A Study of Abortion-Behavior among vulnerable women in Mumbai and Jalgaon (Dist.) in Maharashtra

Research conducted as part of the Maternal Health Young Champions Program of the Maternal Health Task Force, Harvard School of Public Health (HSPH), Institute of International Education (IIE) in collaboration with Society for Nutrition, Education and Health Action (SNEHA)

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[**] Study conducted under the guidance and supervision of Mrs. Sushma Shende, Program Director, Maternal and Newborn Health, SNEHA, Mumbai. Funding provided by Maternal health Task Force and IIE.

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BACKGROUND

According to the World Health Organization (WHO), every 8 minutes a woman in a developing nation will die of complications arising from an unsafe abortion. An *unsafe abortion* is defined as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."[1] The fifth United Nations Millennium Development Goal recommends a 75% reduction in maternal mortality by 2015. WHO deems unsafe abortion one of the easiest preventable causes of maternal mortality and a staggering public health issue. Data suggests that even though the overall abortion rate has declined the proportion of unsafe abortion is on the rise, especially in developing countries.[2]

In India, the Medical Termination of Pregnancy (MTP) Act[2], 1971, liberalized the ban on abortion and stated the conditions under which a pregnancy can be terminated, the people who are authorized to do so and the place of implementation. Though it did not provide abortion as a right to women, it expanded the permitted reasons and helped regularize legal abortion and thereby also help control maternal mortality and morbidity caused due to unsafe abortion practices.[3] However, even after 43 years of the implementation of the MTP Act, the issue of unsafe abortions and women dying because of it plagues the country. According to the Consortium on National Consensus for Medical Abortion in India, every year an average of about 11 million abortions take place annually and around *20,000 women die every year due to abortion related complications*. Most abortion-related maternal deaths are attributable to unsafe abortions and are largely preventable.

A recent report, 'Unsafe abortions killing thousands in India'[4] on BBC News India website, on the basis of their reportage in the town of Jalgaon in Maharashtra suggests that an alarmingly large number of women die in India because of unsafe abortions. It was reported that many women do not go to public health facilities for abortion because of want of qualified doctors, fear of action under MTP Act and lack of knowledge because of which they resort to backstreet abortion practitioners, which is not only illegal and unsafe but also carries increased risk. According to the report, "Every two hours a woman dies in India because of an abortion that goes horribly wrong. The problem is particularly acute in rural areas where there is little access to quality healthcare." If the report is to be believed, it is clear that abortion (both safe and unsafe) today is an extremely important yet subdued issue that lurks in the underbelly of the health system.

[2] The Medical Termination of Pregnancy (MTP) Act was approved in 1972. This Act does not replace or negate the Indian Penal Code, but only allows its provisions to be set aside under a prescribed set of conditions. The MTP Act permits the termination of pregnancy up to 20 weeks, on the following grounds (a) Where the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (b) Where substantial risk exists of the child being born with serious physical or mental abnormality. In the explanation of the Act, the note also indicated that pregnancy due to failure of contraceptive methods could also be aborted as the "anguish caused by such unwanted pregnancy may be presumed to contribute a grave injury to the mental health of the pregnant woman". The termination of pregnancy can be carried out only by registered medical practitioners in registered facilities as defined in the Act. For the termination of a second trimester pregnancy, the opinion of two such qualified registered medical practitioners is needed to confirm that there is a valid reason for the termination.

In addition to the MTP Act, the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition Of Sex Selection) Act (PCPNDT Act) was enacted in 1994 (amended in 2003) to stop female foeticide and to attend to the decline in sex ratio. The act puts a ban on pre-conception and pre-natal sex determination and attracts strict penalty for its breach. While both the legislations aim towards the larger goal of empowering women and protecting them, their association and interrelation could be studied to understand the barriers to safe abortions and pathways to unsafe abortions. In Maharashtra, which is one of the better performing states in India with regard to maternal health and maternal mortality ratio, the incidence of unsafe abortions and sex-selective abortions has remained high. In 2012 various cases of female foeticide surfaced propelling the government to step-up surveillance on private abortion clinics leading to the seizure of sonography machines along with arrest of doctors allegedly involved in sex-selection. The Food & drug Administration (FDA) also cracked down on doctors and chemists selling medical termination of pregnancy kits (MTP kits) without prescription and documentation and thereby leading to a shortage of abortion pills.[5] While this naturally lead to an increase in surgical abortion at government hospitals but also gave rise to a black market for MTP kits that sub-optimal providers such as *haqeems* and *dais* sell off-label.[6]

CONTEXT

Abortion as a social reality falls at the tricky intersection of health, law and morality. *A woman's abortion-behavior comprises of all the factors that have an effect on the decisions she takes with regard to her abortion(s)*. By analyzing the reasons for abortion, abortion pathways, role of the husband and family members, experience at abortion centre, knowledge and perspective on abortion and family planning, one can better understand the various interlinked themes that act as barriers to safe abortion, thereby violating the right to reproductive health.

In the context of stigma and confidentiality, abortion is a topic that raises eyebrows when talked about openly and thus not much is known about perspectives on abortion. The focus of this research was to understand why a woman took the decision she took and how was her experience of the same. An effort has been made to corroborate the women's voices with the responses of abortion providers. By identifying the core reasons for such decisions and by understanding the role of decision makers, interventions to make abortions safer for women can be more focused and pertinent. The research aimed to provide SNEHA with inputs from the grassroots, existing realities about women's choices through women's voices.

The **Society for Nutrition, Education and Health Action** (SNEHA) is an Indian non-governmental organization working to promote maternal and newborn health in Mumbai's slums. In the past SNEHA has done exemplary work through effective partnership with the public health system to strengthen it and to provide it with innovate models to ensure better services for both mother and newborn child. SNEHA's presence in the community (slums) provided the support that

was needed to conduct this research. It was aimed that the findings of the study and the themes touched thereupon would provide the necessary backdrop under which further research and community-based interventions could take place. Since SNEHA has not yet worked specifically on unsafe abortion within the fold of maternal health, this research hopes to lay down the groundwork and bring to fore the voices of the women from the community and the current practices and perspective of abortion providers.

OBJECTIVES OF THE RESEARCH

The primary objective of this research is to better understand abortion-behavior among women in terms of choices made and to describe the experiences of women who have obtained induced abortion in two regions of Maharashtra.

The research was conducted with the following objectives:

- to study specific cases of women's abortion behavior and identify gaps between abortion laws and their implementation.
- to study the decision-making process and pathways in abortion among vulnerable women.
- to understand the perceptions of abortion providers in the two regions.

STUDY DESIGN

The study was designed to be exploratory in nature with qualitative methodology. Given the sensitivity of the topic and need for confidentiality the following strategy was adopted:

- That the study be done in collaboration with NGOs which have presence in the selected community and enjoy credibility among the women in particular.
- Informed written consent was taken from all participants
- Study was conducted in their own homes or where confidentiality was a concern at the NGO center within the locality
- The primary researcher was accompanied by community organizers or peer educators from the collaborating NGOs who were familiar to the participants

Although study design employing focus group discussions was also considered, the pilot testing of focus group discussion in one of the areas proved to be unsuccessful. It was found that the participant women were not comfortable sharing their abortion experience within a group. Hence, only in-depth interviews were conducted. Additionally, operational limitations such as sensitivity of the issue, signs/symptoms, recall, trust, time and presence of family members were prohibitive. In-depth-interviews in presence of community organizer or peer educators eliminated most of the operational and confidentiality related limitations, while providing for a safe, confidential

environment for better interaction and openness. Because women were currently receiving services from the NGO, they were more likely to trust the interviewer when accompanied with someone familiar and thus hopefully provide more reliable information. The interviews were conducted on pre-decided dates and timing as convenient to the participants.

At the time of pilot interviews, a need was felt to corroborate women's experiences and findings with the practices and beliefs of the abortion providers i.e. doctors from private hospitals, public hospitals and sub-optimal providers. The interviews with abortion providers were conducted in hospitals or maternity homes or clinics for a better understanding of their patients, clientele and services offered. An effort was made to visit the same doctors or hospitals that the women reported to have visited.

Target Population and Eligibility

1. Women: In total 26 respondents from Mumbai and Amalner, Jalgaon were purposively selected. The presence of SNEHA in Mumbai's Dharavi and Govandi slums and Aadhar in Amalner Taluka helped in data collection and operational support. It was hoped that by identifying and analyzing specific cases of abortion behavior in two regions in Maharashtra (which might be seen as representative of urban and rural landscape), the issue could be explored in greater depth.

The participant-respondents in the study included women of reproductive age (15-49) and abortion providers providing maternity services. The participating women were identified through community organizers and peer educators working with SNEHA and Aadhar Bahuuddeshya Sanstha.

Inclusion Criteria:

- Women who have experienced induced abortion in the last five years and give consent to be interviewed

Exclusion Criteria:

- Women who have had at least one abortion in the past five years but do not consent to be interviewed.
- Women who have had at least one abortion in the past five years but are currently pregnant.
- Women who have had at least one abortion in the past five years but are vulnerable because of any personal reason (For eg. very recent abortion, depression etc)
- Women who have had at least one abortion in the past five years but have experienced a neo-natal death or still-birth recently

2. Abortion Providers: In total 9 doctors were selected on the basis of availability and consent. Out of these, 5 were selected from Mumbai and 4 from rural Jalgaon.

Research Tools

Two sets of semi-structured guideline for in-depth interviews were prepared for conducting detailed interviews with the women participants and the doctors. These guidelines were developed in English and translated to Hindi.

The purpose for the guideline for interview with women participants was twin-fold, a.) to capture basic details about the respondents such as education, age, number of live issues, number of times abortion obtained etc. and b.) to record abortion pathways, decision-making, choices made and overall abortion experience. It included questions on gestational age at which abortion was obtained, reasons, decision making, and choice of provider, experience (consultation, fee, transport, post abortive care and complications), knowledge and perceptions on abortion (MTP, PCPNDT Acts), stigma and regret, sex-selection and contraception usage. Each interview was transcribed in Hindi or English. An iterative process was used, using findings from initial interviews to form subsequent lines of enquiry.

Adherence to ethical Standards:

The research design, tools and protocols were presented before and approved by the Research Group at SNEHA, Mumbai, India. Informed consent in English, Hindi or Marathi was taken from all participants. Consent to record the interview and to take photographs was also taken. The purpose and nature of study was explained to the participants and they were assured that the researcher could be contacted in case any further details were required. All participants signed the informed consent form or gave verbal consent to the interviewer who signed on behalf of the participant. Participant confidentiality was maintained at all levels of interaction with the participants. The interviews were conducted one-to-one with the participants in their homes to ensure that the participant is comfortable. In case confidentiality could not be maintained at a participant's house, she was interviewed at a peer educator's home located within the community. Interviews with abortion providers were conducted at hospitals.

Data was entered and analysed using standard Ms Excel spreadsheet.

FINDINGS AND DISCUSSION

Foreword

Through this study an effort has been made to delve into the various themes related to the issue of abortion by understanding abortion behavior among vulnerable women. The purpose of understanding their abortion behavior is to trace backwards why some women made certain choices and why others did not, what was their abortion experience and perspectives. By tracing backwards the pathways to abortion, this study has endeavored to understand the practices, beliefs, knowledge and attitude of women and abortion providers in the social-cultural backdrop of an urban and rural region.

While the research was open to comparing the two regions where comparisons could be drawn, but given the differences in access, distance from public health facilities and migration of women between the two regions, it was decided not to focus on comparing but explore the current state of affairs and practices. As mentioned before, the study hopes to lay the groundwork for further research on each of the themes.

For the purposes of this research vulnerability is defined as economic or social condition that may expose a subject to physical or emotional hardship.

Reasons for abortion: When asked the reason for terminating the pregnancy, nearly half the respondents from Dharavi and Govandi indicated they did not want another child while equal number of women gave the reason 'previous child too small'. In many cases the women had undergone abortion more than once, because after each complete delivery they again got pregnant within three to four months and could not keep the child during that period. Some other reasons included:

-Limiting family size,

- Financial constraints or lack of income: *Main sochi panch bache ho gaye aamndani nahi hai isliye itna sara bacha kya karungi, padhana likhana hai,* or

- Health problems.

In Jalgaon also some women cited the reason previous child too small. However, there were also cases where women wanted to abort the child because they considered themselves too old to have a child (since they had grown up children), or the abortion was sex-selective. In one case, woman had undergone sex-selective abortion thrice. If the husband's brother also does not have a male child, male preference increases multi-fold.

Mujhe do ladkiyan thi aur mujhe ladka chahiye tha aur 5 baar pata kare, 5 baar larkiyaan hi thi aur girwa di. Check karaya tha. Mere jo pati hain usko aur do bhai hain, un dono ki biwiyaan jo hain unko bhi ladka nahi ho raha tha. Choti wali ko do baar ladka hua par dono baar guzar gaya. (Resp 2)

One respondent in Jalgaon district mentioned that the reason she opted for abortion was because she wanted to find work at the local Anganwadi where the eligibility conditions disqualified women with two or more children.

Yahan jo vacancy nilki hai aaganwadi se usme agar teen bacche kisi ko hote hain to woh jagah nahi milti hai. Do se zyada bacche hote hai to wahan form nahi bhar sakte.

Decision-Making Pathways: In Mumbai, it was noted that there existed different pathways in which the decision to obtain induced abortion was reached. Most women immediately told their husbands about their pregnancy and sought the husband's opinion. The important themes within abortion pathways were

Permission: The women considered the husband's word to be the last on the topic. Most respondents considered abortion decision as the prerogative of the husband. Repetitive use of the word *ijaazat,* or permission/consent was noted. **Decision-making thus primarily relies on whether the partner/husband has given his permission.**

Mere aadmi ijaazat diye toh kara li. Nahi ijaazat dete toh nahi karwa sakti thi. Meri aadmi ke sath hi zindagi guzregi. Agar wo bolte ki rakho toh ghut-ghut ke zindagi nikalna parta, apni tabiyat kharab hoti.(Resp 4)

Agar aadmi nahi maanta tah nahi karati. Agar aadmi ek baar bol deta hai nahi karana hai toh nahi karati. unhone ijaazat diye tabhi kiya.(Resp 5)

Dependency: Many respondents also mentioned the fact that since they were dependent on their partners for their basic needs, they had no option but to act in accordance with their wishes. In most cases had the husband refused consent the women would continue with the pregnancy.

Pati jo bolega unki rai hamesha lekar chana chahiye apne mann se kabhi nahi chalna chahiye. Kyunki agar pati sath chhod dega toh kidhar jane ka. Ma baap bhi bolenge ki idhar nahi aane ka. Isliye zyada pati ki rai lekar hi chalna acha hai.

Agar aadmi bolta hai paida karo toh karne ka paida. Aadmi ka hota hai antim nirnay kyunki aadmi jo kahega wo hi mana jaega. Uske saath mein humko rehna hai na. Aadmi chahega rakhega, nahi chahega uski marzi. (Resp 9)

Out of the complete sample set there was one woman who had chosen not to tell her husband of her abortion. The respondent knew that her husband would not give her 'permission' even though she

already had 6 children and she feared that her health would not permit her to undergo another pregnancy. Though she went ahead and obtained the abortion, but more than an exercise in decision-making it was resort in face of a pregnancy she knew her body would not endure.

Her testimony is as follows:

> *Mane kisi ko nahi bataya. Agar mere pati ke kaan tak ye khabar jati toh wo mujhe ye kaam kabhi nahi karne dete. Main ek baat bolu, ye nirnay akele mein nahi lena chahiye kyunki agar kuch ho jaye, kuch baat ho jaye, toh ghar walon ko bhi pareshani hoti hai lekin abhi mujhe ye doubt tha ki agar main bol dungi toh mere pati mujhe karne nahi denge, mujhe rok denge, aur mein pehle se hi itne bache they ghar pe yani mujhe aaage peeche soch ke kafi uljhan si hoti thi. To isiliye main bina bataye ki.* (Resp 10)

In many cases in Mumbai slums it was noted that the women and the partner opted to not inform the husband's parents because of fear that they will not allow them to terminate the pregnancy. In most cases where in-laws lived away from the couple's home (in village or otherwise) the couple decided not to inform them.

> *Unlog* (in-laws) *nahi karane dete na. Hamlog mein jayaz nahi hai operation iske liye.* (Resp 4)

> *Unlog* (in-laws) *ko kya batane ka unlog ko batayenge toh bolenge dawa karo. Meri saas ke paanch bachhe hain, wo bolti hai jitna hoga utna rakho, dawa karke roko. Bhagwan ki den hai.*(Resp. 7)

> *Saans-sasur ka kya karne ka. Wo toh bolenge paida karo.* (Resp 9)

In one case upon getting to know that the daughter-in-law had obtained abortion against the father-in-laws decision, there was a marked difference in attitude with the daughter-in-law.

In Jalgaon, in families where the respondent lived with the in-laws, abortion was a decision to be taken by the family as it is considered a matter of 'family line'. Even though at times it was the husband's negligence in using contraceptives – it was the wife (respondent) who was held responsible for the unwanted pregnancy.

In cases of sex-selection, decision-making was hugely influenced by what the father and mother-in-law wanted. Thus, there were cases where the respondent underwent sex-selective abortions because the extended family did not have male children.

> *Gharwalon ka sath abortion ke liye bohot zaruri hai kyunki aise ham akele ja kar nahi kara sakte na. Agar kia bhi toh who bolenge.* (Resp 11)

> *Pati aur saans sasur bol rahe the ki hamein ladka chahiye kyunki badi bahu ko bhi ladka nahi, dusri ko bhi ladka nahi hai toh ladka toh chahiye na?. Is liye mera khud*

ka bhi mann hua ki ladka chahiye. Agar ladka nahi hua toh pati ka vansh aage kaise badhega? (Resp 12)

Pati bol rahe the ki nahi hone dene ka. Agar ghar mein sab ke sath ek jagah rehte hain toh sabse darr kar hi rehna padega. (Resp 15)

Role of the Husband/Partner: As noted above, it was noted that all women believed their husbands to have more knowledge about abortion and had complete faith in their partner's decision. This was even seen in cases where the pregnancy was due to neglect on the part of the husband to use contraceptive. **Consent and permission of the husband in matters of abortion seem to be central to many women's decision making.**

*Kanoon kehta hai ki agar aadmi ijaazat de toh aurat bacha gira sakti hai. Par agar aadmi bolega ki paida karne ka, toh karne ka paida. (*Resp 10)

In one case, the husband who was earlier not agreeable to abortion had agreed for it, keeping in mind his wife's sensitive health. It might need mentioning here that the couple had severed relations with the family after their inter-religious wedding and thus the woman had much more say about her life and the husband was found to be more supportive.

Wo keh rahe they ki doctor log bol rahe hain ki 3 maheene ka ho gaya hai toh bache mein jaan aa gayi hai. Inka (husband) bhi dil nahi maan raha tha par meri majboori thi aur koi tha bhi nahi sambhalne ko iske liye main boli ki kar do. (Resp 1)

It was also observed that in cases where the previous child was too small or the wife's health was in jeopardy, the husbands usually supported their partner if she wanted to obtain an abortion. But there were very few cases where husband allowed for the partner to obtain an abortion solely because she did not want another child.

The above mentioned findings were corroborated with the testimonies of doctors who in both regions from public as well as private hospitals said that most women depended on their husband's opinion and decision about their abortion.

Husband will decide. They (women) say, 'Hamara aadmi nahi bolta hai toh nahi karne ka. Aadmi bolta hai karne ka toh karne ka.'" (Doctor 2, Mumbai)

Most women here depend on husband's decision. Women are sometimes dicey. But they are very adamant that the husband will decide. (Doctor 2, Jalgaon)

Method of Termination of Pregnancy: Out of the sample set in Mumbai there were slightly more cases of surgical abortions than medical. One reason could be the increased strictness imposed by the FDA on over-the-counter sale of misoprostol and mifepristone.

It was also observed that more women had first opted for medical abortion and in case of failure or incomplete abortion had resorted to surgical abortion for complete abortion or *saffaiyya* (cleaning).

According to the testimony of a doctor in Mumbai:

> *Many women who come for MTP are the ones who have taken MTP pills from somewhere. Now we know the abortion pills are banned (over-the-counter) but they usually get it from other sources. We do have cases where the women have taken the pill and bleeding was happening but no abortion was done. We scan and then come to know that it was impartial. One in ten cases is like that. It becomes a medico-legal case because no prescription was there. It could be a quack also and is illegal.*

Medical Abortion

Recently much attention has been given to medical abortion. Medical abortion is induced by a combination of pills consisting of Misoprostol and Mifepristone, which are given between seven to nine weeks of gestation. A small number of women had taken the pill more than once. Abortion pills were mostly procured either from the chemist without any label in secrecy or through sub-optimal service provider or procured from their village. (Many women from Dharavi frequented a doctor who administers Ayurvedic medicine. The medical credentials of the doctor could not be confirmed and she refused to talk to us.) **None of the respondents had information about the dosage, method or till what period of pregnancy they should consume it. There is a strong reliance on hearsay with regard to the efficacy of the abortion pills.**

It is noteworthy that the ban on over-the-counter sale of pills has led to the pills being sold anywhere from Rs. 500-1500 while the actual cost is below Rs. 400.

Case Stories of women procuring abortion from unqualified practitioners and chemists

1.) Respondent 5 procured abortion pills from a known chemist without prescription. The chemist at first was reluctant but then relented. He asked her to have only one pill and then visit him after 2-3 days. *Storewallah bola 6 maheene ka bhi agar hoga toh gir jata hai. Ab jo woh bolega apne ko toh maan na padega na.* (The chemist at the store said that abortion could happen with the pills even in the sixth month of pregnancy. We have to believe what he says, what can we do?)

2.) Respondent 10 recalled that at first she visited a quack in the nearby area. The quack told her he could procure her abortion pill for Rs. 700. He told her, *hum chori chipe koshish karenge agar mil gaya toh lakar dete hai*. (I will try to get the pills for you somehow in stealth.)

In Jalgaon District also most respondents had undergone surgical operations while few had taken abortion pills. Out of those who had taken misoprostol and mifepristone, they had procured and consumed it at the advice of either chemists or quacks without prescription who had given the pills to them after removing the label and in secrecy.

The interviews with doctors in Mumbai revealed that at most government hospitals medical abortion pills (misoprostol and mifepristone) were unavailable and thus according to the rules, the doctors could not prescribe the same. The doctors had varied perspectives on the efficacy and suitability of the pills ranging from "very safe" to "not at all safe" for the women. The law prescribes that the pills can be administered till 7th week of pregnancy and should be followed with follow-up visits.

According to one doctor practicing at a Mumbai based government hospital:

I don't prescribe abortion pills. Personally I feel that when you give these pills you require follow up. After you give the pill a patient might start to bleed profusely. Women come to me from most remote areas and they are not able to come again for follow-up.

When asked about her experience with pills:

See we have a certain protocol to take these pills. There is a certain dosage that needs to be given. If it is not being given there could be incomplete abortion. Patients come to us and say they have taken the pill and bleeding is there and yet abortion has not happened. At times they still need surgical curettage. I don't encourage it. It is safe but not in these women because they wont follow up. Taking pills is not good. It is hormones. It is not good for your body, no.

In Jalgaon, doctors from both private clinics and from government hospitals said that they received many cases of incomplete abortions and half the women who come to them have at times already consumed abortion pills from quacks etc., which usually lead to complications. One reason why women go to sub-optimal providers from abortion pills could be an increase in demand on one hand and increased strictness on over-the-counter sale on the other.

Facility-based experience:

Public: Most women related incidents of being sent from one facility to other which cost them precious time and at times if the referred facility was further they preferred going to sub-optimal providers since access is easier. At many maternity homes and secondary hospitals in Mumbai second-trimester abortions are refused and the women were sent to Tertiary Hospitals. In some cases even tertiary hospitals refused to provide abortion services after 12 weeks.

> *Wo keh rahe they ki doctor log bol rahe hain ki teen maheene ka ho gaya hai toh bache mein jaan aa gayi hai.* (Respondent 1)

Interestingly, **not even one of the respondents in Jalgaon was able to obtain surgical abortions at public hospital/health facility**. While some were turned away because they had stopped providing second-trimester abortions, others were denied abortion because of their refusal to undergo tubal ligation[3] or sterilization as a means for birth control. Most women and their families had opted for private abortion centers based in Amalner or Jalgaon.

Some issues related to facility based experienced were noted and they are as follows:

Consent: Under the MTP Act, for an MTP procedure the consent of the husband is not required, only the consent of the woman is necessary. However, in some cases it was found that doctors had refused to perform an MTP unless the husband has given consent for the abortion. Many women reported that abortion providers asked for the express consent of the husband or an immediate family member. Women who could not obtain consent or who went to the facility alone were denied abortion**. The concept of consent and permission that is recurring in women's abortion stories is not only an unlawful restriction but also derogatory to a woman's right over her own body. Responses like *mere aadmi ki ijaazat hai,* reaffirm the prevalent (albeit misleading) notion that the partner's consent is a pre-requisite to abortion.**

Among doctors working in the government hospitals it was found that though they were aware that only a woman's consent is required but in practice they made sure that the husband had consented to the MTP. **In this regard it was observed that MTP services are provided as a doctor's prerogative and only if the doctor so decides would the woman be provided an MTP.**

A doctor practicing at a maternity centre in Mumbai said:

> *Usually for MTP consent of patient is enough. But we usually take the consent of the husband too. The next day the husband should not come and kill me saying ki 'kyu kia' and all those things. In most hospitals they need consent from women. It (husband's consent) is there in most of the hospitals. No body wants to take the risk.*

Similarly according to another doctor:

It is not compulsory that she has to take spouse's consent. But in our set of society it is always better that we take husband's consent.

The situation was similar at the government hospital in Jalgaon. At both regions it was felt that some doctors relied on consent to save themselves from legal ramifications in case of any questioning. While doctor's at private hospitals considered abortion to be a woman's right, the attitude of doctors at public hospitals was more restrictive and they exercised their prerogative.

[3] Tubal ligation or tubectomy (also known as having one's "tubes tied" (ligation)) is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked, or severed and sealed, either method of which prevents eggs from reaching the uterus for fertilization. Tubal ligation is considered a permanent method of sterilization and birth control.

Quality of treatment and infrastructure: It was felt that more than quality of diagnostics, the women at both regions were more concerned with the manner in which they were spoken to or treated by hospital staff and doctors. **Disrespectful treatment can be seen as a crucial hindrance to women utilizing abortion services at public hospitals at both the regions.** Almost all women expressed dissatisfaction at the quality of care and attitude of staff at public hospitals and cited it as one of the main reasons did not prefer to avail services there. However, the respondents also said they would like to go to public hospital if some attention is given, because it costs less.

Many women stated that they do not prefer the services at public hospitals because they treat the patients with a hurry, talk impolitely and at times abuse them verbally.

> *Baki jagah gali dete hain, jhidki dete hain, bhagate hain. Kehte hain- "Kyu aisa kari, kai ke liye kari? Acha lagta hai bachhe paida karne? Bohot kuch bolte hain. Chilla rahe they mujh par ki "pehle kyun nahi aaye agar tumhein bacha girwana hi tha'". Main boli, "madam mujhe sharam aa rahi thi bolne ke liye umar ke hisab se ki bache bhi bade bade ho gaye hain kaise bolu." Wo toh inko (SNEHA workers) ko pai toh inse apne dil ki baat bol di. Lekin kisi se bolne ke liye sharam aa raha tha kyunki bimari bhi hai aur umar bhi ho gayi hai, kaise bolu.* (Resp 9)

> *Private mein baat-cheet ache se karte hain. Lekin sarkari mein dhyaan nahi dete. (Resp 15)*

> *Sarkari mein bohot bheed hai bohot gandagi hai. Koi kisi ki taraf dhyaan nahi deta. Sarkari mein main gayi thi lekin wahan blood aur urine test karne ke baad Dr. ne bola ki aapko khoon ki bohot kami hai hum aapka abortion aur family planning ka operation nahi kar sakte isiliye humlog waha se private hospital mein gaye. Asal mein Civil hospital mein bohot se abortion hote hain to fir unlog bahana karte hai ki isko kaise katana hai to fir nahi karte hai unlog. (Resp 19)*

While none of the doctors expressed any dissatisfaction in terms of respectful treatment of the patients, they did agree that the workload was more than the hospital's resources in terms of infrastructure and manpower. With regard to the workload, lack of staff and the infrastructure, the doctors at Jalgaon agreed:

> *Hamara infrastructure ko lekar problem aata hai aur koi problem nahi hai. Yahan ka mahaul dekhne ke baad bahut se log admit ho kar fir chale jate hain. Load bhi bahot zyada hai. Ek maheene mein pachas (50) MTP hote hain. Staff ka bhi problem hai aur space ka bhi.*

Documentation: Women as well as doctors from both the regions found length documentation needed for MTP to be a barrier in seeking safe abortion and in providing abortion services

respectively. Many women experienced a further delay in MTP because of lengthy documentation, leading them mental agony and desperation. Some of these women resorted to sub-optimal providers or *haqeems* for abortion pills.

One respondent in Jalgaon mentioned that she had travelled to the Civil Hospital in Dhule (situated in another District) for abortion but was asked to come after few days. It included a lot of paperwork, which wasted a lot of their time (since most respondents were already in their 8th of 9th week of pregnancy). The following testimony brings to fore the issues of access, quality of care, and documentation.

> *Wahan sab hi log jate hain paise wale aur gareeb, wo kin kin ki taraf dhyan denge. Toh jinko hatana aasan ho jata hai unko hata dete hain ki 'jao' karke. Mujhe karana tha civil hospital mein par unhone dhyaan hi nahi dia. Agar bohot zyada din ho jate toh fir abortion nahi karwa sakte the. Aur ye bhi hai ki wahan par bohot kagaz jama karne ko bolte hainagar abortion karna hai aur usmein bhi din chale jate hai, itne din Civil hospital mein nahi reh sakte.*

According to a doctor practicing at a private clicnic interviewed in Jalgaon:

> *Doctors have a lot of writing work now. This form, that form. Documentation. PCPNDT ka jo book hai, uske guidelines, niyam, rules, regulations sab hain usmein. To woh abhi headache ho gaya hai. Abhi bohot kam clinics abortion karte hain. Utna documentation hai toh staff rakhnma padta hai. Aur rural logon mein paying capacity nahi rehti.*

Conditional abortion and stress on sterilization: Interviews at both locations revealed that at many government hospitals abortion services were **denied** if the woman has more than 2 or 3 live issues and was not agreeable to permanent or temporary contraception.

As told by a respondent from Mumbai:

> *Main boli mere 6 bache hain 3 ladka, 3 ladki wo usi mein bhadak gaye. Bole ki tum operation karwaoge tabhi ham lenge aur agar tum operation nahi karaoge to hum nahi lenge. Toh main boli ki madam aap karo ke mat karo 6 se 7 hoga toh chalega lekin mujhe operation nahi karna hai. Main unke samne paper faadi aur chali aayi.* (Respondent 10)

Similarly, in Jalgaon one woman underwent severe case of bleeding after consuming abortion pills at home. The pills were prescribed to her by a *haqeem* (*sub-optimal abortion provider)*. Before going to the *haqeem* she had visited a Government hospital but was told that she could only get an abortion if she would also agree to an operation for permanent sterilization. Because she had no one to take care of her children, she could not stay over night at the hospital and therefore, had refused.

Given the circumstances and with less time in hand now, she finally went to a *haqeem* leading her to post abortion complications. Her testimony:

> *Unhone mana kar diye the, operation karna hi padega bole tumko. Bole 'curetting yahan pe band ho gaya hai par agar tum operation (sterilization) karte ho toh doctor abortion karenge.'*

She was further told that MTP services have been stopped now.

> *Bole curetting band ho gaya hai, curetting hone wala nahi. Fir aage abhi bhi gayi thi main samajh lo 4-5 din se main daud rahi hoon, lagatar par wo operation ke chakkar mein fas gayi main.* (Respondent 20)

The testimonies above can be corroborated with the responses of some doctors at both the regions, where doctors agreed that in cases where the woman already has a particular number of children they strongly insist that they go for sterilization (tubal ligation) along with the MTP.

The following testimony of a doctor from a government maternity centre in Mumbai brings to the fore the problem and attitude to the core issue and lack of understanding that women have to face.

> ***In ANC we tell them that you have two children. You <u>have</u> to go for TL (tubal ligation). When patients come to me, they already have three children they say 'hamko bas ye bacha abort karna hai'. So we tell them to go for TL. If they do not agree, then at such moments I refuse.***
>
> ***Because today if I do an abortion they will come again. I had a patient who has had 5 abortions and still would not go for TL. She says "reh gaya"; I say why the hell don't you go for TL! Repeated curettage can lead to problems. Why do you want to abort in the first place? There are people who want to conceive but are not having children.***

Similarly in Jalgaon, where the only civil hospital (government) has stopped providing abortion services to women after 12 weeks of pregnancy, there is a very strong emphasis on the woman to go for sterilization operation along with the MTP for each MTP that takes place at the facility.

> *Hamare yahan frequent abortion ke cases kam aate hain kyunki ham ek toh unko copper-T compulsory karte hain ki apko copper-T bithana hi bithana hai ya fir sterilization karana hai. We always advise them for permament sterilization. This is our counselling. We tell them, "Two children you have to keep. Don't think of the third child. Why are you having a third child?" We tell them, "If two children are there, you have to go for sterilization."*

Second Trimester Abortions: *At the time of field visit it was found that for the past year and a half there was no gynecologist posted at the government health centre. Most of the women with problems related to their reproductive health and abortion had to travel 30 kilometres to the civil hospital in the adjacent district.* In Jalgaon, none of the women interviewed was able to obtain an abortion – either medical or surgical at a public hospital. The women had however, tried to obtain abortion at the civil hospital in adjacent district but were either told directly or had heard that abortion after 12 weeks ie. second-trimester abortions were no longer provided. The reason given was that second-trimester abortion now required more paper work and had detailed procedure because of which they had decided to deny all second-trimester MTPs. It must be noted here that this is the only civil hospital for the entire population of two districts.

Usually hamne second-trimester abortions band kar diye hain yahan par. 12-20 weeks ke andar jo bhi hain cases wo usually ham nahin kar rahe hain yahan par. Kyunki we have to report those cases to the civil surgeon. Procedure bahot hota hai, uske andar. Toh iske liye ham second trimester abhi avoid kar rahein hain.

When asked if they refer these MTP cases to some other hospital, the doctors replied that they sometimes tell women that abortion is no longer provided anywhere. *Abhi ham boltein hain ki nahi hota hai.* When asked for the reason for the same the doctors said that after 12 weeks it is also possible that the women mayhave undertaken a sex-determination test and therefore they deny abortion to all women who come after 12 weeks of pregnancy. *Kyunki uske baad ho sakta hai ki sex-determination test karaya ho. Sensitive ho jata hai. They do sex-determination test somewhere else and come for termination here. Jab se PCPNDT Act thoda sa strict kia hai toh ye sab cheesein band ho gayi hain abhi.*

Perspective on health implications: Most respondents mentioned the weakening of the uterus as an aftermath of frequent and excessive abortions. The same was not based on their own experience but on advice or beliefs of relatives or neighbours. From their own experience some women said that the procedure did not harm them in any way, but did feel that frequent and excessive abortions could have a harmful impact on the uterus. The doctors were of the view that while the newer methods of abortion like vacuum aspiration were not detrimental to a woman's health, however, dilation and curettage (D&C) was a method, which could lead to complications.

> Respondent 1: *Main toh janti nahi hoon par suni bohot hoon ki baar baar abortion karaenge toh theli par asar parega, kamzor ho jati hai.*

Respondent 2: *Ek ya do baar theek hai par us se zyada ho toh thaili kamzor ho jati hai Agar koi aurat ghadi-ghadi bacha girayei to bachhe ki theli khrab ho jayegi, kamzor ho jaegi aurat.*

Respondent 4: m*Baar baar abortion karana mere hisab se toh acha nahi hai.*

Responden 7: *Kharab abhi toh kuch bhi nahi hua magar nuksaan toh pahunchta hogana.*

Respondent 9: *Ab jaise bacha zyada din ka ho gaya toh use giraenge toh kharabi aaegi, takleef toh hoega aur kam din ka hai toh giraenge toh utna takleef nahi hoga.*

Respondent 10: *Mere kehna ye hai ki aisi faltui davaiyaan khani hi nahi chahiye. Kyunki wo hamari sehat ke liye bohot hi nuksaan dayak hai. Abhi apko bata rahi hu na 2-3 auraton ka dekhi hoon. Kisi bhi chaloo doctor se manga liye davai 700 rupay mein aur kuch aata jata nahi hai aise doctors ko. Ye jo khuli davai pudiya mein bandh kar dete hain na jo. Aise davai se kya hota hai baar baar khoon jate rehta hai. Maine boli ek hi kaam kiarne ka jake doctor se milne ka aur ekdum safai karane ka. Kyunki koi bhi takleef sharir mein rakhke fayda nahi hai. Ek hi baar pura saaf ho jaye. Varna baar baar apni sehat toot-ti hai is se.*

In Jalgaon, most women had an idea that frequent and excessive abortion is in some way adverse for their health, but the same did not necessarily translate into more importance being given to family planning.

R1: *Bohot auratein bolti hain ki nahi karana chahiye. Baar-baar abortion karane se cancer ho sakta hai wo toh hamein pata hai.*

R7: *Padta hi hoga na farak. Sehat kharab hoti hai na us se.*

R9: Itna laaprwah koi nahi hota hai ki har maheene abortion karwaye. Gaon mein bhi auratein bohot hoshiyaar ho gayi hain.

Perception on abortion:

Moral: While trying to capture women's perception on frequent and excessive abortion, it was revealed that **on a moral plank most women perceived abortion as a moral 'wrong'**. Counter-balancing it, was a sense of 'justification' towards their own induced abortion. **A weighing therefore takes place between abortion as a sin (based on religious reasons mostly) on one hand and pressing practical considerations such as (previous child is too small, restricting family size or financial constraints).** Most women also justify abortion only once or twice not more than that.

Respondent 10: *Baar baar abortion karana bohot galat hai. Sehat ke liye bhi aur koi bhi mazhab ho kisi ka mazhab ye nahi bolta kisi ki jaan lo. Aisa kar ke ham upar wale se bhi door ho jate hain.*

In all the interviews the mention of sin, *paap* or *gunaah* was recurrent theme which would be quickly followed up by practical considerations which could justify abortion. **None of the women said that it was a matter of their right or *haq* or *adhikar.*** They justify it if the doctors recommended it or there are other pressing reasons. Only one pressed on the need for family planning to avoid the sin of abortion.

R 4 Adhikar nahi hai gunah hai abortion karana.

R7 Bacha girana nahi chahiye. Bacha girana bohot bada paap hai hota hai. Agar nahi chahiye toh operation karwana chahiye taki badan bhi surakshit rahe.

R 10 Mera maanna hai ki yeh buri lat hai, ye nahi karna chahiye. Insan majburan ye kadam uthata hai lekin main janti hoon aisi koi majburi nahi hai kyunki hamein apna pehle se hi intezam karke rakhna chahiye taki ye karne ki naubat hi na aaye. Apne sharir par toh haq hai aurat ka lekin hamein pehle se sochkar rakhna chahiye. Abhi jaise mujhe nahi chahiye tha toh mera haq hai.

One respondent who was 36, however, did not feel a sense of regret as given her age and her six grown up children, she felt it was a good decision that she obtained an abortion.

Lack of knowledge and awareness: Even though all the women who were interviewed had obtained induced abortion in the last five years, but their knowledge about abortion (generally) was found to be critically low or absent on safe and unsafe abortion.

In terms of legal knowledge most women in both regions had **wrong or misleading information about abortion laws in the country**. Some women believed that abortion was illegal now (banned).

Respondent 4: *Sarkar mana karti hai tabhi toh hospital band kara diye the.*

Respondent 8: *Sablog bolte hain ki bachha girana band ho gaya hai.*

The strictness on over-the-counter sale of abortion pills has added to the belief that the Government has now banned abortion.

There is also confusion among some women about contraceptive pills and abortion pills. The following respondent for instance, had taken contraceptive pills after the pregnancy to abort it. When asked whether she had ever taken a pill for medical abortion:

Respondent: *Log dawa khate hain abortion ke liye. Maine bhi khaya hai jhooth nahi bol rahi hu. Mala-D jo goli aati hai*.

Except for one, none of the women interviewed had any knowledge about sex-ratio in India. There is also a lack of awareness (from those who have not heard and those who have wrong information) about medical abortion among users as well as non-users of abortion pills.

Many women believed that abortions from 12-16 weeks were illegal and unheard of. Also that abortion is banned after 3.5 months because after this period 'life' (*jaan)* comes into the foetus and also because it is risky. Respondents corroborate their perception with what they have heard in the neighbourhood or from other women**. It shows a strong reliance on advice and experiences of peers and community in forming of beliefs.**

About the length of pregnancy till which a woman may seek abortion most women had different ideas ranging from 2 months to 3.5 months. **None of the women interviewed knew that abortion could be obtained till 20 weeks.**

One of the respondents from Govandi, Mumbai said that she does not know much law about abortion but cites the Sharia law. According to her under Sharia law, which she follows, a woman can obtain an abortion within 40 days of her last period. However even on the 41st day it becomes a sin. About Indian law she said that 3 months (12 weeks) is the limit and this is what she was told at two well-known secondary-level hospitals in Mumbai.

According to another respondent from Jalgaon, a woman can obtain an abortion till two months and that It is illegal after 2 months She knows this because a doctor /nurse yelled at her when she said e was 3 months pregnant. But when she told them about the bleeding the doctor said, “Ok, since there is bleeding we will do it.”

In Jalgaon, half the respondents said that they did not know the length of pregnancy till which they could obtain an abortion. The others were misinformed about the legality of abortion with many considering it illegal now. There was also very little awareness on sex-ratio, abortion pills, safe unsafe abortion and government certified centers for abortion.

The interviews with doctors revealed the same. Most doctors responded that women coming from under-privileged background (as well as their family members) had near to no information about abortion laws or till what week they could legally obtain MTP.

Regret associated with their induced abortion: There were varied views about regret. Some respondents expressed a sense of regret at having to obtain an abortion, saying,

> *Mann mein toh kharaab lagta hai ki ye nahi hona chahiye tha, fir duniya ko dekh kar, apni majburi ko dekhkar ye lagta hai ki chalo jo kiya wo theek hi kiya.*

Some believed that as long as their husband gave them permission they had no regret.

> *Ab mera aadmi ijaazat diye toh main kara li, nahi dete toh na karati.*

However most stand by their decision and believed that they had strong grounds for terminating the pregnancy.

> *Nahi nahi mujhe aise lagta hai ki achha hua maine bachha giraya kyunki bade-bade bache hain mere.*

Those with abortion complications felt that it would have been better had they continued with the pregnancy because now she did not know where to go.

> *Abhi toh mujhe lag raha hai ki maine galat kia. Nahi girati toh main itni takleef mein toh na aati. Abhi mujhe lag raha hai ki mera pait bahar ko aa raha ha. Ab ismein kya maloom kya hai. Kahin ye 'kachre-kuchre' ki wajah se toh nahi hai. Abhi mere bache bhi chhote hain.*

Most women from both regions were aware of the illegality of sex-determination tests and sex-selective abortions with the television being their source of information. Most respondents mentioned that they considered girls and boys as equal and did not discriminate. However, the elders in the family especially in-laws have a male-preference because of reasons such as dowry and that having a son means that the family name would be taken forward. For these reason the women have to act in accordance to their in-laws' wishes.

> Respondent 4: *Bohot se log aisa karaate hain. Koi batayega thori na. Private mein karaate hain. Chhote chhote jo doctor log rehte hain woh bata dete hain ki larka hai ya larki. Main bhi sonography karayi thi, wahan aur aurat bhi pooche. Unhone mana kar dia ki nahi bata sakte ki larka hai ya larki.*

> Respondent 2: *Wo jo purane log hote hain wo bolte hain ki hamko ladka hi chahiye. Mera aisa maan na hai ki ladka ladki ek samaan hai lekin mere saas sasur aisa maante hain ki apne ghar ko, khandaan ko vansh chahiye. Iske hisab se mujhe chalna padta hai.*

Some women in Jalgaon were of the view that it would be convenient if sex-determination were made legal so that people can decide. When asked what the respondent feels about sex-selection test:

> *Acha hai na. karana achahai. Maloom pad jata hai ki ladka hai ya ladki aur jisko ladki nahi chahiye, bohot log ladki nahi chahte, ladka chahte hain isliye girwa dete hain*. (It is good to get the sex-selection test done. Sex-selection test helps a family decide whether it is a girl or a boy and those who do not want a girl terminate the pregnancy.)

However, when asked about her own wish the respondent said that she considers both equal as both come out of the same womb and that girls give comfort to parents more than boys do.

In many cases across the sample set it was noticed that the decision to get sex-determination test done or a sex-selective abortion is a decision taken in keeping in mind whether they have other grandsons (sons of the husband's brother) in the family. The engrained idea that a male child will take forward the family-lineage and thus a male-child is preferred was observed to be a norm.

In the same way, some respondents were never asked to go for a sex-determination test and did not have to face pressure to have a male child. According to them, they were not asked to under go sex-determination test because the brother of the husband already has two sons.

> Respondent 11, Jalgaon: *Jin ko ek ladka ek ladki hai unko koi zarurat nahi hai. Lekin jinko nahi hai wo karte hain.*

In one case, woman had undergone sex-selective abortion thrice. If the husband's brother also does not have a male child, male preference increases multi-fold.

> Respondent 12: *Mujhe do (2) ladkiyan thi aur mujhe ladka chahiye tha aur 5 baar pata kare, 5 baar larkiyaan hi thi aur girwa di. Check karaya tha. Mere jo pati hain usko aur do bhai hain, un dono ki biwiyaan jo hain unko bhi ladka nahi ho raha tha. Choti wali ko do baar ladka hua par dono baar guzar gaya.*

Family Planning

Though most respondents had heard of condoms and contraceptive but there were considerable number of never-users of condom or contraceptive pills in the group. In most cases the decision to use or not use a condom was the husband's. A small number of women from both regions had opted for Copper-T; however, many misconceptions remain about IUD insertion. There is also a prevalent fear of using copper-T on the basis of hearsay.

> Respondent: *Jab main copper-t bithwayi thi toh mere sath mein ek aur aurat thi. Usko bhi coppert- bithwaya tha. Jab uska aur uske aadmi ka sambandh hua na toh uska taar jo hai wo nikal ke uske kaleje pe chadh gaya tha. Wo khatam ho gayi thi.*

Case Story of a woman whose husband rarely used condoms and relies on 'withdrawl' method for birth control. She already had seven children.

Karte hain condom use par kam karte hain. When asked what if she again got pregnant, she said, *Nahi theherega na, girne ke time bahar nikal lete hai.* (I won't get pregnant, when the husband is about to ejaculate he pulls out.) Husband does not however, allow her to obtain a copper-t or sterilization operation as it is against the religion. *Mere aadmi ka jo baap haim wo aalim hai, matlab padhe likhe hain, wo mana karte hain*. Is also afraid of ostracization by the religious heads as they would not allow her to offer prayers if she has had any operation or abortion done.

CONCLUSION

Foreword:

As far as conclusion goes the findings concur with earlier research done on the subject that most abortion-related decision are either taken by the husband/partner or in accordance with the wishes of the husband. In this regard it could be pertinent to explore ways in which literature and interventions on abortion could be more inclusive and directed at men. While an effort should be made towards creating awareness about women's empowerment and responsibility towards their own health but interventions with husband/partner as recipient could be crucial towards ensuring better decision-making.

There exists a severe **lack of knowledge** and prevalence of misinformation about legality of abortion, safe and unsafe abortion, period till which abortion can be obtained in the country, dosage of abortion pills and sex-ratio. However, most women were aware of sex-selection being illegal. While almost all women maintained that they did not take a sex-determination test but it was observed that most women who obtained an MTP already had the desired number of male children before they decided to go for MTP.

The most common cited cause for an unwanted or unplanned pregnancy is **failure to use contraceptive**. Also, many women obtain abortion when they already have a few months old child to take care of and find their health would not support another pregnancy. Another reason is to limit family size. It has been seen that notwithstanding the awareness in the community about family planning there still remains a considerable population that does not use any method of contraception.

While there is a ban on off-the-counter sale of **abortion pills** in Maharashtra, evidence suggests that the pills continue to be used without prescription or follow-up even after the 7-week period. The ban on over-the-counter sale of these pills and increased documentation has lead to an atmosphere of secrecy, which has further stigmatized abortion and spread a misconception in a community that abortion is illegal or banned. This has also lead to shortage of MTP kits in the market and opened a black market for the same where the pills are being sold at unregulated prices, increasing the cost of abortion for women.

The research has thrown up questions about frequent and excessive use of the abortion pills – in the Indian context where Anemia is a major cause of concern among vulnerable women and there is less emphasis on follow-up visits, the impact of repeated and frequent use of pills is yet uncertain.

As far as usage go, women preferred first taking the abortion pills (off-label) from quacks or chemists. Many women find abortion pills an easier way of obtaining abortion and admitted to having taken them without prescription or after a visit to non-certified doctor in the vicinity.

It can also be concluded from the findings that **the usage of abortion pills is only going to increase in the coming years**. The facts that they are easy to use, comparatively less intrusive and help maintain confidentiality run in the favour of abortion pills over surgical abortion. However, since the pills can only be taken legally in the first 7 weeks of the pregnancy and may require follow-up visits, it becomes necessary to create awareness about the pills without stigmatizing their usage.

As far as public facilities are concerned, women prefer not going to **public hospitals** because of lengthy documentation, distance and attitude of doctors and nurses, which they find disrespectful. Sensitization training about de-stigmatizing induced abortions in this respect could be a step forward in this direction.

Most women interviewed felt that abortion is a 'bad thing' or a ‘sin’ and should be discouraged, unless there is a dire need to obtain it. There is a definite **taboo** associated with abortion. Some women because of their religion also considered it sinful. In this it is important to devise ways by which abortion related information and awareness could be disseminated, while staying clear of people’s religious beliefs.

At both the regions, it was found that at some public hospitals the **husband’s consent** is an informal requirement for MTP. Abortion providers asked for the consent of the husband or immediate family member, failing at which the abortion could be refused. While the doctors are aware that there is no mandatory requirement for such consent and that only the consent of the woman is necessary for MTP, the practice continues.

In addition to the above it can be concluded that the following two issues must be delved into in a deeper manner and should be brought to the notice of policy makers.

1. Conditional abortion and stress on sterilization: Interviews at both locations revealed that at many government hospitals abortion services were denied if the woman already had more than 2 or 3 live issues and was not agreeable to permanent or temporary contraception. This could be a severe barrier to safe abortion and could lead to unsafe abortions. Many cases revealed that women denied MTP at public hospitals had resorted to sub-optimal providers and obtained unsafe and often illegal abortion through various means.

2. Fear of PCPNDT Act: In Jalgaon, the PCPNDT Act has been implemented with utmost strictness and sometimes arbitrariness in the recent year and a half. **On one hand while it has curbed the practice of sex-selective abortion in the region, but has also closed doors to safe abortion for women who seek safe abortion from public or private abortion providers.** Such rigorous implementation in Maharashtra has lead to more and more sex-determination tests and sex-selective abortions being undertaken in the nearby cities of Surat and Vadodara in the state of Gujarat. Blanket implementation has also led to most private clinics refusing second trimester abortions. While one doctor was recently arrested, at many other clinics sonography machines had been seized requiring the doctors to also stop providing MTPs. **Documentation for second trimester abortion**

has been made so rigorous that doctors at public hospitals have either stopped conducting MTPs or made it conditional upon sterilization operation. In addition to this, with the ban on over-the-counter sale of abortion pills, the situation has become even more desperate for women. The result of the same could be that more and more women resort to unsafe means of abortion.

The above-mentioned conclusions provide us with the background necessary for introducing further research or intervention in the area. In this context it is important to mention that an effort must be made by researchers of unsafe abortion to focus on unsafe abortion's health-related harms and

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