on the lives of survivors, which we can assume is worse in the case of a child.

Yet survivors of rape continue to be compelled to approach the Supreme Court or a High Court where the judiciary routinely refer the matter to a medical board. An analysis of 74 court cases where women or girls were seeking permission for termination of pregnancy is indicative of what is happening in India. These survivors all appealed to a court for a decision between June 1, 2016, and February 3, 2018. Of 74 rape survivors, 23 were denied an abortion based on the opinion of a medical board. What is even more disconcerting is that 13 of these 23 had reached the courts through a human rights lawyer, even when the pregnancy was less than 20 weeks. Of the 74, 39 were rape survivors (in all age groups); 18 of the 39 were denied an abortion.[21] The court's decisions appeared to be based solely on the opinion of the medical boards. The medical reports and expert opinions submitted by the petitioners (that is, the women themselves) were not considered. In many cases, the women had seen the doctor before 20 weeks of pregnancy, yet there was no action taken against these doctors for delaying the abortion until it was refused.

Moving forward

India is a signatory to CEDAW, as well as to the International Covenant on Economic, Social and Cultural Rights (ICESCR), and is therefore obligated to fulfill its obligations under these instruments, including CEDAW's General Recommendation 35.

Our experience, as documented in this paper, shows that medical professionals' education and training needs to include understanding of the concept of reproductive rights and the agency of those who have been raped to know what is best for them, particularly in regard to ameliorating the consequences of rape and sexual abuse. Forced pregnancy and motherhood should be considered a form of cruel and degrading treatment, and rejected.

In India, the medical profession has failed to keep up with the scientific and medical evidence and practice of carrying out an abortion safely at gestational stages beyond 20 weeks. This has in turn limited Indian women's and girls' access to abortion services and led to a denial of those services. There is an urgent need to teach these procedures to clinicians in India, and to equip medical practitioners to keep up with international knowledge and standards as prescribed by WHO and other experts.

The reality on the ground shows that pregnancy due to rape is not being addressed in India as either a physical or psychological health concern. Doctors turn women and girls away on flimsy grounds, even if they come before the 20-week limit, and distance themselves from providing the required care if the pregnancy is beyond 20 weeks, advising the families to go to court. There is no doubt that the reported cases are just the tip of the iceberg. Many more pleas may not even reach the courts due to social and economic barriers, and women and girls may be compelled to continue unwanted pregnancies in silence. There is an urgent need to create awareness among health professionals and judges that the rape law makes it mandatory for doctors to provide abortion without any delay for rape survivors. At the same time, doctors need to recognize that marital rape is a form of violence under The Protection of Women from Domestic Violence Act 2005, and that they have a legal duty to provide immediate treatment. Further, the law should require abortion to be provided without delay or excuse in instances of marital rape, as with all other cases of rape. Simultaneously, the criminal law should be amended to include marital rape as a form of rape, so that women may seek criminal action against their perpetrators if they wish to do so.

CEDAW's General Recommendation 35 on gender-based violence recommends establishing state accountability in the case of failure of ser-

vices to rape survivors. India has human rights responsibilities for women's health, and must be held accountable in the periodic reports that India is obliged to submit to the CEDAW committee. The issue of denial of abortion to rape survivors needs to be raised when India is due to make a periodic report to CEDAW, through shadow report for example, and during the Universal Periodic Reviews, as well in as reports to the UN Special Rapporteur on the right to health.

In addition to its international obligations, India's national obligation with regard to rape-related pregnancies is also clear. National guidelines issued to medical providers on provision of medico-legal care specifically state that abortion services are required for rape survivors. Failure to treat rape survivors in India is a punishable offense under Indian Penal Code 166, B. Punishment is accompanied by a fine and/or imprisonment up to one year. But since the passage of this law, not a single medical professional has been penalized when they have failed a patient. While immediate treatment does mention treatment of unwanted pregnancy, the doctors are still constrained by the MTP Act, which does not mention any penalty or punishment for denying an abortion to a woman or girl. There is only one Supreme Court judgment out of the many thousands that exist, in which the Bihar state government was asked to pay compensation to a woman who was not provided an abortion in time.[22] But the doctors went unpenalized.

Professional accountability of healthcare providers could be improved by developing guidelines and a checklist of good practice for gender-sensitive treatment for rape survivors. This could potentially reduce the barriers to reproductive health services, counseling, and abortion care for rape survivors. Such checklists and standards of practice have proven useful in reducing morbidity and mortality in surgery. Additionally, integrating a gender perspective in undergraduate medical education has proven effective in addressing provider prejudices and attitudes towards abortion and changing clinical practice.[23]

Lastly, the Federation of Obstetricians and Gynaecological Societies India (FOGSI) and the Indian Medical Association urgently need to share current information about safe abortions beyond 20 weeks of pregnancy, and achieving safety in later abortions. They also need to sensitize doctors to the negative social consequences of having to continue an unwanted pregnancy following rape, especially in children, and to train clinicians in WHO-recommended methods for providing abortion care without delay. FOGSI needs to take cognizance of developments in the medical field internationally, and the legal mandate to issue ethical guidance on the treatment of rape survivors. We recommend that this be developed and adapted in line with FIGO guidelines and used widely in training.

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