Abortion in India: Emerging Issues from Qualitative Studies

Author(s): Leela Visaria, Vimala Ramachandran, Bela Ganatra and Shveta Kalyanwala

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Emerging Issues from Qualitative Studies

Despite the legalisation of abortion in India, morbidity and mortality continue to remain a serious problem for a majority of women undergoing abortions. A lack of reliable information, wide regional and rural-urban differences and a thin research base all make it difficult for policy-makers, administrators and women's health advocates to develop strategic interventions. This article highlights issues that emerged from eight qualitative research studies that formed part of the Abortion Assessment Project – which sought to create an evidence-based body of knowledge on all facets of induced abortion. These studies have thrown up some common patterns and themes, such as the unmet needs for contraception and abortion, the question of son preference, the preference for private providers and the neglected needs of the single, widowed or separated women. More crucially, they highlight the need to integrate diverse viewpoints that would further ease progression towards the common goal of making abortion an infrequently used but safe alternative for women faced with an unwanted pregnancy.

LEELA VISARIA, VIMALA RAMACHANDRAN, BELA GANATRA, SHVETA KALYANWALA

I
The Indian Scenario

India pioneered in legalising induced abortion (Medical Termination of Pregnancy (MTP) Act of 1971) under which a woman can legally avail abortion if the pregnancy carries the risk of grave physical injury, endangers her mental health, when pregnancy results from a contraceptive failure in a married woman or from rape or is likely to result in the birth of a child with physical or mental abnormalities. Abortion is permitted up to 20 weeks of pregnancy duration and no spousal consent is required. According to the ministry of health and family welfare, in 1996-97 about 4.6 lakh MTPs were performed in the country. Against that, an estimated "6.7 million abortions per year are performed in other than registered and government recognised institutions, often by untrained persons in unhygienic conditions" [Khan et al 1998].

Despite an intensive national campaign for safe motherhood and after the initial attention on unsafe abortion in the 1960s and early 1970s that led to legalisation of abortion, morbidity and mortality from unsafe abortion have remained "a serious problem for Indian women 28 years after abortion was legalised in India" [Johnston 1999]. In the last decade, women's health advocates have tried to draw the attention of policy-makers and administrators to a range of issues and concerns related to abortion in order to improve the availability, safety and use of services. In the post-Cairo period, the comprehensive Reproductive and Child Health (RCH) programme initiated in India has included abortion in the RCH package and work towards making it safe.

While the climate seems to be favourable to initiate debate on safe abortion among key stakeholders, lack of reliable information, wide regional and rural-urban differences, inability to bring various constituencies on a common platform and a thin research base make it difficult for policy-makers, administrators and women's health advocates to develop strategic interventions. The Abortion Assessment Project – India (AAP-I) ventured to fill in the gap by creating evidence-based body of knowledge on all facets of induced abortion. This multi-centric research project commenced in August 2000 and was managed jointly by CEHAT (Mumbai) and HealthWatch (New Delhi). This article highlights the issues that have emerged from eight qualitative research studies coordinated by HealthWatch.

The studies employed various qualitative research methods and some also supplemented with quantitative data. In some studies both providers and clients were interviewed, in some just women (without ascertaining whether they had experienced or undergone abortion) were interviewed. The range of issues covered by the studies was also quite diverse and explored the reasons for seeking abortion, decision-making pathways, intergenerational differences in abortion seeking, selection and, perspectives of abortion providers and quality of care.[1]

Further, these studies were conducted in small geographic areas of a few relatively more developed states and therefore, their generalisabilty beyond the immediate study area is unwarranted. The synthesis of findings does not apply to the entire country or even to the entire state in which the studies were carried out and the analysis needs to be interpreted with caution and within context of the area studied.

Given the sensitivity of abortion and ethical principles adhered to in AAP-I – informed consent of respondents was obtained. In all the studies only married women were interviewed with the exception of a Tamil Nadu study (where sexuality issues were explored in focus group discussions (FGDs) with women regardless of their marital status). Most of the findings on unmarried women reflect the views of the married women and represent community attitudes or the interpretation of the researchers rather than actual behaviours or practices.

In three of the seven studies social mobilisers/service providers of the partner NGO worked as field investigators. While this may

have proved to be valuable in establishing rapport with women and building a relationship of trust, familiarity can lead investigators to assume certain things and preclude probing.

II
Reasons for Seeking Abortion

The reasons for seeking abortion reported in the various studies ranged from proximate causes such as a desire to limit family size or space pregnancies, preference for a son, seeking abortion for medical reasons or availing it on medical advice to distal determinants such as poverty, violence and belief system.

Abortion for limiting family size and spacing: There were really no surprises; the overwhelming reason for seeking abortion among married women was to limit the family size. When women in studies conducted in Maharashtra, Gujarat, Andhra Pradesh and Tamil Nadu were asked to indicate the situations in which they would seek abortion or had actually sought abortion, the majority reported this as the main reason.

Similarly, a very short inter-birth interval between conceptions was also cited as a reason for abortion. During postpartum amenorrhoea and while breastfeeding the child, some women become pregnant without realising it. In order to avoid having another child in quick succession, women opt for abortion as a viable option. In a Tamil Nadu study the younger women viewed frequent childbirth as shameful and resorted to abortion as a spacing method to increase inter-birth interval.

Another contraceptive related reason for abortion that emerged in the studies from Tamil Nadu, Andhra Pradesh, Gujarat and Maharashtra was conception soon after marriage. Although a premium is generally placed on a proof of fertility and elders would like the young bride to bear a child within a reasonable time after marriage, conception almost immediately after marriage was reported as a reason for abortion by a few women in all the four states. Interestingly enough, as reported in a Gujarat study, if girls married to non-resident Indians (NRIs) became pregnant soon after marriage, they opted for abortion. The underlying reasons stated were fear that an immigration visa would not be granted to pregnant women, which would prevent them from joining their husbands abroad within reasonable time after marriage.

Links between contraception and abortion: Non-use of contraception rather than contraceptive failure was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. Actual contraceptive failure was reported only in one study in Andhra Pradesh where one respondent reported tubectomy failure leading to conception and subsequent abortion.

Gap between knowledge and use of contraception: Incomplete information about contraception was a factor seen in several studies. All respondents across studies reported knowledge of sterilisation as a method of limiting family size but knowledge of reversible methods such as condoms, oral pills and IUD for spacing births was lower. Thus for example, in the RUWSEC study in Tamil Nadu, 29 of the 66 women who were interviewed knew about reversible methods. However knowledge was usually based on information received through the health outreach activities of the programme but not on the basis of actual lived experiences of people; the knowledge did not translate into actual practice. Ever use of reversible contraception was not low but many discontinued use or were irregular in their use.

The reasons cited for not using contraceptives by women ranged from fear of some methods, irregular supply, family objection to use, and health concerns. Some women in the study conducted by RUWSEC in Tamil Nadu reported that they could not use oral pills or IUD because of their side effects. Women believed that oral pills "dry up the blood in our body", thereby preventing them from doing hard physical labour. An opinion was also expressed that use of oral pills "is okay for urban women, but we rural women have to do a lot of physical labour". On the other hand, irregular supply of oral pills was reported as a reason for not using them in the Andhra Pradesh study, with some women becoming pregnant.

In some studies women admitted that while condoms were the safest method of contraception, husbands did not always co-operate in using them. In the RUWSEC study, for example, it was reported that men tended to be inconsistent and irregular in use of condoms or complained that condoms interfered with sexual pleasure.[2] As far as IUD was concerned, there was a perception among some women that it leads to pain and discomfort. This may be an outcome of poor quality of care – especially if the IUD is inserted without proper pelvic examination or in settings where basic hygienic conditions are compromised and lead to infection.

Female sterilisation as first and final method of contraception: In some of the studies women reported that they find the spacing methods of contraception inconvenient or unacceptable and prefer sterilisation after giving birth to desired number of children. However, since the desired family size is measured in terms of surviving children, typically couples wait for a few years to ensure the survival of their children before accepting a permanent method. During this intervening period, some women who become pregnant opt for abortion. Curiously, women who opted for abortion in such situations reported that it is a better option as compared to relying on IUD or oral pills. Women in one of the Maharashtra studies also indicated that after abortion they did not require much rest but were able to resume daily routine work almost immediately.

Low risk perception for becoming pregnant: Further, some women who have infrequent sexual contact either because their children are grown up or married or because their husbands are often away for long periods, felt that occasional sexual contact would not lead to pregnancy. However, if pregnancy does occur, some women opt for abortion.

Perception that abortion is safe: All the qualitative studies were conducted in the states where availability of safe abortion services is reasonably good, especially for married women. Perhaps due to this, many study women perceived that abortion did not have any long-term adverse health consequences and perceived it as a 'safer' option compared to IUDs and other spacing methods.

Abortion for desired sex composition of children: While direct questions on sex selective abortion were not asked in most of the studies, some studies pointed out that couples and their extended family chose abortion not only to limit family size but also for achieving desired sex composition of children. The internalisation of son preference was so widespread that studies conducted by Barua, Radkar, Anadhi and Visaria (see Appendix) all reported that couples resorted to female selective abortions after undergoing a sex determination test. The reasons for why sons were preferred were expressed in terms of support in old age, continuing family line (as expressed in a Maharashtra study: 'giving heir is a prime duty of women') and performing death rites.

Women talked about availability of ultrasound facilities in almost all the areas. Also, they were aware that sex selective abortion was illegal and admitted that they would go to different facilities for ascertaining the sex of the foetus and for abortion. Awareness of the new PNDT Act was far greater among women and service providers, than about the details of the MTP Act. Group discussions invariably turned quite spirited when sex selection was discussed. In spite of being aware that sex selective abortion is illegal, women expressed helplessness as their status in the family and sometimes the very survival of their marriage depended on the ability to produce sons. Although the discussion in most of the studies was in terms of perceptions, Radkar's study in Maharashtra indicated that 8 out of 70 reported abortions or 11 per cent were reported as being sex selective. She further reported that "women who go for sex determination follow it up with the abortion of the female foetus. Everyone seemed to know at least some women who had done this". According to Barua's study in Gujarat, 10 out of 62 or 16 per cent of abortions were performed after sex determination test and confirmation of female foetus.[3]

It was further revealed in a Maharashtra study by Morankar that when only female children were born or conceived, the family approved and the community condoned the need for abortion. Thus for a mother of several daughters there was no social stigma associated with sex selective abortion. Women from Gujarat and Haryana also reported that while they were not comfortable with abortion per se, when it was done for the sake of the family honour (not a son-less family), they accepted it.

In the RUWSEC study in Tamil Nadu only in two instances abortion was resorted to avoid a female birth; in one case to avoid giving birth to one more daughter and in the other case, to avoid violence for delivering a female child. Anandhi's study in a similar area in the same state however reported that the preference for male child and therefore for the sex selective abortion has been quite common. At the same time, instead of using new technology for detecting the sex of the foetus, women seemed to rely on prevailing myths for sex determination. For instance, if a girl was born with two circle marks on her bottom, it was believed that the next child born to that woman would also be a girl. Even though women agreed that the predictive power of such beliefs was questionable, nonetheless many tended to rely on this for having an abortion. Also, women preferred to undergo sterilisation only after a male child was born. Further, if the male child was still young and the woman conceived again, she would not hesitate aborting the second child, in order to provide special care and attention to the male child already born.[4]

On 'medical advice': While the studies by Barua, Radkar and Prakasamma indicated that abortions were resorted to for medical reasons such as when the woman's life is threatened or when there is a fear of the foetus being abnormal, a divergence in the reasons cited by women and by abortion service providers was noted in a study by Barua. The providers indicated that they conducted abortions for medical reasons such as the poor health of mother; an ill-formed foetus was rarely the reason for an abortion. On the other hand, some of the women respondents indicated that they resorted to abortion on 'medical advice'. It is a moot point whether the terminology used by women is euphemism for sex selective abortion. This could also be a way of rationalising the decision made about abortion and shifting the onus on to the provider.

Economic Situation, Work and Poverty

Poverty was cited as a reason for seeking abortion by the two Tamil Nadu studies and the Karnataka study. Anandhi's study among pharmaceutical industry workers in Tamil Nadu revealed that almost all the units employing young women insisted on a contract which clearly stipulated that, if unmarried at the time of employment girls could not get married and if married, could not get pregnant during their contract period.

What is significant about the rise in abortion among unmarried young women is that on one hand, it coincides with their increasing employment in the industrial sector and on the other, it appears as a conscious reproductive choice emerging from their role as providers in the family. Unfortunately, it is only a means for negotiating the disempowering conditions of their work and production relations. For some married women the pressures of childcare and responsibility of supporting family were the primary reasons for resorting to abortion.

As observed by the author: "One would assume that ... women's work in the informal sector, such as in the pharmaceutical industry, might have enhanced their status within the family as main income earners or as providers, but it has not empowered them as decision-makers in the domain of reproduction and sexuality. In these circumstances, women's decision to abort does not signify their autonomy or the free choice... but is an act of 'strategic accommodation'[5] or a combination of both complicity and resistance.

Although the Karnataka study interviewed women who were engaged either in beedi rolling or in agricultural work and belonged to lower socio-economic segment of the population, the authors found that within this group, the younger and more literate respondents underwent induced abortions to a greater extent compared to the illiterate or older women. It is likely that the younger and more literate are exposed more to mass media and urban influences, which in turn influence their behaviour.

In the RUWSEC study, on the other hand, poverty and need to earn so as to make both ends meet compelled some younger women to resort to abortion. A concomitant reason given by some women was that they generally did not have any social support during and after the pregnancy. As reported by a respondent "I aborted two pregnancies, my third and fifth one. My family's economic situation was very bad at that time, and I was also not keeping well." Or as reported by another respondent whose husband decided that they should terminate the pregnancy. "...because I would not be able to stand all day in the shop during my pregnancy and that would affect the sales and our income."

Violence – Physical and Psychological

Women in several studies talked of being pressured into having an abortion by their husbands or conjugal family members. Pregnancy may accentuate both physical and verbal violence if husband does not want the child (for example, later order birth or a girl child), or suspects that pregnancy is due to the wife being unfaithful to him. Violence is a way of demonstrating his power over her. In Anadhi's study, some women reported that abortion was the only recourse in order to negotiate the cycle of domestic violence that another pregnancy would bring on. As one 38-year old woman narrated "After three girl children, when I conceived again I was afraid that this might also be a girl. Even that did not bother me as much as my husband's obscene remarks

about my sexuality. For this reason, every time I got pregnant I tried to commit suicide. But this time I decided to abort the foetus. But the doctor advised me against an abortion, as it was too late to have it. So, I threatened the doctor saying that I would commit suicide right inside the hospital, if she did not perform the abortion. Only then she agreed and aborted the foetus. But it turned out to be a male child. Still there was a pleasure in the abortion, as this time my husband could not suspect the child and me."

Women also sometimes reported using abortion as a way to settle a family dispute or to get back at their husbands or conjugal families. As one respondent in Barua's study mentioned "My mother-in-law and husband have been harassing and beating me since my marriage. Once when I was about 4 months pregnant, my husband, who was drunk at that time, beat me up. There and then I decided to abort the baby. The doctor did sonography on his own and said that it was a male foetus and may be I would like to continue with the pregnancy. But I was very clear in my mind. I got the abortion done without letting anybody know except my close friend".

Violence in the form of non-consensual sex also plays a role in women becoming pregnant in the first place. Threats of violence, accusations, either of infidelity and loose sexual morals as well as actual physical abuse are often used to ensure marital sexual relations even if they are against the women's wishes and in most such sexual relations contraceptive use is not likely. Some women in the RUWSEC study reported that their husbands compelled them to have sex saying that if there were a pregnancy, they would pay for the abortion.

Another interesting finding of some of the studies – especially in Tamil Nadu – is that women cited conception during certain inauspicious months as a reason for abortion. The RUWSEC study also reported that there was a myth that the child born from a third pregnancy would not survive (three being an unlucky number) and therefore women becoming pregnant for the third time were forced to terminate the pregnancy. Sometimes if the pregnancy coincided with some accident to the breadwinner or the head of the family, it was perceived as an ill omen and the woman would be compelled to terminate that pregnancy. In one such case the woman was asked: "Is your unborn baby's life worth more than that of your husband'?"

Such myths may be more widely prevalent in Indian society, however, no studies from areas other than Tamil Nadu made specific references to them. It would also be interesting to explore whether there are any intergenerational differences and changing sexual practices among the younger women, who may be more exposed to education and scientific basis of conception.

None of the studies directly inquired about why or when women outside marriage resort to abortion or whether having a child outside of wedlock is an option. At the same time, in the studies conducted in Maharashtra, Tamil Nadu and Andhra Pradesh women reported that pregnancy outside of marriage must be aborted in order to preserve family honour. In the Maharashtra study, during group discussions, some of the women further opined that since such a pregnancy was a result of immoral behaviour of the woman or was an act of sin, it has to be aborted. However, some respondents were sympathetic towards such women and conceded that pregnancy can result from rape or violence or caused by someone known to the women. Overall, abortions outside the framework of marriage were characterised by secrecy, shame and stigma.

III
Decision-Making Pathways

While the studies generally attempted to identify various socio-cultural factors that influence the decision to abort a pregnancy, a few also collected information on the process involved before arriving at the decision for abortion or explored the pathways to such decision-making. In his effort to unravel the socio-cultural meaning of abortion in varying settings (such as need for abortion by a married woman as distinct from that by a widowed or a single woman), Morankar used the vignette methodology to obtain data.

Radkar delineated the stages of decision-making once a woman discovers that she is pregnant and wants to abort the foetus. Women first try out home remedies that are part of folklore, such as eating fruits and foods that are considered 'hot' like papaya, jackfruit and various concoctions, including headache tablets. If the menstruation does not resume after trying these methods, women may attempt invasive methods themselves like inserting a sharp instrument in their vagina and wait for bleeding to start. The study does not throw light on the extent to which such invasive methods are practised in real life. Often hearsay and actual facts get intermingled when women discuss these pathways to decision-making process leading to abortion. Interestingly enough, a few women in the urban Gujarat study by Barua reported that they directly approached the chemist for drugs for abortion. The issue of availability of abortificient drugs with chemists needs to be probed further.

The decision-making process involved in seeking abortion was relatively easy for married women but not for women who conceived outside wedlock. The widowed, separated, divorced or never married women would have to first inform their parents or partners about pregnancy, who would then take the decision whether and how to go about seeking abortion. If an unmarried young girl becomes pregnant, efforts are made by the parents of the girl to get her married to the boy responsible for her pregnancy. Morankar in his study explored in some detail how this is negotiated between the two families. When marriage is not a possible outcome, the girl is generally taken to an informal provider because there is a general perception that s/he would maintain secrecy and confidentiality much better ensured. If either the procedure fails or if the parents cannot afford the cost, the girl is sent off for a few days to a faraway place and abortion is sought in a formal facility.

The situation of widowed or divorced women is somewhat different. If pregnancy occurs while the woman is residing with her in-laws, they would know about it. Even if the person responsible for the pregnancy is known or is a member of the family, the woman is blamed for it. Abortion is sought in order to preserve the 'honour of the village'. Responding to a hypothetical vignette, some respondents in Morankar's study even indicated that such women should commit suicide or leave the village.

Making decisions about abortion is both a dynamic and a complex process. Therefore, it is important to understand with whom women discuss their pregnancy, whom they consult or whose permission is sought or who compels them to undergo abortion. Apart from factors such as caste, education, landholding or economic status that determine the process, reasons for seeking abortion also play a role in who takes the decision. Several studies have addressed this issue. Radkar's study suggested that women

themselves or jointly with their husbands made the decision about abortion in nearly half the cases and husbands took the decision in the other half of the cases. At the same time, the extended family was very much involved in the decision process. As pointed out by one woman: "...If they (family members, especially mother-in-law and sister-in-law) don't approve of abortion, how I can get the required rest? Who will look after my children when I am away in the hospital...?"

In the study conducted in Gujarat and Haryana, when women were asked about the decision-making process if they conceived a female child, their overwhelming response was that the pressure to abort was enormous from the extended conjugal family after one or two daughters. Women in both the states indicated that the decision to abort a female foetus was almost entirely that of their husbands and/or mothers-in-law and women had no say in the matter. However, some differences in the decision-making process were observed between women of higher social groups and of scheduled caste and other backward communities with regard to the influence of the in-laws. The high caste women had to inform and consult their in-laws but the low caste women reported that they had to obtain the consent of only their husbands for abortion. The role of natal family was reported to be minimal in matters related to abortion or sex determination test or sex selective abortion among all. However, the Tamil Nadu study by RUWSEC reported that even when the decision to abort was taken by the women's husbands and the parents-in-law, women were asked to approach their natal family for money or pawn their personal assets such as jewellery to take care of the expenses, especially when the foetus was that of a girl.

Inter-generational Differences

In the two Tamil Nadu studies focus group discussions were conducted with both younger and older women to ascertain whether there were any inter-generational differences in abortion experience or reasons for seeking it. Anandhi, in her study indicated that abortion by older women was considered shameful and dishonouring women. It was perceived that older women sought abortion not to limit family size, (because large families were accepted as a norm and not as a burden or impediment to the standard of living) but because the women desired to free themselves from childcare responsibilities; also it was indicative of women's sexuality and pregnancy perceived as a result of 'too much of sexual desire'.

In contrast, the younger women use abortion as a spacing method not merely because it is permitted by law but also because of the change in the notions of shame and honour. "With the younger generation, it is not frequent pregnancy per se, that was once perceived as an expression of excessive female desire, but the frequent childbirth, especially at the later stage of a woman's life, that is associated with the notion of shame". Honour is in having fewer children and women are not ashamed of their sexuality.

The study undertaken by RUWSEC in the same geographical area, on the other hand examined separately the abortion experience and perceptions of women (and the husbands of some of them) below 35 years and above 35 years of age. The study observed that the instances of women going for abortion without their husbands' explicit consent were far more common among the older women (11/27 abortions) than among younger women (4/25 abortions).

At first glance, the findings from the RUWSEC study are opposite of that of the study conducted by Anadhi with regard to reasons for abortion among older and younger women. Unlike in Anandhi's study, older women in the RUWSEC study mentioned that they opted for abortion 'to limit family size'. A concomitant reason was that their children were teenagers or adults and that they felt embarrassed to continue with the pregnancy or because they could not afford any additional children. Looking deeper, it is however, quite likely that the embarrassment of becoming pregnant beyond a certain age could be due to this being seen as an expression of women's sexuality. However, instead of articulating it in those terms, RUWSEC women perhaps chose to express in terms of limiting family size.

IV
Provider and Nature of Care

It is quite likely that since the studies were carried out in relatively more developed states of the country (and several were located in peri-urban areas), most women reported that they went or would go to qualified private doctors/institutions or government facilities for abortion. However, the married respondents pointed out that the unmarried, separated and widowed women preferred or were taken by family members to informal providers because of the desire for confidentiality and secrecy.[6]

Women generally come to know of the provider through word of mouth from friends and relatives, paramedical workers or from other knowledgeable community members. Advertisements in public places like buses or in the newspapers seem to play a role in urban areas. Morankar's study in Maharashtra found that the "information (on abortion) is usually sought under the pretext that someone else needs it. Women gather this information from other women when walking to the river to wash clothes, while working in the fields, or while fetching water. Men get such information during gossip sessions with friends."

The major determinants of choosing a provider by married women were his/her reputation, vicinity, familiarity and cost. Various alternatives are weighed before taking the decision There was an overwhelming perception that private facilities were better where one could obtain services in much less time, all procedures are attended in one visit, and the providers do not insist on a prolonged hospital stay. According to Barua, women in Gujarat reported that in public hospitals "a lot of time is wasted in waiting and going through formalities, these hospitals are not client friendly and the quality of services is suspect". Radkar also reported that the quality of care and the duration of time needed to be spent at the provider's facility were major considerations in the selection of the provider.

A second group of reasons included the fact that private doctors had better facilities and equipment, they treated women better than government doctors, ensure a confidentiality especially when unmarried women sought their services. Also, the private doctors were not in a hurry to discharge women after the procedure if they needed rest for an hour or so before going home; in public hospitals, on the other hand, there is a shortage of beds and so women are often asked to leave as soon as possible. Exceptions were reported when women wanted to undergo sterilisation along with the abortion. In such instances, women chose a government hospital where the acceptance of sterilisation would mean that the abortion did not cost them anything. Also,

when the family was poor and could not pay for abortion, government facility remained an option.

For women who wanted the sex of the foetus to be known and aborted the female foetus also preferred private providers. In the Gujarat and Haryana study, majority of the women knew the towns where the private doctors with nursing or maternity homes were providing these services and also indicated that they would use them if the need arose.

Cost Considerations

It was accepted that while the services of private providers cost money, visits to the government hospitals were also not cost-free because women often had to pay for medicines and required to make repeat visits before an abortion was performed. The long waiting period implied that time of the service seeker and that of the accompanying person (generally women do not go alone to impersonal large facilities) was wasted; for poor families this meant forgoing wages for that period of time.

In the Andhra Pradesh study, majority of the women who were interviewed selected the government hospital for abortion because of their poor economic status and also because they thought government services were free. However, after coming to the hospital they realised that services were not free and that the doctors charged a fee for performing abortions; the average fee was a little over Rs 600. Barua reported that in urban Gujarat, the government-run tertiary hospital, though not free, was the cheapest and the private gynaecologists were the most expensive and charged according to the duration of the pregnancy. According to her, the cost of the procedure in private facilities varied between Rs 400-600, not much different from what women in urban Andhra Pradesh paid. Interestingly enough, the local NGO in Gujarat charged nearly 15 times the fees it advertised.

It was evident during the focus group discussions that a certain group of women and their families calculate cost of abortion in a somewhat different way especially the abortion of a female foetus. The immediate cost of abortion (and also including that of sex determination test) is compared with the expenditure that would have to be incurred in future on dowry payment to the girl child, (if allowed to be born), and on several occasions after marriage.

Quality of Care

Information collected on the place and the provider of abortion, client-provider interactions, clients' expectations and experiences have provided some assessment of the quality of abortion care. Urban women in Gujarat indicated that no preliminary tests were done before the procedure, other than sonography for foetal sex determination. The latter was done only on the request of the client. The providers also reported that they do not carry out any physical or internal check-up of the clients but rely on the date of missed period as reported by the clients. Some provider do a urine pregnancy test prior to pregnancy termination but clients on their own often get this done prior to coming for abortion. The government tertiary hospital was an exception where several laboratory investigations including blood grouping were routinely carried out.

Further, the providers continued to use older techniques such as D and C for a variety of reasons. The Andhra study reported that three out of the four doctors at the government hospital used D and C even for first trimester abortions. Key informants in Tamil Nadu too reported that most abortions were done by D and C. The choice was governed by factors such as convenience and experience of the provider with the method. While factors like erratic electric supply made use of electric vacuum aspiration method difficult, use of manual vacuum aspiration was not perceived as safe by the providers in pregnancy beyond eight weeks of gestation. Apparently, some providers who used manual vacuum aspiration, also in addition used the D and C to ensure that abortion was complete.

Providers in Ahmedabad were aware of medical abortion and several mentioned that they had used RU 486 (mifepristone) or had treated patients who had taken the drug elsewhere and then came to them. The use of this method was not specifically mentioned in the other studies.

Counselling

Pre- or post-procedure counselling appeared to be limited in scope and content. Women in Ahmedabad reported that they were rarely explained any details about the procedure. Also, women themselves were not interested in knowing the details. Their main concern was to get the procedure over with and leave as soon as possible. The perception among the providers was that the clients were not interested in counselling. Also, the providers reported that they do not have "dedicated staff or incentive to do contraceptive or consequence-related (of abortion) counselling. Further, there is no audit system for counselling in hospitals." The providers in government hospital do not have much time to spend with the clients, and the limited counselling is done to warn the frequent users of abortion about the harmful consequences of repeat abortions.

Coercive contraception was not found in the public hospitals; either in the tertiary hospital in the Ahmedabad study or in the public hospital in Andhra Pradesh. The providers reported that they did not insist on the clients accepting family planning methods. Clients also reported that they were not coerced into accepting contraceptives.

Women in Andhra Pradesh who used the abortion services from the government hospital expressed satisfaction with the procedure, medicines, bed and the availability of toilet facility. They were not happy with diet and water because food was not provided in the hospital and the family had to arrange it from outside. Availability of water was a major problem compromising the cleanliness in the hospital. Similarly women in Tamil Nadu (RUWSEC) also generally did not express any negative views about services unless they had experienced post-abortion complications.

At the same time, there was some evidence that women's sense of dignity was compromised during their hospital stay. On initial questioning, majority of the women in the Andhra study indicated that they were treated with dignity and respect. But on probing more than half (15 out of 27) said that the hospital staff scolded the poor women who did not have money but came to the government hospital because they could not afford to go anywhere else.

The length of the hospital stay for the client depended on the procedure used to perform abortion and the period of gestation; typically the longer the gestation period, the longer was the stay in the clinic. Advice about the need for follow-up visits, danger signals and the need for rest was also generally given. Women,

however, were unable to take rest after abortion due to poverty and domestic responsibilities. Some women even indicated that abortion is not a major procedure (the way sterilisation is) requiring rest.

Overall, very few women in all the studies reported serious post-abortion morbidity. It is quite likely that in most studies women tried to recall morbidity episodes during their lifetime and immediate post-abortion illnesses tended to be forgotten because they were not life threatening. However, in the Andhra Pradesh study, which focused prospectively on this issue (and interviewed women immediately, two weeks, two months and six months after abortion), 21 of the 27 women reported morbidity such as excessive bleeding, weakness/nausea, abdominal pain or discomfort after abortion. Also, 18 of the 21 women sought medical care (which could have been due to repeated contacts with auxiliary nurse midwives). While it is difficult to correlate this with medically significant morbidity, it does mean that women need care and support following an abortion. Morbidity was reported by 21 of 34 women in the RUWSEC study, with the younger and older age groups almost equally represented. Excessive bleeding was the most commonly mentioned problem. The other problems were lower abdominal pain and back pain.

V
Provider Perspectives

Awareness about abortion laws: Provider studies indicated that the formally trained providers were generally aware about the MTP Act, but not all para-functionaries such as the ANMs were aware. At the same time, not all providers knew in detail the various situations in which the Act was applicable. Even when the providers were aware that the consent of family members was not required, majority of them insisted on it in order to protect themselves. In Andhra Pradesh the providers said that they insisted on obtaining husbands' authorisation to conduct abortion so that at a later stage husbands do not blame them for abortion. In urban Gujarat the consent was justified in terms of abortion being a surgical procedure done under anaesthesia.

The Gujarat sex selective study indicated that the service providers who were interviewed were aware about the PNDT Act, its ramifications and the consequences of aborting female foetuses. The ambivalence among them was that while they believed that the PNDT Act should be implemented with an iron rod and the violators should be punished, they nonetheless conducted sex determination tests in violation of the Act, because they sympathised with the families that wanted to decide not only the family size but also the sex composition of their children.

Registration, certification and reporting: Registration is perceived as a long cumbersome procedure and the resultant formal reporting mechanisms are seen as a source of harassment as was revealed by Barua's study. Qualified doctors who perform abortion tend to shy away from registering as abortion providers because of their apprehension about the procedure and resultant legal formalities. Providers also admitted that they do not record or report all the abortions conducted by them. While the registered providers report a few cases, the unregistered providers do not maintain any records.

Perception of providers about abortion seekers: According to the providers, women who want to limit their family size in urban areas generally come to seek abortion in the first trimester within eight weeks of pregnancy. Those who want to terminate the pregnancy for spacing seek abortion after eight weeks but between eight and 12 weeks. Providers also felt that some of the clients came to them after sex determination. But since the sex determination test and abortion can be obtained from different facilities, it was difficult for the providers to find out whether the woman coming for abortion of 'unwanted' pregnancy had undergone sex determination test elsewhere. Since they were essentially service providers, according to Barua, many of them in urban Gujarat preferred to maintain silence or presume that abortion is sought for termination of unwanted pregnancy and they have limited responsibility.

In Tamil Nadu, several providers mentioned that the stigma related to unmarried women seeking abortions is decreasing and many such women have started accessing abortion services early.

Emerging Challenges and Advocacy

As highlighted earlier, findings and leads from small and disparate micro-studies cannot be generalised to represent the situation in the country as a whole but need to be interpreted with caution and in context. Nevertheless, these qualitative studies undertaken to look into abortion issues, though small in scope and size, have thrown up some common patterns and themes, some of which are listed below:

The links between unmet need for contraception and abortion: While across studies women wanted to limit family size or space births, abortion often seemed to be a preferred alternative to the perceived side effects and the difficulties of obtaining and using temporary spacing methods. This was especially so in the two Tamil Nadu studies but similar reasons for not wanting to use spacing methods emerged across all studies.

Son preference: Averting the birth of a female child or ensuring the birth of a male one, often under pressure from conjugal and extended families was reported as one of the major reasons for abortion in most settings. While the use of 'modern' sex determination tests was more common in the western and northern parts of the country, the studies from the southern part of the country highlighted that women rely on more traditional methods of predicting sex of the foetus but with the same objective of averting the female birth.

Preference for the private provider: Wherever private providers were available and women could afford abortion services from them, they seemed to be the preferred choice because they were perceived to be more qualified, providing quick services, less waiting time and better at maintaining confidentiality.

The needs of single, widowed or separated women: Although none of the studies were able to directly interview unmarried adolescents, widowed or separated women, there were sufficient indications that stigma is associated with pregnancies among these group of women, the decision-making pattern is different and family and community support is not always very forthcoming.

Several studies also highlighted emerging areas of relevance for policy or programmatic action. These are outlined below.

Addressing contraceptive needs: Since most women reported relying on abortion for limiting or spacing children, the unmet need for contraception among them needs to be addressed in family welfare programmes. There is a need not only for expanding contraceptive choice but also for ensuring their availability and informing women and men about merit and limitations of

various reversible methods of contraception. While it is heartening to note from the various studies that neither the public hospitals nor private providers any longer insist on or coerce clients into accepting family planning after abortion, providers cannot absolve themselves from promoting responsible family planning through appropriate counselling and informing the clients about various methods of contraception.

The links between the PNDT act and the MTP act: Although the two pieces of legislation are independent of each other, the qualitative studies suggest that this distinction is hard to maintain in actual practice. The widespread campaign around the PNDT act has led to high awareness about it among the community; however knowledge of the legality of abortion services and the MTP Act still remains low. While abortion remains a right of a woman in India who can access it on economic or social grounds, there seems to be some evidence that abortion is equated with a ban on sex detection tests and with 'killing of girls'. Further, the PNDT Act is interpreted to mean that all abortions (whether sex selective or not) have now become illegal. Providers too often link the provisions of the two acts. As the studies show, the most common reason for women to have an abortion is still linked to limiting and spacing their children (irrespective of sex composition), and unless a clear distinction can be maintained between these two issues and the reasons for the enactment of PNDT Act be made very clear, effort to expand access to safe abortions will receive a setback in the coming years. Concerted efforts and sending out correct messages are very essential to clear the confusion.

Increasing awareness of the provisions of the MTP Act: There is a need to expand awareness about when, where and under what circumstances legal abortion can be availed not only among women but also among decision-makers in the family as well. Women also need to know their rights, what are safe quality services, to help them ask for information or question poor quality care. Providers of services too need to know what the legal provisions are so that their own moral stands or their misperceptions about legal requirements (for example, taking signature of husband) do not get in the way of providing services that are legal.

The role of medical technology: The qualitative studies highlight that D and C continues to be used for performing abortion for reasons of familiarity, convenience, lack of training or misperceptions about safer options like vacuum aspiration. The recent legalisation of mifepristone in the country provides yet another option for a safe and effective technology that can increase access and expand choice. Since the legalisation of this technology happened after these studies were designed, none of them explored the implications of these changes in a systematic way. The little information that did emerge points to the fact that it is used by some practitioners and is preferred by some clients. The Ahmedabad study suggested that in some settings it might also be available directly to women over the counter (as indeed

Appendix: Geographical Coverage and Objectives of the Eight Quantities Studies

Researcher, Organisation and Title of the Study	Geographical Area	Study Population/ Respondents	Main Focus of the Study
S Anandhi, Madras Institute of Development Studies, 'Women, Work and Abortion Practices in Chengalpattu District, Tamil Nadu'	Four villages in Kancheepuram district of Tamil Nadu	Dalit women (married and unmarried) working in pharmaceutical companies; village functionaries and opinion leaders; abortion service providers	Abortion decision-making and practices in the context of increasing employment of rural women in industrial sector in peri-urban area
Alka Barua, Foundation for Research in Health Systems, Ahmedabad, 'Study on Availability of Abortion Care, Gujarat'	Two urban slums in Ahmedabad	Married women with an induced abortion experience; Abortion service providers	Provider choice; women's perspectives on quality of abortion care; provider perspectives on accessibility and quality of abortion care
S N Morankar, Maharashtra Association for Anthropological Sciences, Pune, 'Ethnographic Exploration of Abortion and Abortion Care Related to Community Needs in Velhe Block of Pune, Maharashtra'	Fourteen villages in Pune district, Maharashtra	Married women and men from the community; opinion leaders; service providers	Ethnographic exploration of community attitudes around abortion
M Prakashamma, Academy for Nursing Studies, Hyderabad, 'Post Abortion Care through the Public Health System, Andhra Pradesh'	Three villages and selected public health facilities in Medam district, Andhra Pradesh	Women with a spontaneous or induced abortion; service providers both doctors and mid-level providers (ANMs); facility assessment	Role of public health system in care for women during and after abortion (both spontaneous and induced)
Anjali Radkar, independent researcher, Pune, 'Abortion in Rural Community neat Urban Areas, Maharashtra'	Two peri-urban villages near Pune, Maharashtra	All currently married women in the 15-49 age group	Decision-making and provider choice
TK Sundari Ravindran, RUWSEC, Chengalpattu, Tamil Nadu, 'Process and Factors Underlying Choice of Induced Abortions: A Qualitative Investigation in Rural Tamil Nadu'	98 hamlets from the RUWSEC project area in Kancheepuram district of Tamil Nadu	Low income, socially marginalised couples (both wives and husbands)	Gender dynamics and abortion decision-making; inter-generational differences in abortion-seeking behaviour
K Susheela and K Nagaraj, Madras Institute of Development Studies, Chennai, 'Abortions in Dakshina Kannada: Socio-Cultural and Medical Underpinnings and Consequences'	One village in the Udipi district, Karnataka	Women – Beedi workers and agricultural workers	Estimate the extent of pregnancy wastage (including spontaneous and induced abortions) and socio-economic, cultural and medical factors associated with it.
Leela Visaria, Gujarat Institute of Development Research, Ahmedabad, 'Sex-Selective Abortion in Mehsana and Kurukshetra Districts of Gujarat and Haryana'	Six villages in Mehsana district in Gujarat; Six villages in Kurukshetra district in Haryana	All currently married women in the age group 15-49; abortion service providers in Gujarat	Decision-making process and role of son preference in sex-selective abortions

are most drugs in the country). All these issues require further exploration. The technology is known to be safe and effective and we need to understand how best to exploit its full potential in promoting safe abortions, while at the same time guarding against misuse that can stem from misinformation.

Quality of care: While life threatening morbidity from abortions did not emerge as a major issue of concern, women's experiences at health facilities as well as the assessment of the providers themselves show that quality of care, especially of counselling, is a neglected area. Public sector facilities appear to have high case load and do not have adequate time to devote to pre- or post-procedure counselling, while private sector providers appear not to see the necessity of counselling. In public facilities women often experience judgmental attitudes and rude behaviour from providers. All types of providers could benefit from gender sensitivity training, inculcation of non-judgmental attitude and value clarification and all programmes should focus on putting women and their individual needs as the focal point around which services must revolve.

The entire process of the qualitative studies also showed that partnerships between diverse groups of people drawn from different disciplines and with differing ideologies and positions are possible and productive. The collective process of integrating diverse viewpoints enhances a common understanding of the issue of unsafe abortions and in the long run is an essential step in progressing towards the common goal of making abortion an infrequently used but safe alternative for women faced with an unwanted pregnancy. EPW

Address for correspondence:
erudelhi@sify.com

Notes

[The overview is a synthesis of the findings from the eight qualitative studies undertaken by partners whose names, affiliated organisations, and titles of their studies are shown in tabular form in Appendix. Without their seminal contribution to the issues and discussion this overview would not have been possible. We thank each and every one of them for the hard work and commitment to the cause of abortion as women's right. We also extend thanks to Manisha Chaudhry for her excellent editorial input. MacArthur Foundation funded the qualitative studies and we are grateful for their support.]

1 Please note that each of the eight studies explored some or all of these issues to varying degrees based on the focus of the study.

2 The RUWSEC study was carried out in an area where the organisational activities have focused on increasing the awareness and use of spacing methods. Condoms are promoted in the community and also among men. The methods are also available in the clinic free of cost. In spite of this, as the study findings on contraception show that it is difficult to increase the acceptance of reversible spacing methods.

3 Radkar's sample consisted of all women 15-49 who reported an induced abortion in the two study villages where the study was conducted. Barua's sample of 62 women who had an induced abortion was purposively selected. The two figures therefore do not indicate the extent of sex selective abortion in the states and should not be compared.

4 This is not unique to Tamil Nadu or to the study villages. There are studies, which refer to this phenomenon for seeking of abortion. For instance, see, Bela Ganatra (2000).

5 This term has been borrowed from an Egyptian study of women's reproductive lives. It is a useful analytical tool to understand how unmarried girls who work in the companies comply with the discriminatory and sexually exploitative work culture against their own wishes for the sake of deriving some strategic benefits like income and some freedom and mobility. At the same time, they constantly complain and regret the situation they are in. Here, we can see 'accommodation' interacting with 'resistance'. For a detailed discussion on 'strategic accommodation' see: Dawala et al, 2001.

6 Although in the research reported here informal providers of abortion were rarely mentioned by the study participants, HealthWatch in association with Ipas, India, conducted a multicentric study of informal providers in six parts of the country where excepting for one centre, women did seek the services of informal providers in certain situations.

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