National Baseline Research

Claiming the Right to Safe Abortion: Strategic Partnerships in Asia

INDIA

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHAs	Accredited Social Health Activists
C- Section	Caesarean Section delivery
CAP	Comprehensive Abortion Policy
CASSA	Campaign Against Sex Selective Abortion
CBHI	Central Bureau of Health Intelligence
CBOs	Community-Based Organisations
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEO	Chief Executive Officer
CGHR	Centre for Global Health Research
CHC	Community Health Centre
CSOs	Civil Society Organisations
CSO	Central Statistical Organisation
D&C	Dilatation and Curettage
DH	District Hospital
DLHS	District-Level Household and Facility Survey
ECP	Emergency Contraceptive Pill
EVA	Electric Vacuum Aspiration
FGD	Focus Group Discussion
FOGSI	Federation of Obstetricians and Gynaecologists Societies of India
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
ICDS	Integrated Child Development Scheme
IDI	In-depth Interview
IIPS	International Institute for Population Sciences
INR	Indian Rupees
IUCD	Intrauterine Contraceptive Device
JSSK	Janani-Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KII	Key Informant Interview
LCVK	Lok Chetna Vikas Kendra

MMA	Medical Methods of Abortion
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NACO	National Aids Control Organisation
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHP	National Health Policy
NPP	National Population Policy
NSSO	National Sample Survey Organisation
OCP	Oral Contraceptive Pills
OOPE	Out-Of-Pocket Expenditure
ORS	Oral Rehydration Solution
PCPNDT	Pre-conception and Prenatal Diagnostic Technique
PHC	Primary Health Centre
PIPs	Project Implementation Plans
PLHA	People Living with HIV/AIDS
PNC	Post-natal Care
POCSO	Protection of Children from Sexual Offences Act
PPIUCD	Post-Partum Intrauterine Contraceptive Device
PWDVA	Protection of Women from Domestic Violence Act
RGI	Registrar General of India
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RUWSEC	Rural Women's Social Education Centre
SAAF	Safe Abortion Action Fund
SHG	Self-Help Group
SNCU	Sick Newborn Care Unit
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SRS	Sample Registration System
TBA	Trained Birth Attendants
TN	Tamil Nadu
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNHRC	United Nations Human Rights Council
USG	Ultrasonography

GLOSSARY

Sexual and reproductive health and rights

Sexual and reproductive health and rights refer to eliminating preventable maternal and neonatal mortality and morbidity, ensuring quality sexual and reproductive health services including contraceptive services, and addressing sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and sexual and the reproductive health needs of adolescents (WHO 2014a).

Abortion

The term abortion is commonly used as a synonym for induced abortion, which is the deliberate interruption of pregnancy, as opposed to a miscarriage, which connotes a spontaneous or natural loss of a foetus (Medical Dictionary 2019)

Unsafe abortion

An unsafe abortion occurs when a pregnancy is terminated either by people lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. The people, skills, and medical standards considered safe in the case of induced abortions are different for medical abortions (performed with drugs alone) and surgical abortions (performed with a manual or electric aspirator). The skills and medical standards for safe abortion also vary depending upon the duration of the pregnancy and evolving scientific advances (WHO 2018).

Medical abortion

Medical abortion is a multistep process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol) (WHO 2014b).

Surgical abortion

A surgical abortion involves the use of trans-cervical procedures for terminating pregnancy, including vacuum aspiration, and dilatation and evacuation (D&E) (WHO 2014b).

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EXECUTIVE SUMMARY

This report presents the results of a baseline study undertaken as part of the project "Claiming the Right to Safe Abortion: Strategic Partnership in Asia", carried out by CommonHealth, an Indian coalition for reproductive health and safe abortion. The project, initiated in 2018, is supported by RFSU (Riksförbundet för Sexuell Upplysning or in English: The Swedish Association for Sexuality Education), a Swedish organisation, and implemented by the Asian-Pacific Resource and Research Centre for Women (ARROW). The project aims to facilitate and strengthen capacities to improve engagement and ensure rights related to access to safe abortion services, including post-abortion care in five countries in the South Asian and South-East Asian regions: Bangladesh, India, Nepal, Cambodia and the Philippines. The baseline study is the first phase of the project and is aimed at generating evidence that will help plan for advocacy in the years 2019-22.

The baseline study in India was the result of the many gaps we at CommonHealth perceived in our understanding of the barriers to safe abortion services. One, we did not have adequate data on the actual availability or non-availability of safe abortion services in the public and private domains. Two, while there is a perception that attitudes to abortion were becoming negative, we did not know whether this was a fact and, if so, what the reasons were. Three, studies and reports indicated a growing reluctance among health providers to provide safe abortions, but could not shed light on whether providers would support these services under specific conditions. Four, we needed to understand better the views of local community leaders, women and men, on abortion. Fifth and most important, we did had no indication of whether civil society organisations – even those working on health and gender – would support abortion as a women's right. Without a fair understanding of these issues, meaningful advocacy for safe abortion as a women's right would be difficult.

The baseline study therefore had three broad objectives:

- To provide an overall picture of the extent of support for safe abortion by government and civil society organisations;
- To generate evidence on the availability of affordable and safe abortion services in the public and private health sectors, and its consequences for women; and
- To understand the perspectives of different actors on abortion as a women's rights issue.

The study was conducted in the districts of Nawada and Kancheepuram in the states of Bihar and Tamil Nadu, respectively, in India. It was designed as a rapid assessment to inform advocacy, given the limitations of time (about five months) and other resources. The study used a mixed-method approach based on secondary and primary data. Secondary information sources included published and unpublished studies, media reports, a range of official documents and data sources, and reports from national and district surveys. Primary data was collected from in-depth interviews with

key informants among community leaders, healthcare providers and leaders of CSOs; focus group discussions with a spectrum of women from vulnerable groups; facility surveys in selected government and private facilities; and meetings with community leaders in each of the sample districts.

The states of Bihar and Tamil Nadu are very different in terms of their socio-demographic and health profiles. Bihar is among the poorest states, with poor health indicators, weak public health infrastructure and few personnel trained to provide safe abortion services. In contrast, Tamil Nadu is among the states with relatively high per capita income levels, good health indicators, and a good network of public health facilities with a high utilisation rate, including primary health centres (PHCs) for pregnancy and delivery-related services. Despite these differences, the states share many common features in terms of support for and availability of abortion services.

Both states had some government initiatives aimed at improving access to safe abortion services, but in neither was it a priority health issue. Neither was it a priority for CSOs, including those working on maternal health and adolescent sexual and reproductive health. From CSO leaders in Bihar we learnt that none of the CSOs working on maternal health made attempts to promote safe abortions. Four of five CSO leaders did not think abortion was a priority issue. In Tamil Nadu, only two of the five CSOs involved with women's issues worked on health, and neither of these dealt with safe abortions. Several CSOs in Bihar focussed on preventing gender-biased sex-selection; Tamil Nadu had a strong presence of groups advocating the restriction of second-trimester abortions to prevent gender-biased sex-selection and protect the rights of the unborn child. Thus, the milieu did not appear to strongly support safe abortion as a women's right.

In both states, fewer than 5 per cent of the estimated abortions were recorded in the official Health Management Information System. Further, there was only one abortion facility for 370,000 people in Nawada, Bihar, while Kancheepuram, Tamil Nadu had one abortion facility per 70,000, far lower than the recommended norm of one facility per 20,000.

In both Nawada and Kancheepuram, more than 60 per cent of the facilities providing abortion services were private. In the former, these were mainly facilities run by unqualified providers, while in the latter they were nursing homes run by qualified medical professionals. The only public facility providing abortion services in Nawada was the district hospital, while in Kancheepuram all the district, taluk and non-taluk hospitals provided abortion services, but not the PHCs and CHCs. In both districts, qualified abortion service providers, public and private, were concentrated in the urban centres, leaving vast rural pockets with hardly any abortion facilities.

Even in public facilities that provided abortion services, the availability of second-trimester abortions was highly restricted, both for married and unmarried women. Unmarried women reported being refused abortions in government hospitals or subjected to abusive and disrespectful care. Other women reportedly had to make several visits in order to undergo an abortion in a government health facility. These delays would often result in women exceeding the legal gestational limit for a MTP, in which case they would be denied the service. In both states, married and unmarried women typically needed to be accompanied by their husbands or 'guardians,' who had to provide consent for the procedure, which created another major barrier for unmarried women. From our provider interviews in both states we deduced that abortion services in public facilities were conditional on the acceptance of contraception post-abortion.

The cost of private abortion services by a qualified medical professional was very high. For example, in Nawada, Bihar, the lowest reported charges was almost equal to the per capita average daily income for about 77 days. The comparable figures for Kancheepuram, Tamil Nadu, were a little over 30 days' per capita income. This does not include non-medical costs and the opportunity costs of obtaining an abortion. Private services were unaffordable for women from low-income groups and the marginalised sections in both states, although much more so in Bihar.

Several women who could not afford the services in either the public or private facilities, resorted to self-medication with drugs from pharmacists. Some women, usually from the most vulnerable sections, resorted to unsafe abortions with serious negative health consequences. Unmarried women denied abortion services were ostracised by their community for single-motherhood and, in extreme cases according to stories from respondents, even took their own lives.

The availability of medical methods of abortion (MMA) – especially the mifepristone-misoprostol combi-pills in pharmacies – may offer women some respite in an extremely difficult situation. Healthcare providers in the study reported self-medication by women to induce an abortion, but we found that most women respondents had only heard about MMA and did not know how to use these safely and effectively. The incorrect or inappropriate use of MMAs could result in incomplete abortions, necessitating hospitalisation, and even if the complications are not severe, considerable out-of-pocket health expenditure which for most was unaffordable.

Overall the results show that even after five decades of legalising abortion, access to safe abortion remains a major challenge for women, not only in a low-resource settings such as Nawada, Bihar, but also in the relatively privileged setting of Kancheepuram in Tamil Nadu.

The baseline study also found that there was a low level of awareness on the legal status of abortion in the sample districts of both states. A significant proportion of women in the community believed that abortion was illegal, and there was confusion between the illegality of all abortions or only those that take place after sex-determination.

In terms of attitudes, abortion appears to be strongly stigmatised. While opinion was divided on the circumstances in which abortion was justified, the general perception was that women seeking abortions were likely to be humiliated, gossiped about, considered immoral, and unlikely to receive any support from peers and family members. Respondents reported that people viewed an unintended pregnancy as completely within the power of the woman to avoid, and an abortion to terminate an unintended pregnancy as not justifiable.

Provider attitudes towards abortions were most disconcerting. They were generally against providing abortion services to married women with an unplanned or mistimed pregnancy, believing there was no justification if the father was the woman's husband. On the other hand, all providers supported an abortion in the case of foetal anomalies. Attitudes towards abortions for unmarried girls were mixed, with some willing to provide these services and others not, but the overall attitude was one of disdain for the girls, for not having used contraception. They seemed unaware of or insensitive to the gendered circumstances that lead to unintended pregnancies.

Based on our findings we identified priority issues for advocacy to promote access to safe abortion services as a women's right. One of the key priorities would be to advocate for the availability of abortion services in all designated public facilities. Enhancing the levels of knowledge and awareness about the legality, public health importance, availability and various abortion methods was a second key priority. A third priority would be addressing the stigma associated with abortion through the creation of champions for women's right to safe abortion among key constituencies, local, state and national. A special area of focus would be to sensitise the public on the gendered reasons why women seek abortions and to promote support for safe abortion services among health professionals and students training to be health professionals.

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1 INTRODUCTION

1.1 Overview of the national project and research objectives

As early as 1971, India passed the Medical Termination of Pregnancy Act, making safe abortion services available to women for a wide range of indications, including grave danger to their physical and mental health, rape, severe foetal abnormalities, and contraceptive failure in married women. And yet, unsafe abortions still accounted for 8 per cent of all maternal deaths in 2006 (RGI and CGHR 2006). According to the most recent (2015) national estimates, about three out of four abortions in India were medication abortions performed outside a health facility (Singh et al. 2018). What are the circumstances surrounding this extraordinary situation of abortions being 'legal yet out of reach' for Indian women after almost five decades of the MTP Act being passed? And, what can advocates for sexual and reproductive health and rights do to change this situation? These are the concerns that motivated this study, which was undertaken by CommonHealth (Coalition for Maternal-Neonatal Health and Safe Abortion) India.

1.2 Brief introduction to CommonHealth

CommonHealth, constituted in 2006, is a multi-state coalition of organisations and individuals working to advocate for better access to sexual and reproductive health and healthcare, with a specific focus on maternal health and safe abortion. We incorporate views from diverse constituencies to influence discourse at the national level through advocacy in states where CommonHealth members have mobilised local communities and partners.[1] We also work to mobilise a new generation of advocates from various sectors, and on building synergies across progressive movements to strengthen advocacy within and across states.

Since its inception, CommonHealth has been concerned about the limited access to safe abortion services for women, especially those from the rural poor and other marginalised communities. The situation on the ground became complicated by the campaign against sex-selection, which appeared to have created anti-sex-selection champions inadvertently using anti-abortion language, and to have created fear and reluctance amongst service providers to provide second-trimester abortions, or any abortions at all. Several gender-sensitive activists working at the grassroots felt that advocating for access to safe abortion services could result in an increase in sex-selective abortions. Given this situation, CommonHealth was among the first to propose an agenda (in 2009) for 'creating common ground' between activists working to prevent sex-selective abortions and those trying to promote access to safe abortion, so as to expand the constituency calling for safe abortion services in India.

CommonHealth partnered with CREA in a project supported by the Safe Abortion Action Fund (SAAF) to build capacity in a core group of women's rights advocates and abortion service providers. This

1 As of August 2017, we have 35 institutional members and 250 individual members from around 20 Indian states.

group of change-makers, 'the champions' – with support through various actions – were empowered to sustain the right of women to access safe abortion. CommonHealth's involvement in the present project marks another step forward in its agenda for promoting access to safe abortion in India, through focused enquiry in two states followed by advocacy interventions.

1.3 The baseline study in India: Objectives and research questions

The focus of this baseline research was to conduct a mapping exercise to ascertain the availability of abortion services, present barriers to service provision and the perspectives of key actors and women on the right to safe abortion.

This document presents the results of the baseline study undertaken in the districts of Nawada and Kancheepuram in the states of Bihar and Tamil Nadu, respectively, in India. The document has eight sections. The first presents the background, objectives and research questions of the baseline research and the methodology of the study. Sections two and three document the country's socio-economic and political profile and the sexual and reproductive health and rights situation in the country, respectively. Sections four and five focus on the critical issues related to safe abortion services in India and the gaps in our understanding. Sections six and seven, constituting the core of the document, present results from the field studies in Bihar and Tamil Nadu, respectively. The final chapter summarises the key findings of the study and discusses potential directions for advocacy in these states.

1.3.1 Rationale

In order to develop an appropriate theory of change for guiding advocacy, we need to understand the perspectives of potential users: these are key opinion makers in the communities; health administrators and healthcare providers ranging from specialists to frontline workers such as accredited social health activists (ASHAs), community leaders and civil society.

The baseline will give an indication of the gaps in policy, actual implementation of safe abortion services in the states, and barriers that impact implementation. It will also document the perceptions and attitudes of different actors in a context of growing anti-abortion sentiment and confusion among providers on the legality of abortion within the country, because of the interpretation of other legislation related to the prevention of prenatal sex-determination and sexual violence against children.

1.3.2 Research objectives

1. To document the availability of affordable, safe abortion services in public and private facilities, and the impact on women in Bihar and Tamil Nadu, through a detailed case study of representative districts; and

2. To understand the perspectives of CSOs and CBOs, local community leaders, women, and healthcare providers at different levels in representative districts of Bihar and Tamil Nadu, on abortion as a women's right.

1.4 Methodology

The study was conducted in one district each in two states of India. It was designed as a rapid assessment to inform advocacy, given the limitations of time (about five months) and resources.

1.4.1 Research questions

1. What is the context and who are the actors influencing public attitudes to safe abortion in these states?

2. a) Which facilities provide safe abortion services in the sample districts? How are they distributed geographically and across the government, private, formal and informal sectors? What methods of safe abortion are available in these facilities? How many women were served by these facilities in the six months preceding the survey?

b) What are the consequences to women of the limited availability of safe abortion services (incorporating the perspectives of various marginalised groups)?

3. What are the values and attitudes towards women's right to abortion of:

a) Leaders of CBOs and CSOs working on health and gender issues;

b) Healthcare providers across various levels (physicians, nurse-midwives, ASHA workers, rural medical practitioners); and

c) Community leaders (panchayat members, SHG leaders, teachers, youth leaders).

1.4.2 Study design

The study was based on a mixed-method approach combining secondary data and information sources and qualitative methods such as key informant interviews (KIIs), focus group discussions (FGDs) and community leader meetings. It applied tools such as validated scales on the attitudes of providers and perceptions of community leaders to obtain in-depth information in a short span of time.

Methods: Table 1 presents the methods used for each objective of the study and the sample for each method.

Table 1. Research Questions, Methods and Samples

Research Question	Methods	Sample from each site	
		Bihar	Tamil Nadu
1. What is the context; who are the actors influencing public attitudes to safe abortion?	**Secondary data** Government reports, data from National Family Health Surveys and Family Welfare Year Books, state-level project implementation plans (PIPs), data from health management information systems (HMIS), and published research studies, evaluation reports, media reports on in print and on websites.	Not applicable	Not applicable
	Primary Data Key informant interviews with CSO leaders from across the state	5 (2 women, 3 men)	5 (4 women, 1 man)
2. a) Which facilities provide safe abortion services in the sample districts? What is their distribution, geographically and across government, private, formal and informal sectors? What methods of safe abortion are available and to which sections of women in these facilities? How many women were served by these facilities in the last six months?	1. **District HMIS** data 2. **Facility visits** to government and private registered facilities	2 private facilities	1 private facility 3 government secondary hospitals
	3. **Key informant interviews**		
	• Accredited social health activists (ASHAs)	1	Nil[2]
	• Trained birth attendants (TBAs)	4	2
	• Self-help group (SHG) leaders	1	3
	• Anganwadi workers	1	2

2 b) What are the consequences for marginalised women of the limited availability of safe abortion services? (Perspectives of various marginalised groups)	**Focus group discussions (FGDs)** with specific marginalised groups (Dalit, HIV-positive, young [married and unmarried]), and other relevant marginalised groups	• 1 married rural Dalit woman 18-25 years • 1 married rural Dalit woman 35-50 years • 1 unmarried adolescent girl	• 1 married rural Dalit woman, under 40 years • 1 married rural Dalit woman, over 40 years • 1 unmarried rural Dalit woman • 1 married rural non-Dalit woman, over 40 years • 1 HIV-positive woman • 1 married tribal woman
3. What are the values and attitudes towards women's right to safe abortion of: a. Leaders of CSOs working on gender or health issues b. Healthcare providers at different levels (physicians, nurse-midwives, ASHAs, rural medical practitioners)	1. **Key informant interviews** • CSO leaders • Healthcare providers, who were given a self-administered questionnaire with a validated attitude scale[3]	• 5 (2 women and 3 men) • 1 woman doctor from a government secondary hospital • 2 women doctors from PHCs • 1 woman doctor from a private facility • 2 auxiliary nurse midwives (ANMs)	• 5 (4 women, 1 man) • 3 women doctors from government secondary hospitals • 1 woman doctor from a private facility • 2 auxiliary nurse midwives (ANMs)
c. Community leaders (panchayat members, SHG leaders, teachers, youth leaders)	· One community meeting with local leaders (CBO functionaries, panchayat leaders, youth leaders, teachers, etc.); use of a community perception questionnaire[4]	31 participants: 3 teachers; 6 panchayat members; 9 youth leaders; 13 SHG members. All but two were women.	35 participants: 9 CBO staff ; 6 teachers; 8 SHG leaders; 6 panchayat members; 4 youth leaders; 1 TBA and 1 nurse All but two were women.

[2] In Kancheepuram district, ASHAs are not the front-line health workers as in other states . As of 2017, only 2,650 ASHAs worked in the tribal areas, and 1,255 were deployed in the malaria programme (NHM website for the state).

[3] Chowdhury (2012) "Attitudes of obstetrics and gynaecology professionals towards provision of medical termination of pregnancy and emergency contraception pill services in south Kerala, India" (MPH Dissertation, Sree Chitra Tirunal Institute of Medical Sciences and Technology, Trivandrum).

[4] The questionnaire had 10 questions which drew on a 33-item scale to measure community perceptions of stigma (Sorhaindo, A.M., Karver, T.S., Karver, J.G., and Garcia, S.G: Constructing a validated scale to measure community-level abortion stigma in Mexico. Contraception. 2016 May;93(5):421-31).

1.4.3 Data collection techniques, sample size and sample selection

Secondary data

Secondary sources of data were used for the situational analysis (research question 1), and for a small part of the mapping exercise on the availability of abortion service (research question 2).

Primary data

Primary data were collected to answer research questions 2 and 3 and to complement the information obtained through secondary sources for research question 1.

CommonHealth member organisations from the district helped identify appropriate interviewees. Both organisations (Lok Chetna Vikas Kendra in Bihar and Rural Women's Social Education Centre in Tamil Nadu) had a track record of decades of working on health, including sexual and reproductive health, with the local communities.

Primary data collection relied mainly on qualitative methods: key informant interviews (KIIs), focus-group discussions, group interviews, an attitude-assessment scale to complement the KIIs with health providers, and a community-perceptions questionnaire to complement the group interview of community leaders.

Participants in the KIIs were chosen to represent a range in each category. For example, women leaders in the community included self-help group leaders, traditional birth attendants and anganwadi workers (AWWs); and healthcare providers included front-line workers such as ASHAs, ANMs working in the government health system, and doctors from public and private facilities. Further, CSOs included leading organisations working on gender or health from across the state, and the KIIs were with leaders who had agreed to voice their views. Some CSO leaders in Tamil Nadu did not want to be interviewed as they did not support the promotion of safe abortion services. Participants in the focussed group discussions included marginalised women of various ages and castes, and from specific groups such as HIV- positive women.

The interviews with doctors took place in their health facilities – private and government – which gave our researchers an opportunity to observe the infrastructure and human-resource availability for abortion provision and, where available, to obtain data on abortions performed in the previous six months. KII interviews took place in the villages where the interviewees lived or worked, in a place of their choice. We organised the FGDs in locations identified by LCVK and RUWSEC in Nawada and Kancheepuram districts, respectively, to suit the convenience of the participants.

1.4.4 Tools for data collection

As per the research questions presented in Table 1:

Question 1

An outline for the content of the situational analysis of the two states and appropriate sources of data.

Question 2

a) Data-extraction tool: to extract HMIS data on MTP facilities, number of MTPs, types of procedures and acceptance of post-abortion contraception;

b) KII guidelines: to conduct key-informant interviews; and

c) FGD guidelines: to conduct FGDs with women.

Question 3

We applied two different attitude scales, one for the health providers and one for the CBOs and community leaders. Group interviews and discussions with community leaders were also used as sources of data on perspectives on women's right to safe abortion services.

1.4.5 Ethical considerations

We submitted the study protocol along with the tools and consent forms to the Institutional Ethics Committee (IEC) of the Rural Women's Social Education Centre, and revised it based on feedback from the IEC members.

We obtained informed consent from all the participants in the research for taking notes and for the audio recording. Some healthcare providers did not concede to an audio recording, but permitted note taking. The privacy and confidentiality of all the data obtained is being maintained.

1.4.6 Study setting

The study was conducted in the states of Bihar and Tamil Nadu in India. One district from each state was chosen, namely Kancheepuram in Tamil Nadu, and Nawada in Bihar. The states were chosen to represent two contrasting scenarios within India, in terms of socioeconomic and demographic indicators as well as the strength of the government health system. Tamil Nadu is among the more economically developed states, with below-replacement level fertility, and a well-resourced and effectively governed government health system, while Bihar is a contrast to Tamil Nadu on all these indicators. (See Table 2 for an overview of these; detailed descriptions

are presented as part of the situational analysis of the states in the results section).

The two districts were chosen based on CommonHealth members' existing networks. The two member organisations were Lok Chetna Vikas Kendra (LCVK) in Nawada, Bihar, and the Rural Women's Social Education Centre (RUWSEC), Kancheepuram, Tamil Nadu. Neither of the districts is an outlier within the State, and their socioeconomic and demographic indicators are a little above or below the state average.

Table 2. Socioeconomic and Demographic Indicators

Indicators 2011	Bihar State	Nawada District	Tamil Nadu State	Kancheepuram District
Total population	104,099,452	2,219,146	72,147,030	3,998,252
Male	54,278,157	1,144,668	36,137,975	2,012,958
Female	49,821,295	1,074,478	36,009,055	1,985,294
Total literacy (%)	61.8	59.8	80.1	84.5
Male	71.2	57.6	86.8	89.9
Female	51.5	40.2	73.4	79
Scheduled caste (%)	8.2	25.5	20	23.7
Scheduled tribes (%)	1.3	0.1	1.1	1

Source: Registrar General of India. 2011. Census of India 2011: General Population Tables. Ministry of Home Affairs, Government of India.

1.4.7 Limitations

This study covered only two states of a country as diverse as India and only one district from each state. This limits its general application to the country as a whole. Although the case study covered only one district of each state, the situation analysis using secondary sources and KIIs with CSO leaders attempted to develop a state-level scenario.

We applied to the state government authorities in Bihar and Tamil Nadu for permission to visit and study the government health facilities. In Bihar, we did not succeed in obtaining permission – there were promises but no official permission came through till the end of the data collection period. We had to limit ourselves to interviewing healthcare providers who were willing to be interviewed and give us information about their facilities. In Tamil Nadu, we obtained permission to visit the district and taluk hospitals but not for the PHCs and CHCs. Our findings are therefore limited to facilities that we were able to visit, complemented by information provided by key informants. We were also not successful in obtaining state-level data on medical terminations of pregnancies (MTPs) and relied on HMIS data in the public domain.

The representation of men in the community leaders' meetings was very low in both states,

and the responses predominantly reflect women leaders' perspectives. In Tamil Nadu, some of the leaders of CSOs that we approached for key informant interviews did not consent to participate as they did not want to be associated with a study that sought to advocate for right to safe abortions. We therefore have a one-sided representation of CSO leaders who believed in access to safe abortion services as women's right.

Although there is a stigma surrounding abortions, most respondents were willing to discuss the issue openly. The one exception was in focus group discussions with young married Dalit women in Bihar, who were too shy to talk about the issue and did not provide much information.

The results of this study are from a rapid assessment and need to be understood as indicative rather than definitive.

1.4.8 Data management

Two teams were responsible for data collection, transcription, entry and analysis, one for each state. Each team comprised research assistants and a co-ordinator. All the team members had research experience and were guided by a mentor. In each state, local CBO members of CommonHealth provided guidance and support for conducting FGDs with local women, KIIs with various stakeholders and meetings with community leaders.

The research tools applied in both states were the same, and the training for all the research assistants followed the same pattern. The information collected and transcribed by the research assistants was crosschecked by the coordinators by listening to a sub-sample of the audio recordings of the interviews. We prepared data-entry boards, dummy tables for the quantitative data from the HMIS and facility visits, and procedures for coding and collating qualitative information. A meeting was held between the two coordinators and the mentor to go through the transcripts and the key themes emerging from these, to discuss the major findings and identify areas in which further analysis was needed. The two coordinators documented the results of the baseline studies conducted in their respective states. The mentor completed the first few sections and supplemented the results where necessary. She also wrote the first draft of the conclusions and recommendations, which was added to by the coordinators and Steering Group members of CommonHealth. All the original data and extraction forms have been carefully stored, and the soft copies backed-up on an external hard disk.

1.4.9 Key areas of analysis

Each state study had three major outputs. One was a situational analysis of the state, of its socio-economic and political milieu, abortion policies, and programmes and interventions by the government, the for-profit and not-for-profit sectors. We also documented past efforts at abortion advocacy and the related players to help us assess the scope for advocacy for safe abortion in the state.

The second output was evidence on the availability of safe-abortion services and the impact of this on women. The focus areas in the analysis were the extent of non-availability, women's

experiences of refusal of services and the physical and mental health consequences of these. This gave us the data/information we needed to develop messages for abortion advocacy. We adopted a rights-framework to analyse the data, and to highlight the extent to which women's sexual and reproductive health rights are being upheld or violated. The rights framework here implies guaranteed access to safe abortion and to human rights-based entitlements enshrined in the Constitution and in international treaties and agreements signed by the country.

The third output was an analysis of the perspectives on abortion by key influencers of the discourse and potential advocacy allies.

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2 COUNTRY PROFILE: SOCIO-ECONOMIC AND POLITICAL CONTEXT

2.1 Socio-economic and demographic profile

India is a parliamentary democracy with a federal structure comprising 29 states and seven Union Territories. The states have considerable power and are responsible for organising and providing healthcare (public health, hospitals and sanitation) for their residents. The central and state governments are jointly responsible for medical education and national programmes.

India is a country with more than a billion people, with a population growth rate of 1.1 per cent during 2015-20. Life expectancy at birth was 70.4 for females and 67.3 for males in 2017 (Table 3). Literacy rates among young people were above 80 per cent, with a marked gender disparity in the mean years of schooling. The per capita gross national income was 6,353 PPP$, with the estimated male income almost four times that of female (UNDP 2018).

In addition to the stark gender inequalities, economic inequalities in the present decade are reported to be the highest ever in India's history. The share of national income accruing to the top 1 per cent of India's population was 22 per cent in 2017 compared to only 8 per cent in the early 1980s (Oxfam International 2018).

Table 3. Basic Socio-economic and Demographic Details, India

Population (in persons): estimates for 2017	Total: 1,339.2 million % female: 48.5
Rate of growth of population (2015-2020)	1.1%
Literacy rate among young people (15-24 yrs.) (2017)	Female: 81.8% Male: 90.0%
Mean years of schooling (2017)	Female: 4.8 yrs Male: 8.2 yrs
Life expectancy at birth	Female: 70.4 yrs Male: 67.3 yrs
GNI per capita (2011 PPP$) (2017)	Total: 6,353 Male: 9,729 (estimate) Female: 2,722(estimate)

Source: United Nations Development Programme (2018). *Human Development Report 2018: Statistical Update).* New York, UNDP.

2.2 The healthcare system and its impact on marginalised communities

India's health system has a significant presence of both the public and private sectors. Despite a wide network of government primary, secondary and tertiary care facilities across all Indian states, the public health system is poorly resourced, with the government health expenditure for 2014-15 being only 1.1 per cent of the gross domestic product (GDP). The private health sector is unregulated and diverse, characterised by the presence of state-of-the-art corporate hospitals on the one hand to untrained informal practitioners of modern medicine on the other, and a large number of clinics, nursing homes and hospitals between the two extremes. The country also has multiple systems of medicine coexisting, ranging from the Ayurveda, Unani, Siddha and Homeopathy (AYUSH) groups of codified systems to faith- healing. Households' Out-of-pocket expenditure (OOPE) on health is the main source of health financing, and accounted for 67 per cent of total health spending in 2014-15 (Government. of India, 2017a). Government-sponsored health insurance schemes for the poor have not resulted in a decline in OOPE in health (Philip 2018, Ramprakash 2018).

The National Health Policy of 2017 envisages 'attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive healthcare orientation, and universal access to good quality healthcare services, without anyone having to face financial hardship as a consequence' (Government of India 2017b). The policy rests on two key policy principles: universality by including the entire population (including special groups); and reducing inequity through affirmative action by minimising disparities related to gender, poverty, caste, disability, and other forms of social exclusion and geographical barriers. It aims to progressively achieve universal health coverage by providing free, comprehensive primary healthcare services for all types of reproductive, maternal, child and adolescent health issues and for the most common communicable, non-communicable and occupational diseases (ibid. 3).

2.3 Political context and spaces for CSOs

Since 2014, there has been a growing atmosphere of intolerance of criticism and dissent in the country. Many think tanks partially or fully funded by the government are being under-funded, progressive civil society does not appear to have space to voice its' concerns, and human rights activists are often subject to intimidation for defending the rights of others. The government has in several instances blocked foreign funding for human-rights organisations and progressive academic and civil society organisations, to silence those advocating civil, political, social and economic concerns against the views held by the government (CIVICUS, 2017). The newly enacted labour law, wage code and social security law blatantly trample on workers' rights. The democratic space for dissent is shrinking sharply.

These changes over the years has propelled the members of CommonHealth to move out of their silos, beyond maternal-neonatal health and safe abortion, and join campaigns and movements of groups such as Dalit women, positive women's groups, sex workers' movements and the Right to Food Campaign, to work together on common concerns.

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3 PROFILING INDIA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

3.1 Sexual and reproductive health in India

The overall approach to sexual and reproductive health (SRH) in the country has been narrow. Since 2005, SRH has come to stand for institutional deliveries, antenatal coverage, immunisation, and family planning. The focus has been largely to reduce maternal mortality through the promotion of institutional deliveries and to reduce the total fertility rates. Over the years, dependence on private provision has increased due to the lack of availability of government services for safe abortion, reproductive morbidities and adolescent healthcare as envisaged in the national reproductive health programmes (RUWSEC 2015).

While overall maternal mortality rates have declined, there are wide regional and inter-regional disparities and inequities in the overall provision of and access to basic health services. These are because of the poorly resourced government health system, which fails to address the problems faced by people from low-income and socially marginalised groups in accessing quality care. According to the NFHS-4 report, only 32.4 per cent of women from the lowest wealth quintile were provided assistance by a doctor during delivery, as against 80.7 per cent among the highest wealth quintile (IIPS and ICF, 2017: Table 8.19).

In general, the health outcomes among marginalised communities and poorer quintiles of the population continue to be poor. While the right to access several SRH services by marginalised people is constrained by lack of public provision, women's rights are violated by coercive practices such as post-partum intra-uterine contraceptive device (IUCD) insertion without consent, and medical termination of a pregnancy provided only on acceptance of sterilisation.

Some of the important sexual and reproductive health and rights (SRHR) indicators are presented in Table 4, which provides a snapshot of the unmet reproductive health needs. More than a fourth of Indian women are married before 18 years of age and 8 per cent of adolescents are already mothers or pregnant. Female sterilisation continues to be the dominant method of contraception, one in five women is under-weight and one in three has at some time experienced spousal violence.

Table 4. Key Sexual and Reproductive Health Indicators, India (2015-16)

Indicators	Urban	Rural	Total
Women (20-24 yrs) married before 18 yrs (%)	17.5	31.5	26.8
Total fertility rate (children per woman)	1.8	2.4	2.2
Women (15-19 yrs) who were mothers or pregnant at the time of the survey (%)	5.0	9.2	7.9
Maternal mortality ratio (MMR) 2014-16#			130
Under-five mortality rate (per 1,000 live births)	34	56	50
Current use of contraceptive by any modern family planning methods among married women (15-49 years) (%), 2015-16	51.2	46.0	47.8
Female sterilisation	35.7	36.1	36.0
Male sterilisation	0.3	0.3	0.3
Female modern reversible methods	5.9	5.4	5.6
Male condoms	9.1	3.9	5.6
Unmet need for family planning (%)	12.1	13.2	12.9
Unmet need for spacing (%)	5.1	5.9	5.7
Mothers who delivered in institutions (%)	88.7	75.1	78.9
Mothers who received full antenatal care[5] (%)	31.1	16.7	21.0
Women whose body mass index (BMI) is below normal (<= 18.5 kg/m2) (%)	15.5	26.7	22.9
Ever married women who have experienced spousal violence (%)	25.3	34.1	31.1

Source: International Institute for Population Sciences (IIPS) and ICF. (2017). National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS. # Registrar General of India. 2017. Sample Registration System's Maternal mortality ratio bulletin 2014-16. Ministry of Home Affairs, Government of India.

The new RMNCH+A Programme aims to provide a wide range of reproductive health services including adolescent-friendly healthcare services, such as safe delivery, safe abortion, contraception and so on (Government of India, NRHM 2013).

3.2 Laws and policies on SRHR

This section discusses the main laws and policies pertaining to this project (links to laws and Acts provided in references and a detailed table on India's policies and programmes on sexual and reproductive health are available in Appendix 1).

5 Full antenatal care includes at least four antenatal care visits, at least one shot of tetanus toxoid and at least 100 days of consumption of iron and folic acid tablets or syrup.

3.2.1 Medical Termination of Pregnancy (MTP) Act, 1971

Abortion has been legal in India since 1971, permitting termination up to 20 weeks of gestation. The six major grounds legally permissible for an abortion are: to save a woman's life, preserve a woman's physical health, preserve a woman's mental health, and in cases of rape or incest, a foetal impairment, or contraceptive failure in a married woman.

The amendment to the Act in 2002 simplified the approval procedures and promoted an increase in the number of approved medical facilities. The Act allows a medical abortion till 49 days of gestation. In 2008, the Drug Controller General of India approved the mifepristone-misoprostol combi-pack for use till 63 days of gestation. The Comprehensive Abortion Care Guidelines mention as a footnote that medical abortions are safe up to 63 days of gestation (Ministry of Health and Family Welfare 2010), but the MTP Act has still not been altered to reflect this.

3.2.2 Pre-conception and Prenatal Diagnostic Techniques (PCPNDT Act, 2002)

This Act makes the act of sex-determination illegal. The amended 2002 Act makes it illegal to apply pre-conception techniques for sex-selection using assisted reproductive technologies.

3.2.3 Protection of Children from Sexual Offences Act, 2012 (POCSO)

This addresses sexual abuse and sexual exploitation of children. It makes it mandatory for physicians to report sexual activity in minors and pregnancies as evidence of sexual activity in minors.

3.2.4 Other policies and programmes addressing SRH

Some of the relevant policies and programmes addressing SRH include the National Population Policy (2000), the National Health Mission, Reproductive, Maternal, New-born, Child and Adolescent Health, RMNCH+A (2013), National Youth Policy (2014), Rashtriya Kishor Swasthya Karyakram[6] (RKSK, 2014) and the National Health Policy (2017). The Janani-Shishu Swasthya Karyakram (JSSK) provides cashless maternal and newborn health services in government health facilities for households below the poverty line and/or belonging to some marginalised sections.

The Protection of Women from Domestic Violence Act (PWDVA) 2006 represented a major achievement for the women's movement in India which had been campaigning against domestic violence since the 1970s. However, even a decade after the Act came into force there is little awareness among women and community leaders about it and even about what constitutes domestic violence (CARE India 2016). Only two states – Maharashtra and Kerala

6 The programme is aimed at enabling all adolescents to realise their full potential by making informed and responsible decisions related to their health and wellbeing and by accessing the services and support they need for this.

– have one-stop crisis centres in some government hospitals to address and support women experiencing domestic violence.

The newly enacted HIV/AIDS Act of 2017 recognises a broad range of rights for persons living with and affected by HIV, and provides statutory legitimacy to government efforts to prevent and control the transmission of HIV (Government of India 2017c).

Homosexuality was a criminal offence under Section 377 of the Indian Penal Code, but in September 2018, the Supreme Court decriminalised homosexuality by striking out a part of Section 377.

Transgender persons have been formally and legally acknowledged as persons of equal rights through a Supreme Court ruling in 2014. However, the trans community has widely opposed the Transgender Persons (Protection of Rights) Bill, 2018, passed by the Lok Sabha, because it proposes to set up a five-member district screening committee comprising a medical officer and psychiatrist to certify whether or not a person qualifies as transgender. This directly violates the Supreme Court's orders in the NALSA judgement, 2014, which underlined the right to self-determination of gender as male, female or transgender. Also, the Bill does not provide for employment opportunities through reservations, disregarding the directions of the apex court in the NALSA judgement, which asked the state 'to treat them (trans people) as socially and educationally backward classes of citizens, and extend all kinds of reservation in cases of admission in educational institutions and for public appointments.' Further, while refusing to help create job opportunities where they can earn a living, the TGPB criminalises and threatens to target trans persons begging for sustenance under the anti-beggary laws (Pawar 2018).

3.3 Critical country-level issues and trends that may affect SRHR

Three critical national issues need to be highlighted: widening economic and health inequities; growing religious and cultural fundamentalism; and major demographic transitions.

As mentioned in Section 2, Indians are living through a period of unprecedented economic inequality. Alongside the widening wealth gap, there are significant and persisting inequities in health by socio-economic position, gender, and among socially constructed vulnerable groups such as Dalits and Adivasis, those with physical and mental disabilities, people living with HIV and AIDS, internal migrants, and the elderly (Ravindran and Gaitonde 2018).

India ranks 108 out of 144 countries on the Global Gender Gap Index 2017. While gaps in labour force participation and education have narrowed over the past decades, there is still a long way to go: only 27 per cent of Indian women are in the paid labour force and, apart from a miniscule minority holding leadership positions in elite institutions and government, most work in poorly paid and onerous jobs. Further, there are significant male-female gaps in health. India is among the few countries with higher female mortality than male mortality in infancy and childhood. While life expectancy for women exceeds that for men, life expectancy among Dalit women is lower than for Dalit men by 6 years, and lower than that for women from other castes by as much as 14.6 years (Ravindran and Gaitonde 2018).The government health system, weakened by decades of under-investment, has failed to fulfil its expected role of protecting the poor and marginalised from inequities induced by the market

mechanism. Sexual and reproductive health services, apart from maternal healthcare, are accessed predominantly from private institutions, resulting in considerable OOPE for patients.

An example of a marginalised group whose SRH needs have failed to receive due attention is women living with HIV and AIDs. In India, there were 214,000 persons living with HIV/AIDS in 2017, of which a little over two-fifths were women. Anecdotal reports by representatives of HIV-positive women's organisations suggest that scant attention has been paid to the overall sexual and reproductive health needs of women living with HIV and AIDS, beyond anti-retroviral therapy.

A crucial issue affecting women is the growth of religious and cultural fundamentalism, as this has had a direct impact on women's liberty and autonomy. Strict control over women's mobility, dress codes and interactions with members of the opposite sex have been accompanied by 'kangaroo-courts,' ruling against inter-caste or inter-faith marriages, witch-hunting and honour killings (Jamia Millia Islamia 2015, Supreme Court of India 2018). The country's modest advances towards gender equality made in previous decades are under threat.

Regressive misogynistic positions are often expressed by persons in key positions – an example is the view voiced by the Minister for Women and Child Welfare that a law against marital rape was not in line with the social and cultural norms of India (The Hindu, 2016). A recent study by the Rural Women's Social Education Centre (RUWSEC) on religious fundamentalism in India and sexual and reproductive health and rights, which included a review of parliamentary debates and Parliamentary Committee Reports, related to issues of sexuality states:

The opinions of key political persons who hold positions of power and who influence the law and policy making processes in the country on issues such as sexual violence and rape, homosexuality, expression of consensual sexuality, women who occupy public spaces at night, etc., clearly indicate the fusion and influence of the State ideologies and acts of institutions and individuals working for state mechanisms with religious fundamentalist and conservative ideologies (RUWSEC 2016).

Another important trend is the change in the country's population structure. Fertility has been steadily falling, and was 2.3 in 2016 (IIPS and ICF, 2017), with wide rural-urban and state-level variations. The proportion of elderly in the population is rising. Because population control is no longer a concern in many Indian states, which have achieved below-replacement fertility, healthcare providers no longer feel obliged to provide safe abortion services in the larger interest of curtailing India's run-away population growth.[7]

These three factors make for an unhealthy combination that could adversely affect the availability, access and attitudes to abortion in India. The growing religious and cultural fundamentalism contributes to negative attitudes towards sexual rights, which are likely to affect support for access to abortion services. Providers no longer feel that by providing abortion services they are contributing to curtailing the population explosion in the country and hence to development. Given the depth of health inequities overall and in the access to health services, women from marginalised groups would be most affected by barriers to accessing safe abortion services.

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7 Many studies have reported the negative attitudes towards the medical termination of pregnancies among healthcare providers and medical students. The reason listed in this study is based on discussions the first author (TKSR) had with several obstetrician/gynaecologists.

4

ABORTION: COUNTRY SITUATION, CRITICAL ISSUES AND ATTEMPTS TO ENSURE THE RIGHT TO SAFE ABORTION

A 2015 study documented that 15.6 million abortions were performed in India. The majority of the abortions (81%) in this study were carried out through a medical abortion, performed either at a health facility or another location, 14 per cent were performed surgically in a health facility, and the remaining 5 per cent were performed outside a health facility using other, typically unsafe and/or ineffective methods (Singh et al., 2018). The Sample Registration System data has estimated deaths from unsafe abortions at around 8 per cent of all maternal deaths (RGI and CGHR 2006). However, a hospital-based study over a 15-year period reported the proportion of abortion deaths to be as high as 17 per cent (Jain et al., 2004). Abortion-related complications appear to be disproportionately suffered by women from lower castes (UNHRC 2017).

There is limited availability of safe abortion services in public facilities, although all of them at the PHC level and above are approved MTP centres by law. Despite the fact that at least first-trimester abortions have to be provided at the PHC level, they are not provided even in some of the well-functioning health systems such as in Tamil Nadu. There are inefficiencies in private institutions too, given the overall lack of professionals trained to provide abortions, and the cumbersome approval and certification procedures . Several detailed and critical reviews of abortion studies have been conducted in India between 2000 and 2014 (John 2017, Stillman et al. 2014). According to one study, the intense public focus on sex-selective abortions had led to the widespread misperceptions that all abortions are illegal; 95 per cent of the women in another study conducted in Jharkhand in 2012 were unaware that abortion is legal in India (Nidadavolu and Bracken 2006; Banerjee et al., 2012). A study in Rajasthan found that the misconceived notion that the husband's consent is required for an abortion has created a situation where women were less likely to terminate a pregnancy (Elul 2011).

The close interplay between three factors has shaped the abortion scenario in India. The first is the predominance of permanent methods of contraception. A little over 50 per cent of women of the reproductive age 15-49 years used modern contraceptive methods in 2015, of which 80 per cent underwent sterilisations (IIPS and ICF, 2017). Sterilisation is the most- desired method of contraception for many women, who have no experience of most spacing methods. Faced with an unintended pregnancy, when their previous child is very young, women often seek an abortion. The latest study on abortion conducted in 2015 reports these rates as 47 per 1,000 women, and unintended pregnancies at the rate of 70 per 1,000 women aged 15-49 in India (Singh et al., 2018).

The second factor is the early age at marriage. A little over 36 per cent of women are married before they are 20 years (IIPS and ICF, 2017). More than 50 years of family planning propaganda has firmly established the small-family norm among a vast majority of women, but modern spacing methods of contraception are neither widely available nor desired even when available. This leads to

a large number of unintended or mistimed pregnancies and the need for abortions. The absence of comprehensive sexuality education and lack of access to contraception makes abortion the only way to prevent an unintended pregnancy for many adolescents and young women.

While the above two factors increase the need for induced abortions, the availability of safe abortion services is under threat because of the decline in the child sex ratio (0-6 years) (RGI 2011), and the attribution of this to sex-selective abortions. Programmes such as the Save the Daughter Campaign have adversely affected the provision of safe abortion services in most states. Sting operations targeting providers of ultra-sound scanning and abortion services, and their consequent prosecution has created an atmosphere of fear among providers, who have become reluctant to perform any abortions, especially during the second trimester. All these factors impact women's SRHRs in various ways, and compound the difficulties faced by almost all women, but especially those from the poor and/or marginalised communities, or who are single, adolescent, or HIV-positive.

Based on anecdotal evidence and specific events, the current situation on safe abortion availability in the country is disquieting (there is limited data on the availability or unavailability of these services across geographical and social groups). Over the past five years or so, there appears to be a growing intolerance among healthcare providers of induced abortions. Many anecdotal reports talk of women being denied abortions and instructed to continue with their pregnancies. There is a growing number of court cases seeking abortions for survivors of rape, including minor girls, and medical opinion has often not supported an abortion over the continuance of pregnancy, resulting in children giving birth to children, with traumatic consequences for their lives and wellbeing (The Guardian 2017; Daily Hunt 2017). Cases have also been being filed by pregnant women beyond 20 weeks of gestation in case of foetal abnormalities detected in later gestational stages. While some of them were progressive judgments favouring abortion in the light of a woman's health (Manglik 2016), others used the language of the rights of the foetus (Choudhary 2017), a deviation from the actual MTP Act, which premises the termination of a pregnancy on women's health.

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ABORTION: GAPS IN UNDERSTANDING AND ADDRESSING THE ISSUES

There are many gaps in our understanding of the barriers to safe abortion services. One, we do not have adequate data on the actual availability or non-availability of these services in the public and private domains. Two, while there is a perception of growing anti-abortion sentiment in the country, we do not know enough about which groups subscribe to these sentiments and why they oppose the provision of abortion services. Three, studies and reports have noted health providers' general opposition to providing safe abortions, but not whether they would support abortions under specific conditions. Four, we need to understand better how local community leaders, women and men, perceive abortions. Fifth, and most important, we do not know whether CSOs – even those working on health and gender – support abortion as a women's right. Without a fair understanding of these barriers, meaningful advocacy on safe abortion as a woman's right would be difficult.

Advocacy to promote access to safe and high-quality abortion services has to be based on state-specific strategies. These strategies further need to take into consideration past policies and interventions on safe abortions (or prevention of sex-selective abortions) in the state; the availability of and access to health services in public and private facilities especially the availability of safe abortion services; the marginalised groups in the state; and the cultural sensitivity and norms surrounding abortion practices. It is also important to map key actors and their positions on promoting safe abortion services. For such research findings, it would be necessary to involve the various stakeholders and set up networks at the community level and among health administration and medical professionals.

The next two sections present the findings of the study; section 6 presents the findings from Bihar, while section 7 presents findings from Tamil Nadu. The sections are further divided into three major sub-sections. The first sub-section presents the broad context of the state and a situational analysis of its abortion scenario, based mainly on secondary sources, including government reports and data, websites of non-governmental organisations and published studies. The second describes the availability of and access to safe abortion services and the impact on women of non-availability of these services. In sub-section three we have summarised the knowledge, values and attitudes related to abortion held by community leaders and civil society actors active in the state and working on gender and/or health issues.

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6 RESULTS: BIHAR

6.1 Abortion in Bihar: An overview

6.1.1 Background to the state

Socio-demographic indicators

Bihar, a state in eastern India is the third most-populous state in India, with a total population (2011) of 104 million, and a sex ratio of 919 females for 1,000 males. The population is predominantly rural (88%). Scheduled Castes constitute 15.9 per cent of the population, while Scheduled Tribes are 1.3 per cent. Almost 58 per cent of the population is below the age of 25 years. The proportion of women in the reproductive age group of 15 to 49 years is 46.3 per cent. About a third (36.2%) of the state's population is illiterate (2011), with a large rural-urban gap: the rural literacy rate is 53.9 per cent while the urban rate is 81.9 per cent (RGI 2011).

Bihar is one of the economically less-developed states in the country, with a per capita net state domestic product (2018) of around Rs. 78 per day, just over half the international poverty line threshold of US$1.90 (CSO 2018).

Gender inequality

Indicators comparing male and female literacy and work participation rates indicate high levels of gender inequality in Bihar. Almost half of the female population (48.5%) was illiterate in 2011, nearly twice the male proportion (28.2%) (Census 2011). The female work participation rate (2011) was 19 per cent compared to 46.5 per cent for males (RGI 2011). The prevalence of child marriage was reported to be 43 percent (UNICEF 2019).

Violence against women is widespread and takes many forms. Intimate-partner violence against women is an indicator of the status of women and their capacity to negotiate safe sex. In 2015-16, as many as 43.2 per cent of ever-married women reported ever experiencing spousal violence, almost twice the national figure of 21.2 per cent. Close to 5 per cent (4.8%) reported experiencing violence during pregnancy (IIPS and ICF, 2017).

Studies from the 1990s indicate the prevalence of extreme forms of gender discrimination such as female infanticide in the districts of Katihar, Sitamarhi, Gumla and Purnia (Saravanan 2002). The practice appears to have continued till recently, according to a CSO leader included in our study. The significantly higher female infant mortality compared to male (46 against 31 per 1,000 live births in 2016), suggests the continued presence of discrimination against the girl child[8].

8 These are based on Sample Registration System (SRS) data which consistently show high female mortality rates even in previous rounds. The National Family Health Survey - 4 shows a higher male IMR than female.

Table 5. Socio-demographic and Health Profile of Bihar

Population (2011) a			
Total	104.1 million		
Rural (%)	88.7		
Urban (%)	11.3		
Overall sex ratio (females per 1000 male)	918		
Scheduled Caste population (%)	15.9		
Scheduled Tribe population (%)	1.3		
Youth 10-24 years (%)	30.2		
Women in the reproductive age group (15-49 years) (%)	46.3		
Literacy rate (2011) a	**Total**	**Male**	**Female**
All (%)	61.8	71.2	51.5
Rural (%)	59.8	69.7	49.0
Urban (%)	76.9	82.6	70.5
Health Indicators	**Total**	**Male**	**Female**
Infant mortality rate (SRS 2016) b	38	31	46
Infant mortality rate (NFHS4, 2015-16) c	48	52.3	43.6
Under-five mortality rate (NFHS4, 2015-16) c	58	60.2	55.8
Maternal mortality ratio (RGI 2018) d	165 per 100,000 live births, 95% CI (124-206)		
Average population covered by (DLHS4, 2012-13) e			
Health sub-centres	9,954		
Primary health centres	1,43,222		
Community health centres	2,36,612		

Sources:

a) Registrar General of India. 2011. *Census of India 2011: General Population Tables.* Ministry of Home Affairs, Government of India.

b) Office of the Registrar General and Census Commissioner (India). I*ndia SRS Statistical Report 2016.* Available at: http://ghdx.healthdata.org/record/india-srs-statistical-report-2016

c) International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey* **(NFHS-4),** *2015-16:* India. Mumbai: IIPS.

d) Registrar General, India. 2018. *Sample Registration System's Maternal mortality ratio bulletin 2014-16.* New Delhi: Ministry of Home Affairs, Government of India.

e) International Institute for Population Sciences (IIPS). 2014. District Level Health and Facility Survey (DLHS-4), 2012-13: India. Bihar. Mumbai: IIPS.

Health indicators

The state lags behind other Indian states in its vital indicators. It has higher levels of infant and under-five mortality rates, at 48 and 58 per 1,000 live births compared to the national average of 41 and 50, respectively (IIPS and ICF, 2017). It did however register a sharp decline of 43 percentage point in its maternal mortality ratio from 208 in 2011-12 to 165 per 100,000 live births in 2014-16 (RGI 2017). The proportion of institutional deliveries was 63.8 per cent in 2015-16, most (47.7%) were in government health facilities. However, in 2015-16 only 14.4 per cent of all the pregnant women had four antenatal check-ups and 3.3 per cent had all the antenatal check-ups (IIPS and ICF. 2017).

Bihar's poor health indicators need to be viewed against the chronic under-investment in the government health system. It has four doctors (allopathic and AYUSH) per 10,000 population, among the lowest in the country (National Health Profile 2018.) The average number of people per government allopathic doctor was 28,391 (more than twice the national average of 11,082) and per government hospital bed was 8,645, more than eight times the national average of 1,844 (CBHI 2018).

There are substantial gaps in the availability of human resources, equipment, drugs, and consumables in the primary healthcare institutions. For example, there are no specialists at the CHCs, which are meant to be first referral units for obstetric care. According to a 2007 document by the Government of India laying out a road map for the development of Bihar's health sector, the percentage of PHCs with adequate equipment was only 6.2 per cent compared to the national figure of 41.3 per cent. These facilities faced an inadequate and erratic supply of essential drugs, supplies and equipment including oral rehydration solution (ORS) packets and weighing scales. There was a significant shortage of gynaecologists and obstetricians to provide maternal health services in peripheral areas of the state; and nearly 80-85 per cent of the posts of gynaecologists and paediatricians were reportedly lying vacant (Government of India 2007).

Figures for 2014-15 show that the average medical expenditure per delivery in the public sector in Bihar was as high as Rs. 2,197 and Rs. 2,584 in the rural and urban areas, respectively. Costs in the private sector were substantially higher, at Rs. 16,322 in rural and Rs. 13,795 in the urban areas (NSSO 2016).

Indicators of the need for abortions

In 2015-16, Bihar's TFR was 3.4, higher than the national average of 2.2. Rural-urban differences in fertility are marked, with the TFR being 3.6 in rural areas and 2.4 in urban areas. The state has a low level of contraceptive prevalence for any method (24.1%) and a high unmet need for contraception of 21.2 per cent. The unmet need for spacing was around 10 per cent (IIPS and ICF, 2017). These figures were worse for Nawada district, where the use of any contraceptive method was only 31.5 per cent (information on modern methods alone was not available), and the unmet need for contraception was 39.3 per cent (RGI 2011).

Table 6. Fertility and Contraception in Bihar (2015-16)

	Urban	Rural	Total
Total fertility rate	2.4	3.6	3.4
Contraceptive prevalence			
Any method (%)	34.6	22.6	24.1
Any modern method (%)	32.1	22.0	23.3
Female sterilisation (%)	26.8	19.8	20.7
Male sterilisation (%)	0.1	0.0	0.0
IUCD/PPIUCD (%)	1.3	0.4	0.5
Oral contraceptive pills (%)	1.1	0.7	0.8
Condoms (%)	2.3	0.8	1.0
Total unmet need for contraception (%)	19.1	21.5	21.2
Unmet need for spacing (%)	8.1	9.6	9.4

Source: International Institute for Population Sciences (IIPS) and ICF, 2017; National Family Health Survey (NFHS4), 2015-16: India. Mumbai: IIPS.

6.1.2 Government and NGO initiatives for safe abortion services

Government initiatives

Recognising the need to increase access to safe abortion services so as to reduce maternal mortality and morbidity, the state government of Bihar introduced an innovative system of accrediting private healthcare facilities for safe-abortion services. The programme, Yukti Yojana ('a scheme for solution'), was introduced in 2011. It accredits eligible private health facilities and supports them (reimburses cost of services) in providing free abortion-related services to rural and low-income urban women. A study in 2015 found that 53 per cent of the beneficiaries of the scheme reported holding a Below Poverty Line (BPL) card, while 71 per cent had a low standard of living (Banerjee et al. 2015).

The Project Implementation Plan (PIP) for Bihar, (the annual plan document at the district level on the basis of which funds are allocated) for 2018-19 does indicate a commitment to ensuring safe abortion in the state. Rs 385.9 lakh has been approved for operationalisation of safe abortion services, which includes the Yukti Yojana, treatment of first-trimester incomplete abortions, a transport subsidy for health workers accompanying women under the Yukti Yojana, and incentives for medical officers to provide comprehensive abortion care (Rs 500 per patient). However, only 0.1 per cent of the total approved health budget was set aside for abortions, while 5 per cent was earmarked for strengthening maternal health services (Government of India 2017-18).

NGO initiatives[9]

Bihar has a strong presence of NGOs, many international in scope, working on sexual and reproductive health issues. Major NGOs include CARE India, MAMTA, IPAS Development Foundation (IDF), Pathfinder International, Plan International, Population Foundation of India, and the YP Foundation. The Bill and Melinda Gates Foundation is a major donor to the state government and to many international NGOs head-quartered in the US. The state is home to several local branches of US-funded international NGOs, which are bound by the 'gag rule,' which prevents them from funding abortion services of any kind. CSO leaders spoke about being offered funding by US-based donors conditional on their organisations not being involved in any work related to abortions. One explicitly stated that they did not provide any information on services related to abortions, because their funds would be stopped if they did. It was alright to talk about contraception with young women and men, but not about abortions (KII4-CSO leader).

The NGO CHARM has been leading the health movement in the state, actively raising issues such as the right to health, low public health budgets, and regulation of the private health sector which has expanded significantly in the last decade. IPAS Development Foundation (IDF) has consistently worked on improving access to abortions through training of providers at the PHC level and equipping facilities to provide first-trimester abortion. Its efforts have focussed on increasing access to first-trimester abortions using MVA (manual vacuum aspiration) techniques by providing MVA kits at all government health facilities.

While NGOs other than IDF have not paid any attention to access to abortion, NGO action to prevent sex-selective abortions has gained momentum following a study by UNFPA on the poor implementation of the Pre-Conception and Prenatal Diagnostic Tests (Prevention of Misuse) Act (KII-1, CSO leader, male). Organisations such as CHARM, Shakti Vardhini and Population Foundation of India (PFI) were involved in guiding the government on better implementation of the PCPNDT Act and on creating awareness in communities.

Historically, Bihar has not been a state with alarmingly low sex ratios at birth, and therefore it had not witnessed a massive campaign against sex-determination tests. Between the 2001 and 2011 censuses, the decline in Bihar's child sex ratio was 7 points, from 942 to 935 (the child sex ratio of the country too declined by 9 points, from 927 over this decade). A 2014 study by UNFPA on the implementation of the PCPNDT Act, based on interviews at facilities and with government officials, indicated that the Act had been only partially implemented in the state. It found several lapses in implementation as well serious legal violations, particularly in unregistered ultrasound centres. Even in registered facilities, the study found poor compliance with the requirements under the Act. Under pressure from the Supreme Court and central government, in 2015 the state government monitored all the ultrasound clinics in the state and closed down several where there were irregularities (Civil Society Leader 2018).

9 The information in this section has been mainly gathered from KIIs with CSO leaders.

6.1.3 Data from other studies on abortion services

The incidence of abortion

An estimated 1.25 million abortions were performed in Bihar in 2015 (study by the Guttmacher Institute in partnership with International Institute for Population Sciences [IIPS] and Population Council, India), both safe and unsafe and in health facilities and other settings. The state's abortion rate was 49 terminations per 1,000 women of reproductive age (Stillman et al. 2018).

Government statistics seems to capture only a miniscule fraction of these. Data from 2014-15 on the number of medical terminations of pregnancies (MTPs) in Bihar, compiled by the Ministry of Health and Family Welfare, showed only 4,877 induced abortions in the 12- month period (Government of India 2015a). In 2012, a study using two indirect estimation techniques (the Mishra-Dilip and the Shah Committee's methods) placed the state's induced abortion incidence far higher, between 414,000 and 608,000 per year (Banerjee 2012). Another estimate of the induced abortions in Bihar recorded 384,999 abortions between April 2010 and February 2011. Clearly, there is a huge gap between what is happening on the ground and the official statistics, with the actual number of abortions many times higher than even the most recent highest official estimates.

Profile of abortion service users

According to the 2015 Guttmacher study, 84 per cent of women who had an abortion were from the rural areas, and 60 per cent belonged to the other backward castes (OBCs) – whose characteristics were similar to the population of women in the reproductive age group. About 43 per cent were 20-29 years old; a little over half (51%) had three or more children; and 33 per cent had two children. Women who had had an abortion tended to be more educated than the general population of women in the reproductive age group (Stillman et al. 2018). Two earlier studies suggest that abortion users may be predominantly women from the lowest- income groups (DLHS 2007-08, Banerjee et al. 2015).

Reasons for seeking an abortion

A study by Jejeebhoy et al. (2010) explores the reasons for abortions among married and unmarried women aged 15-24 years who were clients of 16 clinics run by an NGO in Bihar. Among the unmarried women, 92 per cent terminated their pregnancies because they were not married (and presumably because of the stigma of being an unwed mother); the pregnancy was a result of forced sex (11 per cent); and because they wanted to continue their education (13 per cent). Among the married women, the two most prominent reasons for an abortion were that the pregnancy had occurred too soon after their marriage or they were too young (51%), or they were economically weak (37%). About a fifth of the abortions (22%) were because the partner or family did not want the pregnancy; and 1.2 per cent of the women reported the reason to be forced sex.

Sources of abortion services

An estimated 2,834 facilities in Bihar provided abortion-related care (induced abortions, post-abortion care or both) in 2015; 22 per cent were government, and 78 per cent were private. The majority (70%) of the government facilities offered no abortion-related care (Stillman et al. 2018).

Government statistics from 2010 show that there were only 146 government and registered private facilities approved for providing abortions in the state, for a population of 23 million women of reproductive age. However, this number is an underestimate as it excludes facilities that do not report these services (Government of India 2011). A slightly higher number was identified in a community-based study conducted in all 38 districts of Bihar. It found that in 2010–11, there were 334 facilities providing abortion services, 79 per cent of which were privately owned (Aich et al. 2011a5). It suggested that more than 90 per cent of all induced abortions that took place between April 2010 and February 2011 were not reported or counted in any official statistics. Further, the number of abortions performed varied from as low as 20 in Jamui district to 2,380 in Gopalgunj district, and that 11 districts in the state accounted for only 6 per cent of all the abortions.

According to the Guttmacher study (2015), only 16 per cent of abortions in Bihar during that year (194,300) were performed in health facilities. Private facilities provided nearly all facility-based terminations (92%). The vast majority of abortions (79%, or 992,100) took place in non-facility settings using medical methods of abortion (MMA), and 5 per cent (64,500) were performed outside of health facilities using methods other than MMAs (Stillman et al. 2018).

Abortion methods and gestational period at the time of abortion

The vast majority (91%) of abortions conducted in a health facility in Bihar took place in the first trimester of pregnancy (up to 12 weeks' gestation), and slightly more than half (52%) occurred at less than eight weeks' gestation (Stillman et al. 2018). Most facility-based abortions were performed surgically using manual or electric vacuum aspiration (43%), a D&E or a D&C (31%).

As mentioned above, MMAs were not performed in registered health facilities for the vast majority of abortions in Bihar. An earlier study (by Ganatra in 2005) found that the use of MMAs were not widespread in Bihar, but in the last ten years the picture appears to have changed dramatically. Five per cent of all induced abortions used procedures other than MMAs, outside a health facility. These may include unsafe methods or safe methods provided by unqualified providers, or surgical abortions performed by trained professionals outside the facilities covered by the Health Facility Survey (Stillman et al. 2018). Earlier studies from Bihar suggest that Ayurvedic and Homeopathic preparations, oral contraceptive pills, emergency contraceptive pills and other hormonal preparations procured from chemists are used by women to terminate an unintended pregnancy (Kumar et al. 2013, Jejeebhoy et al. 2010, Ganatra et al. 2005).

Cost of abortion services

In a 2009-10 survey of 270 providers in Bihar and Maharashtra found that the costs associated with an early surgical abortion (up to eight weeks' gestation) was Rs 1,500 ($34), and for abortions performed after eight weeks' gestation, it was Rs 2,000 rupees ($45). However, obstetrician-gynaecologists often adjusted the cost of services according to a client's economic situation and the method.

6.2 Availability of and access to safe abortion services: A case study of Nawada district

We chose Nawada district in Bihar for a detailed case study on the availability, access and awareness and attitudes to safe abortion services. (A socio-demographic profile of the district is presented in Table 2). The study collected data for the district from the HMIS and other official sources, as well as from primary sources: key informant interviews with healthcare providers and CSO leaders, a community leaders' meeting, and FGDs with local women.

6.2.1 Government statistics on abortion facilities and MTPs performed

Table 7 provides data on the number of government health facilities in Nawada. All the public facilities above PHC level are authorised to provide MTP services, according to the MTP Act. Actual provision depends on the availability of providers trained in MTP and of equipment and infrastructure available for manual vacuum aspiration (MVA) and surgical abortion services.

Table 7. Authorised Government Health Facilities in Nawada District (2017-18)

Type of facility	Number
District hospital, Nawada	1
Sub-divisional hospitals	0
Community health centres, CHCs	2
Primary health centres, PHCs	16
Total	19

Source: International Institute for Population Sciences (IIPS). 2017. National Family Health Survey-4. 2015-16. District Fact Sheet. Nawada, Bihar. Mumbai: IIPS

According to data for the district (from the HMIS), 64 first-trimester abortions and seven second-trimester abortions took place during the preceding year. All 71 abortions were reportedly performed in government health facilities in the rural areas. However, this data does not add up as 153 post-abortion IUCD insertions and three post-abortion sterilisations were also reported for the same period (Table 8).

Table 8. Reported MTPs in Nawada District (2017-18)

	Total	Government	Private	Urban	Rural
MTPs up to 12 weeks of pregnancy	64	64	0	0	64
MTPs for over 12 weeks of pregnancy	7	7	0	0	7
Post-abortion sterilisations (within 7 days of spontaneous/ surgical abortions)	3	3	0	0	3
Post-abortion IUCD insertions (within 12 days of spontaneous/ surgical abortions)	153	153	0	0	153

Source: HMIS data for Nawada district, April 2017- March 2018

We attempted to estimate the extent of under-reporting of abortions in the district using estimated abortion rates for the state, which is 49 per 1,000 women of reproductive age (Stillman et al., 2018). The current population for the district was calculated using 2.3 per cent as the annual growth rate since the 2011 census. Using the sex ratio of 939 per 1,000, the female population for the district was estimated at 1.27 million, of which 0.62 million women were in the reproductive age group.

Table 9. Estimated and Reported Number of Abortions in Nawada district

Total population (2011 census)	22,19,146
Population, 2018 (@2.3% growth rate)	26,27,469
Sex ratio	939
Female population, 2018	12,72,405
Reproductive age group, 2018 (48.9%)	6,22,206
Number of abortions (@49 per 1,000 women of reproductive age)	30,488
Number of MTPs (HMIS)	71
Number of unreported MTPs	**30,417**
Number of MTPs based on facility visits	19

As per the estimates, more than 30,000 abortions were unreported in 2018 in Nawada district alone, and only 0.2 per cent of the abortions were recorded in the HMIS.

6.2.2 Availability of abortion services from the field survey

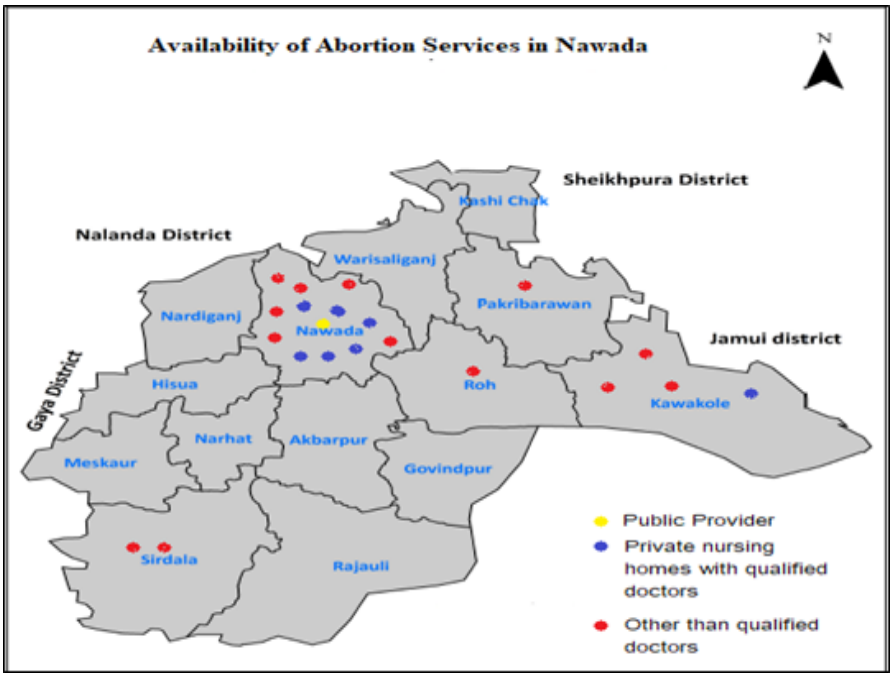
Community leaders' meeting

Part of the study included an exercise to map the abortion providers from a meeting with community leaders from the district. The participants listed 20 facilities that provided abortions services in the district. The district hospital in Nawada was the only government facility. About a third (6) of the abortion facilities were private nursing homes run by qualified allopathic doctors; and 13 were clinics run by unqualified providers, including those without any medical training, known as jhola doctors, auxiliary nurse midwives working in public facilities but not authorised to perform these services, and chemist shops.

The abortion facilities identified by the community leaders have been mapped in Figure 1. It is evident that qualified private providers are concentrated in Nawada city around the district hospital. Women from the rural areas have, therefore, to travel a long distance to access safe and legal abortion. The unqualified providers were spread across five blocks, and nine blocks of the district had no abortion providers at all.

If we count only the seven abortion facilities with qualified providers identified in the mapping exercise (1 government and 6 private), Nawada district has only one abortion facility for 0.3 million people. There is one abortion facility per 1.82 lakh women (88,886 women in the reproductive age group), way below the 2012 norm of one abortion facility per 20,000 population (recommended by the Federation of Obstetricians and Gynaecologists Societies of India (FOGSI) and Population Services International). By these norms, there is a huge gap in the availability of safe abortion services in Nawada.

Figure 1. Location of Abortion Service Providers in Nawada District (2018)



KIIs with Healthcare providers

As part of our study, we interviewed healthcare providers working in public and private health facilities who agreed to being interviewed. Their reports corroborated those by the community leaders, that the only public abortion provider was the district hospital. The hospital had five MTP providers trained in all methods of abortion, and it provided abortions up to 20 weeks of gestation. But there were contradictory reports from the providers, with some saying that they did not provide abortions beyond 2.5 months.

We also learnt that none of the community health centres (CHCs) provided any abortion services at all. In two CHCs, at least two providers were trained in MVA, but no MTPs had taken place in the past year as there were no MVA kits. The 16 PHCs had at least one provider trained in MMA, but only one PHC medical officer was known to prescribe medical abortion pills and explain the process to women, although she did not actually provide the service.

The one private nursing home we visited had qualified doctors, but it only responded to emergency cases – incomplete abortions. Interestingly, the ASHA reported dispensing emergency contraceptive pills to prevent an unintended pregnancy to unmarried women who approached her soon enough after a sexual encounter.

Table 10. Providers, Methods and MTPs in Sampled Facilities in Nawada District

	Trained Providers	Methods	Gestational age	No of MTPS
DH	5	MA, MVA, D&C and D&E (drugs unavailable for the last five years)	20 weeks (but later, contradicted this saying they did not provide abortions beyond 10 weeks)	Reported 4-5 through MVA in the previous three months; but hospital records showed 19 abortions in one year, through D&C
CHC	2	MVA, D&C given when woman also wants tubal ligation. No medical abortion drugs available	12 weeks	None
PHC/CHC	2	MVA (said medical drugs available but not mentioned as a method)	12 weeks – only in cases where health is at risk	None
Private Hospital	1	-	Only treated incomplete abortions	No data provided

Source: Provider interviews

FGDs with women in the community, KIIs with women leaders

Both groups of respondents confirmed that for an abortion in a public health facility the women had to travel to the district hospital in Nawada. Nursing homes and jhola doctors (unqualified providers) were the only private abortion service providers. TBAs mentioned that they treated delayed periods in the early stages of a pregnancy through abdominal massages, but otherwise referred women to the hospital or nursing home for an abortion.

The single public abortion facility was perceived as an appropriate provider only for married women. While some reported that unmarried women were denied abortions in the district hospital, others stated that unmarried women chose to go to private facilities because they wanted confidentiality to safeguard their identity. At times single women could not afford the private facility services. The ASHA who was part of the KII with providers recounted how she helped women in such a situation:

I have taken one or two widows for abortions at the government hospital. Their economic condition was not good, so I have taken them in disguise as Mohammedan (since they do not apply sindoor) and in this way an abortion was done.
(Provider-KII3, ASHA worker).

Not all married women could access abortion services in the district hospital. KIIs with women leaders and FGDs among older Dalit women revealed that unless the women were accompanied by their husbands or 'guardians', they would be denied an abortion. This was confirmed in KIIs with ANMs.

Some of the TBAs in the KIIs mentioned other barriers to abortions in the district hospital:

The government hospital refuses an abortion – they say you are doing it to remove the female foetus (KII-2, TBA).

Government facilities don't want to do it (for us). We are harijans, we are poor. Those who can bribe or pay well are treated" (KII5-TBA)

KIIs with healthcare providers indicated other potential barriers in public facilities – seekers of abortion services were 'counselled' to accept contraception. Healthcare providers in PHCs and CHCs did not refer women to a higher facility to enable them to access abortion services. They told them that abortion services were unavailable at their facility, knowing that women would have to go to a more expensive private facility or opt for an unsafe abortion.

All the FGD respondents stated that abortions were possible only in the first trimester. Older Dalit women (FGD) said that due to suspicion about sex selection, abortions were not performed in the second trimester. Some women leaders such as the traditional birth attendants (TBAs) and leaders of self-help groups also felt that second-trimester abortions could not be done because there was life after early pregnancy – after 3-4 months. In contrast, some community and CSO leaders noted that a second-trimester abortion following sex-selection was easily available if women were willing to pay.

Women in the FGDs were aware of medical and surgical abortions. Respondents in the KIIs added other methods of abortion such as oil massages till bleeding is initiated, ingestion of certain food such as ballary juice, or engaging in abortion-inducing physical activity.

The ASHA interviewed mentioned the use of catheters by nurses (ANMs) to induce abortions:

But here, the abortion tablet is used less, mainly the catheter method is used. It is used generally by the nurse (who works in the hospital – the abortion is provided privately). (Goli ki suvidha bahut kam hai. Zyadatar catheter se hota hai. Catheter hospital ki madam (nurse) use karti hain.) (Provider-KII3, ASHA worker).

The 'catheter method' was described by one of the healthcare providers as follows:

They insert a catheter through the cervix to cause bleeding and then pull out the foetus (Provider KII-5, obstetrician/gynaecologist running a private nursing home).

Doctors reported that chemists, ANMs and other unqualified providers with no medical background supplied medical abortion drugs to women, which could lead to many incomplete abortions.

Table 11. Availability of Abortion Services in Nawada District

	Availability /place of abortion	Gestation period	Methods
FGDs with women	Government: DH Private: nursing homes, jhola doctors	3 months	Medical abortions and surgical
KIIs with women leaders	Government: DH Private: nursing homes, chemists, jhola doctors, TBAs	3 months	Medical drugs and surgery; oil massage till bleeding starts; prescribing papaya and bellary juice and climbing stairs with heavy weights
Community leaders' meeting	Government: DH Private: chemists, nursing homes, jhola doctors	3 months	MMA and surgery

Note: DH - district hospital

6.2.3. Abortion costs

The FGDs with women and KIIs with SHG leaders, anganwadi workers and ANMs yielded information on the costs of an abortion. Their reports corroborated each other. The cost of an abortion for married women was reportedly in the range of Rs 5,000-7,000 in a private facility; for an unmarried woman it was as high as up to Rs 30,000 in the worst-case scenario. One key informant said that the costs for an abortion following sex-determination were also higher than for a routine abortion. Some private providers charged according to months of gestation, with higher rates for a later abortion.

Reports on the cost of an abortion at the district hospital varied. Older Dalit women reported the cost as only Rs 500, while an SHG leader said that the cost could range from Rs 2,000-3,000.

The women in the FGDs, as well as respondents in KIIs, did not mention the state-funded new insurance scheme, Yukti Yojana, which is meant to provide free abortion services.

6.3 Reasons for abortions among women

Women who participated in the FGDs and respondents in KIIs enumerated various reasons why a woman would ask for an abortion: she may already have 3 or 4 children and may not want another child; the previous child may be too small; the pregnancy may have occurred too soon after marriage when she was still very young; she was still in school/college and wanted to continue her education. Poverty and the inability to support another child because of the increasing "mahangai" (cost of living) was a recurring theme in many responses. Their lack of knowledge about contraceptive methods and contraceptive failures were also mentioned by some. In some cases, her husband or in-laws advised the woman to terminate her pregnancy.

> *If they have one or one-and-a-half year old child and in between become pregnant, then they say they don't want to keep the baby (KII-1, anganwadi worker).*

> *After 2-3 children, if we don't want children then only we get abortion done" (FGD with older Dalit women).*

> *(They opt for an abortion)..because some women suffer a lot, puke for nine months, or feel weak; or they may have just got married and don't want children immediately as they have desire and wants in life (provider-KII3, ASHA worker).*

It is interesting to note that abortions for reasons of gender-biased sex-selection were rarely mentioned in the KIIs and FGDs. A CSO leader, who was also a member of the PCPNDT Committee for Bihar, talked about sex-determination and subsequent abortions by unregistered private health facilities as being common. Abortions for gender-biased sex-selection were also mentioned by community leaders.

6.4 Awareness about and attitudes towards abortion

In addition to assessing the extent of availability and cost of abortion services in Nawada district, we also sought to explore the level of knowledge about the legal status of abortion in India, and about attitudes towards abortion. The assumption that abortion is not legal would discourage women from openly seeking out abortion services in registered and legal facilities. The extent of stigma associated with an abortion would also impact the utilisation of services, even when women know that these are legal and available. The following sections discuss the extent of knowledge about the legal status of abortion and attitudes to abortion among women themselves, women and men community leaders, civil society organisation leaders and healthcare providers at different levels.

6.4.1 Awareness about the legal status of abortion

Few women in the community seemed to have accurate information on the legal status of abortion. In FGDs with Dalit women, the older women said that abortion was illegal, but the young married and unmarried women were hesitant to say anything at all about abortions. Among the five women leaders who were interviewed as key informants, three said they were unsure of the legal status of abortion, while the TBA and SHG member who responded were certain that abortion was illegal in India. The ASHA included in KIIs with health providers, said that abortion was legal only for married women and illegal otherwise. They did not know about the legally permissible gestational limit because they did not know much about the legal status of abortion.

6.4.2 Attitudes towards abortion

Women and community leaders

Abortion was very much a taboo subject among all groups of women. In all the FGDs, women were reluctant to talk about it. Women started their conversation by saying that they had never heard about abortions and that no one they knew had undergone one.

We don't ask anyone about these things. Abortion is bad (FGD with married older Dalit women).

On further probing, the women said that they had heard about it and knew that some women had had abortions. The older women started by saying that they had never had an abortion, but then went on to talk openly about it. Women in many of the FGDs said that they had not heard of unmarried women needing abortions, suggesting that they did not engage in sex before marriage. They also said that rape did not occur in their communities, but they had heard of instances of rape in other places.

Unmarried women - no they never get pregnant… No, this (rape) has never happened in our village. It has happened in other villages. We saw unmarried pregnant women in the hospital; they had come to the hospital for treatment, so we came to know. We saw it, but we did not ask. These are things that we don't ask or talk about, isn't it? (FGD with married Dalit women)

The predominant sentiment among Dalit women in FGDs was that 'it is better to use contraception than go for an abortion.'

It is better to have (OC) pills than abortion. There is a lot of weakness after abortion. Have to go to Nawada all the way. If it was available through TBA, it would have been close by.

If you have two children and you get pregnant, you should have the baby – don't go for MTP.

If we don't want children, better to get the operation (sterilisation) done.

The respondents in KIIs were also not forthcoming when asked about abortions. TBAs and anganwadi workers categorically stated that they did not advise women to have an abortion. The TBAs said that no one came to them seeking any information about abortions.

Yes, I tell them to keep (the pregnancy). I don't send them for abortion … rather keep the child, after that either operate or have a Copper T inserted (KII-1, Anganwadi worker).

In the community leaders' meeting, the participants (youth leaders, SHG members, high school teachers, panchayat members) were uncomfortable with the idea of discussing abortion. We summarise below the discussions with them, and also the findings from a questionnaire administered to them on attitudes to abortion.

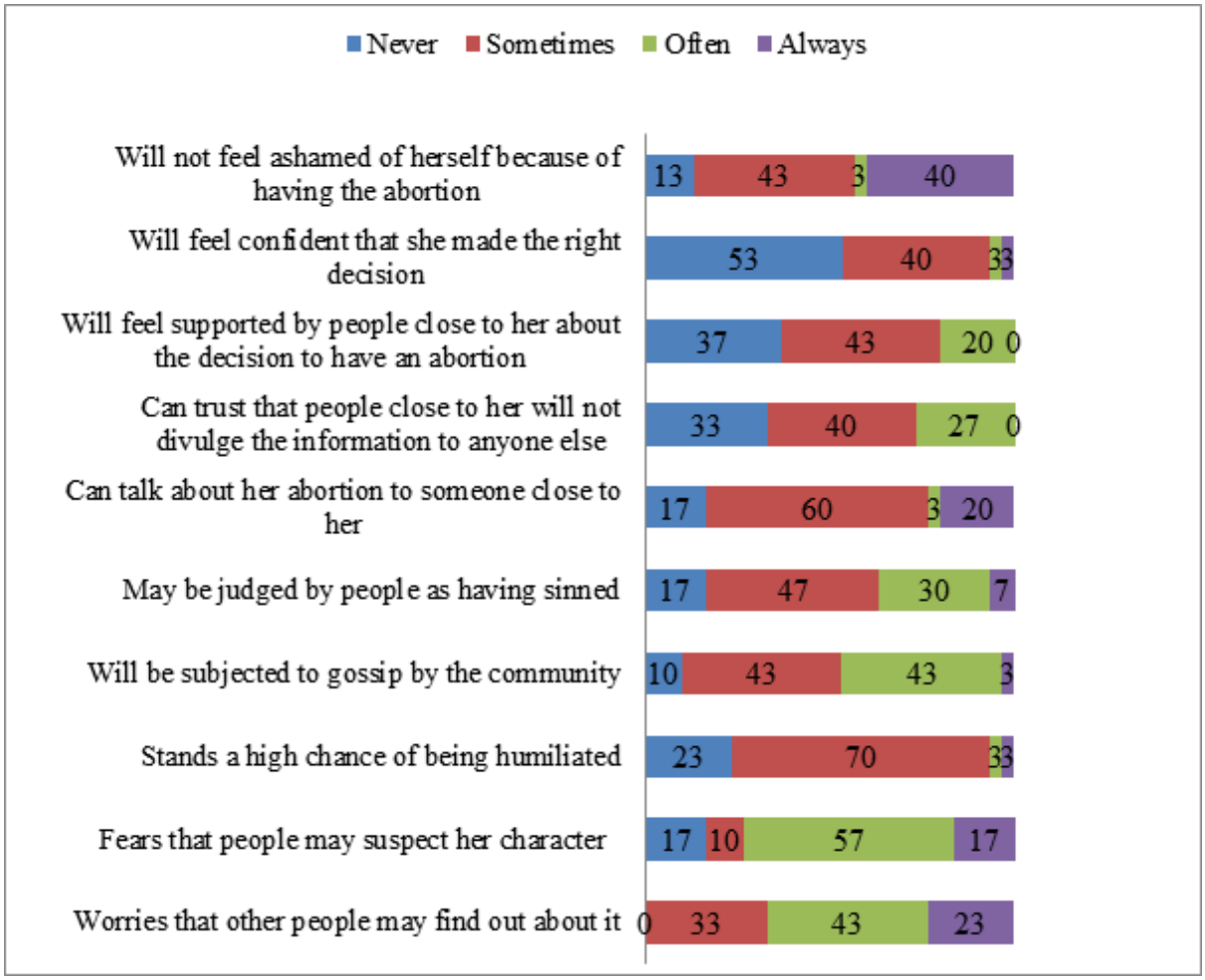
There was confusion among community leaders between safe abortion services and sex-selective abortions. There seemed to be a belief that abortions were being carried out predominantly for 'killing the female foetus'. Many of the youth leaders and teachers were involved in creating awareness about the PCPNDT Act and the Beti Bachao Abhiyan (Save the Girl Child Campaign). They were able to articulate that sex-selective abortions were carried out because of dowry, poverty, and the misperception that girls will leave home and boys will look after their parents. Some of them said that sex-selective abortion was akin to 'strangling motherhood' (mamta ka gala ghotne jaisa hai).

For the community leaders, an abortion was to be carried out only if the life of the pregnant woman was in danger; if the pregnancy was harmful to her due to an illness; or in pregnancies resulting from rape. They believed that abortions were illegal and ought to be discouraged. They also said that abortion were not possible after three months of gestation. Some members stated that abortion in the fourth month was unsafe, and that abortions in general caused weakness in women. Some went as far as saying that an abortion was akin to murder.

All the community leaders were asked to respond to 10 possible concerns that a woman seeking an abortion would have. Based on their responses (Figure 2), it is evident that most of the community leaders thought that a woman seeking an abortion would want to keep her abortion a secret, as she would be terrified of being labelled immoral and consequently humiliated. She would seldom be able to talk about her abortion with anyone, and would not be able to expect support from those close to her or trust anyone to keep her abortion confidential. Most respondents also thought that a woman seeking an abortion was unlikely to feel confident she had made the right decision.

The community leaders were divided on whether or not an abortion-seeker would be a source of gossip for the community, be judged as having sinned, or be ashamed for having had an abortion. The responses of community leaders on what a woman seeking an abortion is likely to experience indicates the barriers the latter are likely to face. These attitudes could contribute to women's inability to access abortion services from established health facilities and to her seeking care from unqualified providers.

Figure 2. Community Leaders' Views on Woman Seeking an Abortion



Healthcare providers

We interviewed doctors who are legally eligible to provide abortion services, and nurses who usually give women advice on whether and where to terminate a pregnancy. While all the doctors were trained and qualified to provide MTP, several said that they did not provide abortion services either because of their religious beliefs or the lack of equipment at their health facilities. Their attitude to abortion was in general, negative:

I am a follower of …..sect/disciple of guru …..and don't do MTPs because I don't want to terminate a life. Don't want to make money through MTPs as it is akin to killing. I do ligation but not abortion (Provider KII-5, private gynaecologist).

Another private gynaecologist who also did not perform MTPs because of her religious beliefs, added that her husband was also against abortions. She only treats 'missed abortion' cases or cases with complication to save the woman's life. She did not perform an MTP on second-trimester cases, even if the child or mother were facing complication, as she felt that a foetus starts taking human form after 12 weeks (Provider KII-7; private gynaecologist).

One doctor thought that MTPs should not be done at all. In the situation of a pregnancy in an unmarried woman where the partner does not take responsibility for the pregnancy, she counsels the woman and her family to opt for an arranged marriage and suggests that the delivery be passed off as a premature birth. If they do not agree, she refers them to a private doctor who can perform the abortion secretly

In an attempt to further explore attitudes towards abortions, we asked all the healthcare providers to respond to an attitudinal scale,[10] which had 12 profiles of girls or women needing an abortion. These profiles describe the age, gestation and reason for seeking an abortion. The providers had to state their views on whether an abortion should be provided in all circumstances, some circumstances or not at all (Table 12).

All six providers thought that an abortion should be provided under all circumstances when the period of gestation was under 20 weeks and there was a congenital anomaly, or the pregnant woman had a disability complicating her pregnancy. Likewise, all were agreed that an abortion should be denied under all circumstances when it was for gender-biased sex-selection, thus indicating their understanding of the PCPNDT Act.

The responses for the other situations were mixed. The providers were generally not in favour of second-trimester abortions and abortions beyond 20 weeks of gestation. Some said that an abortion should not be provided for a failure of contraception (although this is clearly permitted by law), so the woman is more careful next time! Four of the six providers were against an abortion in a pregnancy resulting from marital rape, as they believed that a husband could not rape his wife. Opinions were evenly divided in two cases, one when the woman was a primigravida and the period of gestation was 20 weeks, and the second when the pregnancy had resulted from a condom failure because the conception was through the husband and there was no harm in keeping the baby.

10 This is derived from a validated scale to be used in a quantitative survey. We nevertheless decided to use the vignettes in the scale so that the healthcare providers could respond to concrete cases.

Table 12. Provider Views on Provision of Abortion Services in Nawada District

	Circumstances	Should be provided under all circumstances	Should be provided in some cases	Should not be
1.	A 20-week pregnant, married woman, first time pregnant, whose mental health will be affected if the pregnancy is continued	3	1: because she was 20 weeks pregnant, he was not sure	2
2.	A 16-week pregnant, married woman with a serious heart condition, had been advised against getting pregnant	5	1: not sure, as beyond 12 weeks	
3.	A 16-week pregnant unmarried woman with a lower limb disability indicating a complicated pregnancy	6		
4.	A 22-week pregnant 10-year old whose pregnancy is a result of incest	5	1: as it is 22 weeks, have to look into it	
5.	A 19- week pregnant 17-year-old whose pregnancy is because of consensual sex sex	4	2: not sure as she is minor	
6.	A 19-week pregnant, married woman whose USG shows evidence of a congenital disorder, trisomy 18	6		
7.	A 16-week pregnant woman whose pregnancy is the result of marital rape	2	1: since pregnancy is the result of marital rape, have to look into the case	3
8.	A 16-week pregnant, married woman who failed to use oral pills consistently	4		2
9.	A 6-week pregnant, married woman who is pregnant because condom failure by her husband	3	2: only if there is a short interval between two children; will check if to see if true	1

	Circumstances	Should be provided under all circumstances	Should be provided in some cases	Should not be
10.	A 16-week pregnant, married woman whose	6	USG has shown evidence of a foetal anomaly	
11.	A 16-week pregnant married woman whose husband has been abroad for a year	4	2: need to consult woman's family members; not sure who will give consent for the abortion	
12.	A 16-week pregnant, married woman, with two daughters, whose USG shows a female foetus			

6.5 Consequences of the limited availability and access to safe abortion services

The non-availability of abortion services in most public facilities and non-affordability of these services in authorised private facilities have many serious consequences for women.

6.5.1 Unsafe abortion and its negative health impacts

A major impact of the limited availability of safe abortion services in the state is that many women are left with no choice but to go to informal, untrained providers. There are several in the district ranging from unqualified providers to ANMs to chemists selling drugs.

Many patients still go to quacks. It is very common. They insert a catheter through the cervix to cause bleeding and then pull out the foetus. In most cases, the abortion remains incomplete when such cases reach doctors like us. We then do D&C. In one such case, the gut had come out of the vagina and the woman reached me in that state. The quacks tried to pull it out as they cannot distinguish between different body parts. Sometimes they even pull out the intestines (Provider KII5 – private gynaecologist).

Another doctor narrated her experience when a poor Dalit woman in a desperate condition came to her private clinic. The patient had gone for an abortion to an informal provider when she was four months pregnant, and was given some medicine. She had been bleeding for ten days, the placenta was still inside and her haemoglobin level had fallen to 2.5 mg. The informal provider had told her that the placenta would come out in a few days. The doctor had to perform an emergency D&C on the patient. As this was a high-risk case the doctor had to take consent for carrying out the procedure, cognisant of the possibility of death (Provider KII6 - public sector doctor).

The ASHA worker interviewed talked about some women who boiled and drank the tar of a tree to induce an abortion:

…and due to this, women start bleeding….(the foetus) may not completely abort, they think it will wash away but it will not. They will start bleeding, so they have to go to a doctor anyway…. some women will have excess bleeding due to this, which can become serious (Provider KII3 - ASHA).

A TBA narrated a case where she found that a woman had an odour, but did not say she had any problem. Only when the TBA spoke to her at length, did she reveal the fact that she had consumed something to induce a miscarriage. The odour came from infection as part of the product of conception was left inside (KII-2: TBA).

Other healthcare providers reported that untrained providers even perform abortions in their homes. The two obstetrician/gynaecologists interviewed said they had encountered cases of complications from unsafe abortions, with excessive bleeding and infection. Other consequences included uterine or gut perforation, swelling of the uterus and pelvic inflammatory diseases. All of these require long-term treatment imposing a huge economic burden on the woman and her family. However, they did not report any deaths from the unsafe abortions.

6.5.2 High costs

As abortions are not being provided in most government facilities, women, both married and unmarried, are compelled to go to private providers who are very expensive. However, because abortions for single women are believed to be illegal, they almost always go to private abortion providers.

The government doesn't treat any unmarried women - and private facilities charge 5,000-6,000 rupees…For unmarried women it could be as high as 30,000 (KII3- TBA,)

Suppose an unmarried girl becomes intimate with someone, she is a daughter of a village, for which we cannot create a scene in the village. So, we take her to the hospital. In the government hospital they enquire about the guardian…we have to keep it secret, due to this they go to the private hospital... There they don't enquire much, they sign by themselves (Provider KII3 -ASHA).

According to the KII with a women SHG leader, high costs were a major barrier to accessing abortion services for Dalit women:

Mahadalit women – they need it, but they cannot (get it); they are poor and cannot afford (KII-3, SHG leader).

6.5.3 Self-induction of abortion

Often, women self-medicate to induce an abortion with medicines bought from a chemist. Self-administration of the correct dosage of MMA to induce an abortion can be safe and effective and not result in complications. One of the gynaecologists felt that MMA had made abortions safe:

…women are aware of medical abortions, which are quite easy and have become uncomplicated these days. Now women know that medical abortion kits are available at medical shops, so they purchase them and use them frequently (Provider KII-5, private gynaecologist).

However, according to an ASHA worker, there were also women who ingested drugs bought from a chemist which may or may not be MMA to induce an abortion. Some women also had no information on how the method works and what to expect:

…nowadays they take medicine, and they don't tell what medicine they took. They see a doctor and whatever they prescribe they take it, and sometimes some women suffer from bleeding, and it will not stop as long as it is not completely aborted. I take them to the hospital. This happens a lot (Provider KII3-ASHA).

Self-induction of an abortion because of the absence of any other option, without any information, counselling or back-up health support, can only be viewed as a desperate way-out for women caught between the devil and the deep-sea.

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7 RESULTS: TAMIL NADU

7.1 Abortion in Tamil Nadu: An overview

7.1.1 Background to the state

Socio-demographic indicators

Tamil Nadu is situated in the southernmost part of the Indian peninsula. The state had a population of 72.14 million in 2011, with a sex ratio of 996 females per 1,000 males. Almost half the population (48.5%) was urban; about one-fifth were from the Scheduled Castes and about 1 per cent were Scheduled Tribes. Youth constitute a significant proportion of the state's population, with a little over one-fourth (26%) in the 10-24 age group. Women in the reproductive age group constituted 57 per cent of the total female population. The literacy rate in 2011 was 80.33 per cent, with a rural rate of 73.8 per cent and urban rate of 87.2 per cent (RGI 2011) (Table 13).

Tamil Nadu is one of the industrially developed states in the country. Its per capita net state domestic product (NSDP) at constant prices (2011-12) was approximately Rs. 341 per day in 2016-17, which is almost four times that of Bihar for the same year (CSO 2018).

Table 13. Socio-demographic and Health Profile of Tamil Nadu

Population (2011) a			
Total (million)	72.1		
Rural (%)	51.5		
Urban (%)	48.5		
Overall sex ratio (females per 1,000 male)	996		
Scheduled caste population (%)	20.1		
Scheduled Tribe population (%)	1.1		
Youth 10-24 years (%)	26.1		
Women in the reproductive age group (15-49 years) (%)	56.9		
Literacy rate (2011) a	**Total**	**Male**	**Female**
All (%)	80.1	86.8	73.4
Rural (%)	73.5	82.0	65.0
Urban (%)	87	91.8	82.3
Health Indicators	**Total**	**Male**	**Female**
Infant mortality rate (SRS 2016) [b]	17	18	17
Infant mortality rate (NFHS-4, 2015-16) [c]	20.3	21.9	18.7
Under-five mortality rate (NFHS-4, 2015-16) [c]	26.9	29.8	23.8
Maternal mortality ratio (RGI 2018) [d]	66 per 100,000 live births; 95% CI (32-99)		
Average population covered by (DLHS4, 2012-13) e			
Health sub-centres	4,736		
Primary health centres	29,023		
Community health centres	41,366		

Sources:

a) Registrar General of India. 2011. *Census of India 2011: General Population Tables.* Ministry of Home Affairs, Government of India.

b) Office of the Registrar General and Census Commissioner (India). *India SRS Statistical Report 2016.* Available at: http://ghdx.healthdata.org/record/india-srs-statistical-report-2016

c) International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4), 2015-16:* India. Mumbai: IIPS.

d) Registrar General, India. 2018. *Sample Registration System's Maternal mortality ratio bulletin 2014-16.* New Delhi: Ministry of Home Affairs, Government of India.

e) International Institute for Population Sciences (IIPS). 2014. District Level Health and Facility Survey (DLHS-4), 2012-13: India. Bihar. Mumbai: IIPS

Gender inequality

Despite the state's overall good indicators, gender gaps in education and employment persist. Gender and rural urban differentials in literacy rates are fairly significant: of the rural female population 35 per cent were illiterate in 2011; work participation rates was 31.8 per cent for women and 59.3 per cent for males (RGI 2011).

Gender-based discrimination and violence against women is common. A little over two-fifths of the ever-married women have ever experienced spousal violence. The prevalence was higher among rural women (44 per cent) than their urban counterparts (37 per cent). There had been little change in these figures between the two NFHS surveys (2005-06 and 2015-16, IIPS and ICF, 2017).

The state appears to be witnessing a resurgence of caste-based restrictions on women's sexual rights. Between 2013 and 2017, 187 honour killings were reported in Tamil Nadu, to penalise young persons who were in a relationship across caste-lines. About 80 per cent of those killed were women (Muraleedharan 2017). Female infanticide had been an issue in the Dharmapuri, Salem and Madurai districts of Tamil Nadu for several decades, and it is believed that gender-based sex-selection may be high in these districts even today.

Health indicators

According to a recent report Tamil Nadu is one of the top-ranking states in India in terms of its overall performance in health (NITI Aayog 2018). Estimates for 2014-16 placed its maternal mortality ratio at 66 per one-lakh live births, while the national average was 130 (SRS 2017); its infant mortality rate was 20 per 1,000 live births, and the under-five mortality rate was 27 per thousand live births in 2015-16. Institutional deliveries were nearly universal, at 98.9 per cent. More than four- fifths (81.2%) of the women had received four antenatal visits, but only 45 per cent had received 'full' antenatal care (IIPS and ICF 2017).

The more-recently released National Health Profile 2018 shows that Tamil Nadu has eight doctors per 10,000 people, with every government allopathic doctor in the state serving 9,544 people, which is considerably lower than the national average (11,082). The average persons served per government hospital bed in the state is 899 as against 1,844 in India (National Health Profile, 2018). Each health sub-centre served a population of less than 5,000 on average, while the average population served by a PHC and CHC was 29,023 and 41,366, respectively (IIPS 2014); less than one-fourth to one-fifth of the figures for Bihar during the same period.

The average cost of medical expenditure per delivery in a public facility in Tamil Nadu was Rs. 325 for rural women and Rs. 661 for urban (NSSO 2016). However, in the private hospitals, the costs were Rs. 28,862 and Rs. 30,132 in the rural and urban areas, respectively, which is far higher than the national average (rural Rs. 14,778 and urban Rs. 20,328).

Indicators of the need for abortions

Tamil Nadu had witnessed a rapid decline in its fertility rate since the early 1980s. The current total fertility rate (TFR) of the state (average number of children born to a woman in her reproductive period) is 1.7, with a very small difference in the rural (1.86) and urban (1.54) TFRs (IIPS and CFI, 2017).

The results of NFHS-4 (2015-16) indicate that the current contraceptive prevalence was 53 per cent. Female sterilisation alone accounted for 49.4 per cent of contraceptive use, while the use of spacing methods was lower than 3 per cent. There were almost no vasectomies, and condom use declined between 2005-06 and 2015-16 (IIPS and ICF, 2017).

Table 14. Fertility and Contraception in Tamil Nadu (2015-16)

Selected health indicators	Urban	Rural	Total
Total fertility rate (TFR)	1.86	1.54	1.7
Contraceptive use in currently married women aged 15-49 years			
Any method	52.3	54.1	53.2
Any modern method	51.6	53.5	52.6
Female sterilisation	49.4	49.4	49.4
Male sterilisation	0	0	0
Intrauterine device	1.4	2.3	1.9
Oral pills	0.1	0.4	0.2
Condom	0.5	1.2	0.8
Unmet need for contraception			
Total unmet need	9.6	10.6	10.1
For spacing methods	4.5	5.1	4.8

Source: International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.

7.1.2 Government and NGO initiatives for safe abortion services

This section attempts to document the government and civil society organisations' position on abortion, from secondary sources, complemented by interviews with CSO leaders.

Government initiatives

The state government's Comprehensive Abortion Policy (CAP) developed in 2011 has not been adopted. The CAP's preliminary aim is to increase the availability of safe abortion services and promote spacing methods of contraception at all levels of healthcare (Government of India 2012-13).

In order to increase safe abortion services in public facilities, between 2011 and 2017, 718 doctors and 622 staff nurses in PHCs and government hospitals were trained in MVA techniques. The Record of Proceedings (ROPs) for Tamil Nadu for 2016-17 and 2017-18 have allocated funds for training of doctors and staff nurses in MVA techniques and for purchasing medical abortion drug kits for all CEmONC centres. (Government of India 2016-17 and 2017-18).

Non-governmental organisation initiatives

Tamil Nadu has very few NGOs working on women's sexual and reproductive health issues. And among these, some are against abortions on moral grounds and many exclusively work on preventing abortions for gender-biased sex-selection.

An activist group in Tamil Nadu called the Campaign Against Sex-Selective Abortion (CASSA) has actively promoted implementation of the PCPNDT Act to prevent sex-selection. The group runs intensive campaigns through its members to ban second-trimester abortions in all districts of the state. Its members comprise many feminists concerned about gender-biased sex-selection. CASSA has complained that in cases of violation of the Act, government authorities do not use the powers of the Civil Court to verify registrations and other records including Form F, to summon those involved along with relevant records, to seize the machines and cancel registrations, etc. They organised a public protest in Chennai on December 16, 2014, to demand stricter enforcement of the PCPNDT Act 2002 and MTP Act 1971 (HRF 2013). CASSA activists have submitted more than 500 petitions in the past few years seeking action against scan centres and fertility clinics that misuse medical technologies. CASSA's work indirectly affects the provision of safe abortion services, as they view all second-trimester abortions as sex-selective. .

Another campaign gaining ground in Tamil Nadu is called 'Girls Count'. This is ongoing only in two districts (Madurai and Cuddalore). Its activities involve gender sensitisation workshops on laws related to gender-equality. The activities target frontline health workers, youth, community women, adolescent rural girls, panchayat representatives, and government officials (Girls Count 2013).

Thus, it seems that there are two prongs in the campaign against sex-selection; one for strict implementation of the PCPNDT Act and monitoring of scan centres and the other focussing on challenging patriarchy. CASSA is leading the first group and in the second group Girls Count and a few others, like EKTA in Madurai, work on young people's SRHR (KII -2 with CSO leader).

Besides these broadly feminist groups working against sex-selection, there are also child rights groups such as Child Rights and You (CRY), Save the Children, Human Rights Foundation and

For You Child which have a strong presence in the state. Some of them have an anti-abortion stance, stating child rights starts from conception.

There is also an explicitly pro-life group called Uyirkkural, which has developed short videos with images and false statistics aimed at impacting the provision of safe abortions in the state (Uyirkkural 2018). A few popular Tamil films and documentaries also promote pro-life ideologies: for example, the recent film Dhiya is the tale of the ghost of an aborted foetus returning for revenge; and a short film which was shared on social media (by the students of the PSG College of Arts and Science) takes an anti-abortion stance (PSGCAS 2018). There is a danger that such films could promote a facilitating environment for an anti-abortion stance among the general public as well as among key opinion-makers and shapers in Tamil Nadu.

The 11-year ban (2006-17) on emergency contraceptive pills (ECPs) in Tamil Nadu by the Drug Control Authority of Tamil Nadu was instigated by two Chennai-based civil society organisations called Responsible Parents Forum and Satvika Samuka Sevaga Sangam, which argued that ECPs 'encourage women to think they could do anything and get away without pregnancy.' The ban was lifted following the Jhatkaa campaign by another CSO, after they ran a signature campaign to lift the ban and appealed to the government (The News Minute 2016, The Times of India 2016).

Overall, it may be said that even among groups upholding gender equality, many are not willing to take on the agenda of safe abortion as a women's right. Most of them believe that advocating for safe abortion services would encourage sex-selection and result in a further decline in the child sex ratio. There are other NGOs and CSOs which have taken an explicit anti-abortion stance or acted to restrict women's sexual rights. The ray of hope lies with a small number of NGO and CSO actors who have opposed the restriction of women's sexual and reproductive rights.

7.1.3 Data from other studies about the need for and availability of abortion services

Incidence of abortion

There are a higher number of MTPs performed annually in Tamil Nadu than the national average. According to official figures, the state has the third-highest number of abortions in India. Annually about 65,000 abortions were reported to be carried out in the approved health facilities in the state (MOHFW 2017 and HMIS 2017-18).

A few studies have reported high abortion rates (abortions per 1,000 women of reproductive age) in Tamil Nadu. A hospital-based study in Vellore district reported 73 abortions per 1,000 married women (Reenu et al. 2017), but a more recent study indicates the state's abortion rate was 33 per 1,000 women of reproductive age (Alagarajan et al. 2018).

Profile of the service users

Studies show that a large majority of the abortion seekers were below 30 years (Balasubramanian et al. 2007, Maheswari and Jayanthi 2017, Reenu et al. 2017) and most of them were from the poor and middle-income groups (Maheswari and Jayanthi 2017). A few studies found that most of the abortion seekers were illiterate or had below-primary school education. One study (early 2002) found that educated women constituted a higher proportion of those experiencing repeated abortions than those who were illiterate (Krishnamoorty 2006). Overall, women below 30 years of age and from lower socio-economic class are more vulnerable to unintended pregnancies and abortion.

Reasons for seeking an abortion

Several studies indicate that an unintended pregnancy is the main reason for an abortion. Non-consensual sex is widely prevalent, and women do not have the negotiating power to use contraception (Krishnamoorthy 2006, Ravindran 2004, Anandhi 2002). The low levels of use of spacing methods of contraception is a factor contributing to unintended pregnancies and abortions. Evidence suggests that while there is widespread knowledge about spacing methods of contraception this has not translated into use (Jayanthi 2017). Some studies mentioned that contraceptives are not regularly available or easily accessible. Recent studies also show that the large majority of abortion users did not use any method of contraception (Jayanthi and Abhishek, 2017). Couples' perception of the low risk of pregnancy particularly among older people was also noted in one study (Balasubramanian et al. 2007). A handful of studies reported that abortion is used as a method of spacing between the births, and to limit the family size (Ravindran 1997, Nagaraj 2002, Krishnamoorthy 2006). Some also mention poverty and other economic reasons for abortions, as also instances of abortions on medical grounds, for the woman's own health or because of foetal abnormalities.

In a large majority of cases, the women themselves made the decision to have an abortion and informed their spouses and in only a few cases, did family members decide on the abortion. Using DLHS-3 (2007-08) survey data for Tamil Nadu, a study reported that 68 per cent of the women took the decision to abort their pregnancies, while 20 per cent were recommended by doctors (mostly on a medical grounds) and 12 per cent by others. This trend was observed in several of the studies.

Sources of abortion services

The private sector plays a major role in the provision of abortion services in Tamil Nadu. According to NFHS-4 (2015-16), the majority of abortions were performed in the private health sector and only 29 per cent were performed in public facilities (IIPS and ICF, 2017). A similar trend was seen from the HMIS data – 60 per cent of the abortions in the state were performed in private and only 40 per cent used government health facilities (HMIS 2017-18). This is also confirmed by the Guttmacher study where private facilities were found to provide 82 per cent of the facility-based terminations (Alagarajan et al. 2018).

Privacy, confidentiality, quality of care services and cost are the important determinants for selecting a provider. Studies show that women preferred a private facility mainly for the better quality of care provided. Although services in the government facilities are free, many women did not want to use these for varied reasons: need for repeated visits, lack of confidentiality, the poor attitude of the provider, indirect costs in accessing the services and poor quality of care (Anandhi 2002, Krishnamoorthy 2006, Balasubramanian et al. 2007).

Abortion methods and gestational period at the time of abortion

A 2002 study reported that 90 per cent of the abortions were done using the D&C method. There has been a decline in surgical abortion use over the years, but it is still the main method for abortions in registered facilities and reported in the official data (Krishnamoorthy 2006, Tamil Nadu Government, Health and Family Welfare 2017-18). In 2017-18, 64,929 abortions were carried out in approved health facilities, of which a little over three-fifths were performed using D&C, followed by one-third done through an MVA; EVA was used only in 2 per cent of the cases. Official data reports that only 5 per cent of the abortions were carried out by medical methods (Government of Tamil Nadu HFW 2018), but the reality appears to be different.

Recent research by the Guttmacher Institute in partnership with the International Institute for Population Studies and Population Council, India, shows that a majority of abortions in Tamil Nadu (63%) took place in non-facility settings using medical methods of abortion, and 5 per cent were performed outside health facilities using other methods. Only about 32 per cent of the abortions were performed in health facilities. The vast majority (92%) of health facility abortions took place in the first-trimester of a pregnancy (up to 12 weeks' gestation), and slightly less than half (45%) occurred at less than eight weeks' gestation. Most facility-based abortions were performed surgically using manual or electric vacuum aspiration (20%) or either dilatation and evacuation or D&C (36%). Evidence also shows that many women first tried to abort their pregnancies using home and herbal remedies and in some cases through self-medication, and only then did they consult an abortion provider (Alagarajan et al. 2018).

Reports indicate that healthcare providers are not comfortable prescribing medical abortion pills (The Times of India 2012, Lakshmi 2005). However, a study carried out in the rural areas of Tamil Nadu, reported that faced with an option, women preferred a medical abortion to a surgical abortion (Subhasri and Ravindran, 2012). Studies also show instances of self-medication without access to medical advice or counselling, where abortion pills were taken without any knowledge about the correct dosage, the period of gestation for which they are effective, the abortion process, and what do to in case of complications (The Times of India 2012, Lakshmi 2005).

Cost of abortion services

Abortion costs varied considerably depending on the method used, type of provider and facility, gestation period and marital status of the woman. Studies documenting the cost of abortions in the state are limited and also dated. A study found the average expenditure on an abortion in the private sector in 2002 was Rs. 1,337, almost double that in a government facility (Rs. 759) (Krishnamoorthy et al 2002). Another study by RUWSEC in 2008 reported that the cost of an abortion in the private sector (Rs. 4,617) was about two-and-half times higher than in a government facility (Rs. 1,940) (Balasubramanian and Ravindran 2008).

7.2 Availability of and access to safe abortion services: A case study of Kancheepuram district

7.2.1 Government statistics on abortion facilities and MTPs performed

There are 73 government health facilities, and 50 private nursing homes in Tamil Nadu's Kancheepuram district (Table 15) which are supposed to provide safe abortion services.

Table 15. Authorised Government Health Facilities in Kancheepuram District (2017-18)

Type of facility	Numbers
Government	
Medical college hospitals - CMC Chengalpattu	1
District Hospital Kancheepuram	1
Taluk hospitals	7
Non-taluk hospitals	2
Community health centres, CHC	13
Main PHC	3
Additional PHC	42
Urban health posts	3
Centre government hospital - Kalpakkam	1
Total	**73**
Private nursing homes	50
Total government and private	**123**

Source:

a) Government of Tamil Nadu, State Health Society, available at http://www.nrhmtn.gov.in/hud.html, 20th June 2018

b) National Health Mission, Rural Health Statistics 2017, available at https://nrhm-mis.nic.in/Pages/RHS2017.aspx?RootFolder=%2FRURAL%20HEALTH%20STATISTICS%2F%28A%29RHS%20-%202017&FolderCTID=0x01200057278FD1EC909F429B03E86C7A7C3F31&View={9029EB52-8EA2-4991-9611-FDF53C824827}

The availability of safe abortion services in the district is far below the recommended norm of one abortion facility per 20,000 people. When we calculate population per abortion facility, we found that Kancheepuram district has one abortion facility per 42,500 people. When we exclude PHCs, as a large majority of them do not provide these services, we arrive at one facility per 70,000.

According to HMIS data, 1,890 abortions were performed in Kancheepuram district in the approved health facilities in 2017-18, 71 per cent of which were through surgical methods (Table 16). Of the reported MTPs in the district, 71 per cent were done by private providers and almost all (97 per cent) were performed in the first trimester (not shown in Table 16).

Table 16. Reported MTPs by Method in Kancheepuram District (2017-18)

MVA	MMA	Other Techniques	Total
427	117	1346	1890
22.59	6.19	71.22	100.00

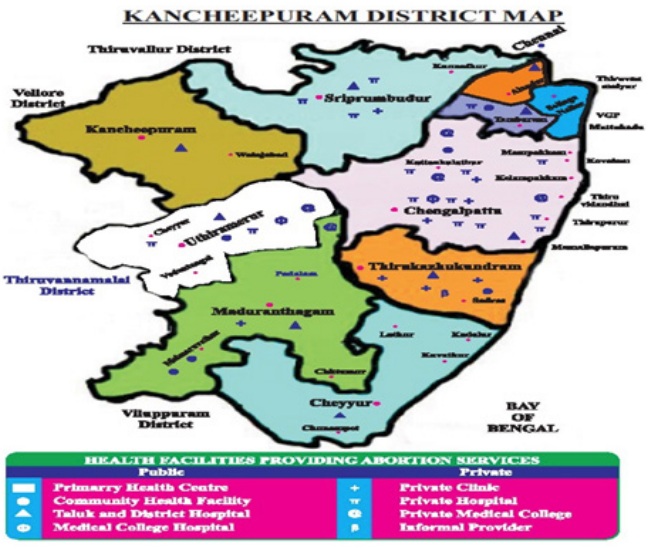
Source: Government of Tamil Nadu. 2018. TN Health and Family Welfare Statistics: 2017-18. Chennai, Ministry of Health and Family Welfare

Based on the Guttmacher (2018) estimate of a state average of 33 abortions per 1,000 women of reproductive age, we found that the annual expected number of abortions in the district was 42,027 (Alagarajan et al. 2018). Thus, the reported number of abortions was only 4.5 per cent of all expected abortions. This may imply that an overwhelming majority of the abortions in Kancheepuram district take place outside formal and registered MTP health facilities, through self-medication using medical abortion pills or from informal or unregistered formal providers.

7.2.2 Availability as reported from the field survey

Figure 3 depicts the results of a facility mapping exercise that we did through a community leaders' meeting and group interview with community leaders. The community leaders identified 42 abortion facilities in the seven taluks of Kancheepuram district; almost all of them are located in urban areas, predominantly in Chengalpattu Taluk. Rural blocks like Uthiramerur, Maduranthgam and Cheyur have only one or two abortion providers.

Figure 3. Location of Abortion Service Providers in Kancheepuram District (2018)



Of the 42 facilities, 26 (62%) were private providers. Amongst the government health facilities, abortion services were available in all the government hospitals (medical college and the district, taluk and non-taluk hospitals), 40 per cent of the CHCs and 4 per cent of the PHCs. Private facilities included private nursing homes run by MTP-trained providers, informal providers who could have been medical or paramedical professionals without MTP training, and pharmacists.

Facility visits and KIIs with healthcare providers

As part of the study, the team visited three secondary government hospitals and one private nursing home. As mentioned in the community leaders' meeting, all the three government hospitals provided MTPs. There were 3, 9 and 6 gynaecologists in the three government hospitals. They were MBBS and DGOs (Diplomas in Obstetrics & Gynaecology). The methods provided included medical abortions, manual vacuum aspiration (MVA) and D&Cs.

Table 17. Providers, Methods and MTPs in Sampled Facilities in Kancheepuram District

	Trained Providers	Methods	Gestational Age	No of MTPS
GH1	3	MMA, MVA, D&C and D and E	MMA <=6 weeks MVA 6-12 weeks D&C 6 - 20 weeks	23 in past 3 months; 9 MMAs and 14 surgical (break-up not available)
GH2	9	MMA, MVA. D&C; post-abortion contraception almost a pre-condition	12 weeks; second-trimester referred to tertiary centres	75 in past 3 months 40 MMA, 35 surgical (break-up not available)
GH3	6	MMA, MVA. D&C; post-abortion contraception almost a pre-condition	12 weeks	60-90 in past 3 months; educated women given MMA
Private hospital	1	MMA, MVA. D&C	MMA <=7 weeks MVA <= 12 weeks D&C 12-20 weeks only for foetal abnormalities	About 15 MTPs per month, 10 MMAs and 5 surgical

Source: Provider interviews and review of records

The private nursing home was run by a single gynaecologist who provided both medical and surgical abortions. The case load of the government facilities varied from less than 10 to about 30 MTPs a month, while the private facility performed about 15 MTPs in a month.

Only one of the three government hospitals performed second-trimester abortions, the other two (one being a district hospital) provided only first-trimester abortions, despite having 6 and 9 trained gynaecologists and operation theatres equipped to provide caesarean sections. They

routinely referred second-trimester abortions to tertiary-level facilities. The private facility also reportedly did not provide second-trimester abortions except in the case of a foetal abnormality.

In two of three government facilities, the husband had to give his signed consent before abortion services were provided. Abortion services appeared to be conditional on acceptance of contraception: women were "counselled" to accept post-abortion contraception. Women with only one child were offered an IUCD, while those with two or more children were counselled to accept sterilisation alongside the MTP.

FGDs with women and KIIs with women leaders

All the respondents were aware that hospitals in the public sector provided abortion services. Although some participants in the community leaders' meeting knew that a few PHCs provided medical abortion services, most of the FGD and KII participants thought that MTPs were not done in PHCs.

Abortion services are not provided in the PHC. It is provided only in the General Hospital (women leader KII-2 - traditional birth attendant).

Not everyone could access abortion services in a public sector facility. All the unmarried women who participated in the study secured abortion services only at private clinics, stating denial and poor quality of care issues at the public facilities.

They (government health facilities) do not do it (abortion) for unmarried girls in government hospitals; only married women can go there (FGD with unmarried women).

A school-going girl described how a young unmarried woman visiting a government facility is usually treated:

It will become a police case. First they first ask your age, then if you are married, and then ask if this is the age for such behaviour. They will then scold you using vulgar language ('asigmapesuvanga'). Then it will become a case (legal case) (FGD with unmarried women).

In addition to acceptability and quality of care issues, this highlights the fact that when a girl below 18 years seeks abortion services, medical professionals have to report it as sexual abuse under the POCSO Act.

HIV-positive women often faced denials in government hospitals:

We go to one place and if they do not provide services there, we will go to another place and if there is a delay, they will say the months have exceeded and they will not provide abortion services. Sometimes it will be dangerous for life (FGD with HIV- positive women).

Married women also expressed a preference for a private facility. One reason was that these services were available only in hospitals which were farther away. More importantly, denial, delays and poor quality of care kept many women away from government hospitals.

When we go to the government hospital it will take at least five days to get the services. They will ask to do some tests, which will take time, and the process will get delayed. We will not get services in a single visit; there will be more visits to the hospital to get services, but in private it is easy (FGD with older Dalit women).

For abortions … people will not go to a government hospital as they scold you, using very bad language if we tell them we need abortion. Even if we go to a government hospital to remove the copper-T they will scold us badly, so how can we go for this (abortion) to a government (hospital)? So, if it is an abortion it is only a private practitioner (FGD with young married non-Dalit women's group)

While the preference for private providers was widespread, we also discovered that many women leaders including TBAs and Anganwadi workers were not aware whether or not a private provider was formally certified. They chose providers that came recommended by their peers or by women leaders in the community.

From the KIIs with TBAs, Anganwadi workers and SHG leaders we noted that most government facilities provided only first-trimester abortions. This is in line with our findings from the healthcare providers and facilities:

In a government hospital they will perform abortions up to three months, after that they refuse to do it. But in the private they can do it even after 8 months (woman leader KII-6: anganwadi worker).

We received similar responses in the FGDs – that abortions were available in government facilities only or a two- or three-month gestational period.

In terms of available methods of abortion, abortion drugs were reportedly freely available in pharmacies in urban centres without a doctor's prescription (mentioned in interviews with private providers, all the FGDs, KIIs and meetings with community leaders). In some cases, a medical abortion included tablets and injections (the injection Methotrexate is given in place of Misoprostol after the vaginal insertion of Mifepristone). Interviews with community leaders in Kancheepuram revealed that both medical and surgical methods were widely used in the district. Interviews with CSO leaders from other districts indicated that a medical abortion may not be widely available in all the districts of the state.

In our interview with CSO leaders we learnt that there were still informal providers in all the districts; Madurai, Chennai, Thirupattur, Dharmapuri and Kancheepuram. In each town there were one or two unqualified informal abortion service providers used by many women seeking an abortion, despite the availability of abortion services in authorised health facilities, government and private. The CSO leaders reported that the number of informal providers has come down over the years, and that all of them now use medical abortion and surgical methods. None of them use the crude methods used in the past.

In summary, although abortion services are reportedly available in all public-sector secondary and tertiary hospitals, services are denied in many instances and, if provided, often involve repeated visits. Abortion-seekers may expect to be subjected to humiliation and abuse. The

difficulties increase many-fold in the case of unmarried women. HIV-positive women also face difficulties in obtaining abortion services from public facilities. Second-trimester abortions are not provided even in well-equipped government hospitals. Government facilities also insist on post-abortion contraception and signed consent from the husband, posing additional barriers to women's access to abortion services. Private facilities are therefore seen as the preferred source of abortion services, but even here, clinics run by lady doctors were preferred to large hospitals. However, the cost of abortion services from qualified private providers could be unaffordable to women from most marginalised groups (as discussed in the next section), who then seek out unqualified providers or rely on self-medication. Table 18 summarises the responses from various groups of respondents on where women go for abortion services, why, and the abortion methods with which they were most familiar.

Table 18. Availability of Abortion Services in Kancheepuram Districtt

Category	Where Women Go for an Abortion	Reasons for Choosing or Not Choosing	Abortion Methods Available
FGD with			
Rural never-married Dalit woman	All chose a private facility; most preferred clinics to hospitals	Confidentiality, privacy, simpler procedures in a private facility.	Drugs from pharmacies (as this is most discreet); MAs with injections and D&Cs
Rural married Dalit women (less than 40 years)	Five (out of 12) did not go to a government facility; two stated they went to Thirukazhukundrum and Chengalpattu medical college hospitals; the others went to a private facility	Discrete, quick procedure in private; high costs in private was their reason for choosing a government facility	Some respondents said it was available in a medical shop/ pharmacy, others disagreed, saying they needed a doctor's prescription All agreed that MAs were not available in public facilities.
Rural married Dalit women (aged 40 or over)	Four out of nine chose government, the Uthiramerur Taluk hospital and Chengalpattu Medical college. The others chose a small private clinic run by a female doctor	Poor quality of care in the government; high costs in the private	Medical methods and D&Cs

Category	Where Women Go for an Abortion	Reasons for Choosing or Not Choosing	Abortion Methods Available
Rural young (below 40 years) married non-Dalit woman	Mostly private, one or two went to government facilities	Poor quality of care, repeated visits	MMAs, drugs or injections, and D&Cs
Rural tribal women	Most went to a private provider in Chengalpattu; a few did not respond	Discrete and confidential	A few said MMAs and D&Cs
HIV-positive women	Two out of nine chose a public facility, the rest private Unmarried can't go to government	In public facilities women faced humiliation, lack of confidentiality and poor quality of care	Medical methods and D& Cs
KIIs with Providers			
Private doctors	NA	NA	MMAs up to 7 weeks, D&C for 7-12 weeks
ANMs	NA	NA	MA, MVA and D&C
Public sector doctors	NA	NA	Two providers: MMAs, MVAs and D&Cs One provider: MAs and MVAs
KII with Women Leaders			
TBA	Most visited a private doctor in Thirukazhukundrum; all unmarried went to a private facility; a few married women went to the government hospital in Chengalpattu Medical College as services not available in PHCs	Private because of confidentially, and they faced humiliation and delays in public facilities	MMAs, giving injection and D&Cs; injecting saline and inducing

Category	Where Women Go for an Abortion	Reasons for Choosing or Not Choosing	Abortion Methods Available
SHG leaders	All private: (for unmarried girls access to private is a problem) Mostly private provision, a few women buy medicines from the shop Not available in the PHC, only in Madurandagam and Chengalpattu CMC SHG 2: for unmarried women, only private provision; married women also usually use private. SHG 3: CMC in Chengalpattu- SHG 3	Private advantages: speed, quality of service, and confidentiality; non-availability and humiliation in government facility	Only MMAs
Anganwadi worker	Unmarried and married – private; one or two visit the government facility, CMC	In government facilities face humiliation, delayed treatment, asked to come for repeated visits, or referred to other facility	D&Cs and MAs
KIIs with CSO leaders			
	Private -as abortion services are not given importance in government hospitals- CSO-1Private and Informal providers- In Government, district hospital only -	Non-availability and those who have money visit private others either to have baby or die. In government hospitals, poor treatment and taunts	MMAs, MVAs and D&C; most women buy medicines from the shop and self-medicate

Category	Where Women Go for an Abortion	Reasons for Choosing or Not Choosing	Abortion Methods Available
Community leaders' meeting	Mostly private hospitals and clinic, pharmacies Few visit Government- CMC, and Taluk hospitals, one or two PHCs	In government there is no confidentiality, poor, quality of care, repeated visits; but heavy expenditure in the private	Private: medical methods and injections; few doctors use MVA and D&Cs; self-medication is common

7.2.3 Cost of abortion

The cost of an abortion in a private facility was reportedly high and varied widely depending on the type of provider, methods used, the woman's month of gestation and marital status, and post-abortion complications if any. For an MMA it ranged between Rs 1,000 to Rs 10,000, and for a surgical abortion it was between Rs. 5,000 and Rs 40,000.

For my daughter-in-law, we consulted one doctor here, but it was not proper, so we took her to a doctor in Kancheepuram and the expenses were Rs.15,000. It did not come out properly, [the foetus did not come out completely] so they asked us to pay Rs.15,000 on the same day and we paid it. They took a scan and asked her to stay in the hospital for a day and did the procedure (from a FGD with older Dalit women).

My first baby was young and suddenly I conceived [again]… when I went to the government hospital they told me that they cannot do it [perform and abortion]. So, we went to a private hospital. We only had Rs. 1,000, so my mother removed her earrings and other jewellery and handed them over to the doctor to pay for the abortion services. She requested the doctor to do the abortion and told her that she will come and discharge me the next day. The next day she paid Rs. 6,000 to the doctor, got back her jewellery from the doctor and took me home (from a FGD with younger Dalit women).

The minimum amount for accessing abortion services in private (hospital) will be Rs.10,000. Ten years back when I had abortion and I spend Rs.6,000. I think now it will be Rs.15,000 or more (from the FGD with HIV-positive women).

Unmarried girls spend Rs. 20,000 to Rs.30,000 for accessing abortion services in private (hospitals), they (the hospitals) also charge based on the gestation period. For a married women, her (natal) family members will make arrangements for the money for the abortion (women leader KII 1: traditional birth attendant).

7.3 Reasons for abortions

The primary reason for abortions, across all the interviews and FGDs, was because women did not want to have another child or wanted to space the next birth as the previous child was too young.

Some women feel that they already have the desired number of children and do not want more, so they go in for an abortion (FGD with older Dalit women).

Poverty was mentioned as a reason by some:

They cannot manage to bring up the children they already have, cannot feed them properly nor provide education, that is why they wish to abort (FGD with older Dalit women).

Being unmarried was mentioned by all respondents as reason enough to terminate a pregnancy, whether pregnancy was a result of forced sex or consensual. The reasons mentioned by younger women's groups included foetal anomalies and wanting to postpone childbirth in order to complete one's education or find a suitable job.

The HIV-positive women's group echoed many of the above reason, but additionally mentioned poor health of the woman and fear of the child being born HIV-positive as reasons for seeking an abortion.

Sometimes, the family advised the woman to terminate her pregnancy because conceiving in certain months was considered inauspicious:

I became pregnant in the (Tamil) month of "adi" (July-August) – my in-laws asked me to terminate the pregnancy (FGD with younger married non-Dalit women).

The tribal women's group brought up some specific issues. Some of them were denied post-partum sterilisation after their second delivery because they were too anaemic to be operated on. They then had to terminate their subsequent pregnancies as they did not want more children.

Not wanting another female child was also mentioned as a reason:

For some couples who have four girl babies continuously, for the fifth pregnancy they do a scan to check whether the foetus is boy or a girl, and if it is the girl again, they do an abortion (FGD with younger married Dalit women).

7.4 Awareness about and attitudes towards abortion

7.4.1 Awareness about the legal status of an abortion

Awareness about the legality of abortions varied across the different groups of women with whom we had FGDs. The older Dalit women's group was certain that abortion was legal, although most of them had less than high-school education. In the HIV-positive women's group, while some did not know the legal status, most were certain it was legal. However, there were some misconceptions:

Abortion is legal only up to two months of pregnancy. For married women, the husband has to agree and sign, and for unmarried women the mother has to sign" (FGD with HIV-positive women).

Of the remaining four groups, in the tribal women's group many were not sure about the legal status, while the three groups of younger women who were more educated said abortion was illegal.

Abortion is a crime (kutram) – and is not legal in our country (FGD with unmarried women).

I saw in the news that they put a couple in jail. If they come to know about killing a foetus they will put me in jail (FGD with young married Dalit woman).

Unlike our findings from the FGDs, all the three SHG leaders, two TBAs and anganwadi workers knew abortion was legal:

I know that abortion is legal. Women can opt for an abortion when they have a small baby or have health problems or problems related to breathing, etc. (woman leader KII-3: SHG leader).

Abortion is legal; that is why women can have one and continue with their lives (women leader, KII-6 anganwadi worker).

Almost all the participants knew sex-selective abortion was illegal. However, a few women extrapolated this to mean that all abortions were illegal: they said they had seen a sign-boards in many hospitals that abortion was illegal – referring to the mandatory sign-boards declaring sex-determination tests to be illegal under the PCPNDT Act.

7.4.2 Attitudes towards abortion

FGDs with different groups of women

As with their awareness about the legality of abortions, attitudes towards abortion were also markedly different between the three younger women's groups and the groups of older Dalit women, HIV-positive women and tribal women. The latter group tended to initially voice the view that abortions were "wrong", but added that there were several circumstances when it was alright for a woman to have one:

Some feel two children is enough, some feel three is enough, and after that if they get pregnant and they opt for abortion, it is not bad/wrong (FGD with older Dalit women).

Only when they feel that they cannot afford it, they opt for an abortion; they decide with lots of difficulty (FGD with older Dalit women).

Women in the tribal group also said that while abortions were wrong, they were permissible for women who do not want another child or whose health is at risk, or if the foetus had a major problem. They also noted that abortion was stigmatised and women rarely talked about it, so it was safer to prevent an unwanted pregnancy through sterilisation:

Generally, in our area a woman does not tell others she had an abortion; she will keep it secret and will not share it. She will say she went to her maternal home or some other place. We prefer to have the required number of children and go for an operation (FGD with tribal women).

It is very personal so they do not share it with others. Even if they go to hospital, they will say that they went to their native place or to some place for a family function (FGD with tribal women).

The HIV-positive women's group echoed these sentiments, saying that abortion was wrong, but that some women needed it. They also spoke about the negative attitudes that women undergoing an abortion had to contend with:

People say that why get pregnant and then abort, it is better to be safe. It is like killing a life. If they decide not to have a child, they should be cautious, follow safe methods (FGD with HIV-positive women).

Younger women tended to see abortion as acceptable only under certain circumstances such as a foetal abnormality, risk to a women's health and in the case of a rape. They were against terminating a pregnancy to allow space between births or to limit the family size. They repeatedly voiced the view in the discussions that when several women in the villages did not have a child, it was wrong to have an abortion. In almost all the FGD groups, there were a few participants who likened abortion to a sin and said it was akin to murder. Others talked about the negative health consequences, risk of infertility following an abortion and, most importantly, said that women who had an abortion would be considered immoral.

People see abortion as a bad thing and women don't have the courage to tell others that they have destroyed their baby. Both for married and unmarried women, abortion is not good thing. People see those who undergo an abortion as bad women (FGD with young, married Dalit women).

A few voiced the view that abortion services should not be provided to unmarried girls, but others believed that unmarried girls should definitely be provided an abortion, otherwise they may be driven to suicide or ostracised from society:

She (the unmarried rape survivor) does not even know who is responsible. What can she do about it? In future there will be problems both for the mother and baby. Why face unnecessary problems, so abortion is the only option for her (FGD with young, married Dalit women).

KII with women leaders

Unlike the women who participated in the FGDs, most of the women community leaders had a favourable attitude towards abortion. Of the two anganwadi workers, one stated that an abortion may be done up to three months of a pregnancy, but after that it was equal to taking a life; the other felt that abortions saved many women's lives and confided that she herself had undergone an abortion. Likewise, both TBAs were in favour of abortions: one reporting that she had herself undergone an abortion and there was nothing wrong with it. Of the three SHG leaders, two said that there was a general perception that abortion was a sin, while the third noted that abortion was legal and there was nothing wrong with it.

Meeting with community leaders

In addition to the FGDs and KIIs, we held a one-day community meeting with panchayat members, youth leaders, CBO leaders, high-school teachers and some SHG leaders. We distributed a self-administered questionnaire to find out their perceptions on the situation of a woman who sought abortion. Table 19 summarises their responses.

Table 19. Community Leaders' Perspective on Women Seeking Abortions in Kancheepuram District

	Never	Some-times	Often	Always	Total N	Missing Cases
In our community, a woman who seeks an abortion						
1. Worries that other people may find out about it	5	10	12	8	35	
2. Fears that people may suspect her character	8	7	11	9	35	
3. Stands a high chance of being humiliated	1	4	9	20	34	1
4. Will be subjected to gossip by the community	2	5	13	15	35	
5. May be judged by people as having sinned	4	3	8	19	34	1
6. Can talk about her abortion to someone close to her	6	21	4	3	34	1
7. Can trust that people close to her will not divulge the information to anyone else	9	20	1	5	35	
8. Will feel supported by people close to her about her decision	6	15	9	4	34	
9. Will feel confident that she made the right decision	13	3	7	11	34	1
10. Will not feel ashamed after having the abortion	11	8	2	14	35	

Source: Compiled from attitude scale used in the community meeting

The findings (table 19) indicate that abortion is best kept hidden, and women who undergo an abortion would worry if it was known to others. An overwhelming majority of the participants felt that a woman undergoing an abortion had a high chance of being humiliated (29/35) and would be seen as having sinned (27/ 35). A large majority of the participants felt that women who have aborted would fear of community suspecting her character. Almost all the participants (32/35) reported that users of abortion will be subjected to gossip by the community. It is evident that there is strong stigma and negative attitude towards abortion.

With regard to a woman seeking an abortion and her possible sources of support, most community leaders felt the woman would not be able to share the fact of having had an abortion with others. Interestingly, about half the participants thought that a woman who opts for an abortion would believe that she has made the right decision and will not feel ashamed about it. What one may infer from this is that although women faced stigma and humiliation, those who chose to have an abortion were sure about their decision.

CSO leaders

The five CSO leaders who participated in the study expressed the view that abortions are very important, as they protect women's, especially adolescent women's, health and life. They all believed that abortions were a woman's right and that there was a need for safe abortion services. Four of them repeatedly said that given the prevalence of premarital sex and sexual violence, abortions could help prevent many suicides. One of the leaders was of the view that they needed to work against sex-selective abortions by monitoring ultrasound centres, but at the same time needed to prevent unsafe abortions by promoting safe abortion services.

Abortion is viewed as a wrong deed. This should change and women should get access to abortion services, at the time of their need and there should be greater awareness about abortions (KII with CSO leader -1).

If you ask me about safe abortion it will be a question mark. Abortion within marriage is ok, but beyond marriage it is still a big problem, as it is a money-minting business. Why is there so much myth around this? You either have a baby or not.. It is like only after marriage you can have a baby, but there are other ways to have a baby. For example, (the film) director Karan Johar can have two babies. When celebrities have babies, we praise them, but when it happens to a common person, this is not accepted. (KII with CSO leader- 2).

As far as Tamil Nadu is concerned, abortion is not at all an issue. Even in India it is not a problem, but due to the new rule by the Bishop in Vatican City, it has become an issue. Roman Catholics do not have the right to abort, but if you ask the common people it is a common event. If women do not want to continue their pregnancy they have an abortion. Abortion services are freely available in the private sector but whether it is done safely and whether the women are aware of its legality are big questions. If you see a doctor they will provide an abortion if the women has a 'thali' (mangalsutra or symbol of marriage) around her neck (KII with CSO leader - 4).

Healthcare providers

In all, six healthcare providers were interviewed. These included one private doctor, three public sector hospital doctors and two auxiliary nurse midwives (ANMs) from public facilities. All the doctors were women and obstetrician-gynaecologists; two were over 50 years and two were in their early thirties, while the ANMs were aged 37 and 48.

As in Bihar, all the healthcare providers were given a tool listing specific circumstances under which an abortion was sought and they had to say whether an abortion should be provided in all circumstances under some circumstances, or under no circumstances in each case. Table 20 summarises their responses.

Table 20. Provider Views on Provision of Abortion Services in Kancheepuram District

	Circumstance	Should be provided under all circumstances	Should be provided under some circumstances	Should not be provided under any circumstances
1	A 20-week pregnant married woman, first pregnancy, whose mental health will be affected if the pregnancy is continued	1 private doctor, 1 government doctor, 2ANMs	2 government doctors: with the husband's consent	
2.	A 16-week pregnant married woman who has a serious heart condition and had been advised against getting pregnant	1 private doctor, 2 government doctors, 2 ANMs	1 government doctor: conditional on acceptance of permanent contraception	
3.	A 16-week pregnant unmarried woman with a lower limb disability indicating a complicated pregnancy	1 government doctor, 2 ANMs	Private doctor: if baby has congenital defects at 20 weeks	2 government doctors
4.	A 22-week pregnant 10-year-old whose pregnancy is a result of incest	1 private doctor, 2 government doctors, 2 ANMs	1 government doctor: with parents' consent	
5.	A 19-week pregnant 17 year-old whose pregnancy is from consensual sex	2 government doctors, 2 ANMs	Private doctor: with parental consent	

	Circumstance	Should be provided under all circumstances	Should be provided under some circumstances	Should not be provided under any circumstances
6.	A 19-week pregnant married woman whose USG shows evidence of a congenital disorder, trisomy 18	1 private doctor, 2 government doctors, 1 ANM	1 government doctor, 1 ANM: only if confirmed abnormality	
7.	A 16-week pregnant woman whose pregnancy is the result of rape by her husband	1 government doctor, 1 ANM	1 private doctor: if the patient wants a termination; 1 government doctor: depends on situation	1 government doctor, 1 ANM: she can continue the pregnancy
8.	A 16-week pregnant married woman who is pregnant because of the failure of oral pills used inconsistently	1 government doctor, 1 ANM	1 private doctor: termination up to 20 weeks if foetal anomaly 1 ANM: after confirming with scan results; 1 government – depends on the woman's circumstance	1 government doctor: she can continue the pregnancy
9.	A 6-week married woman who is pregnant because of the failure of the condom used by her husband	2 government doctors, 1 ANM	1 private doctor: if the patient wants termination	1 government doctor, 1 ANM: she can continue her pregnancy
10.	A 16-week pregnant married woman whose USG shows evidence of foetal anomaly	1 private doctor, 2 government doctors, 2 ANMs	1 government doctor: depending on the woman's circumstances	

	Circumstance	Should be provided under all circumstances	Should be provided under some circumstances	Should not be provided under any circumstances
11.	A 16-week pregnant married woman whose husband has been abroad for a year	1 government doctor, 2 ANMs	1 private doctor: if the patient wants a termination; 1 government doctor: depends on the woman's circumstances	1 government doctor: never
12.	A 16-week married woman, pregnant for the third time, has two daughters and the USG shows a female foetus			All doctors 2 ANMs

Source: Compiled from provider interviews

All the providers interviewed were against sex-selective abortions under any circumstances, but felt that abortions should always be provided to protect the physical and mental health of a married women. All except one public-sector doctor felt that abortions in married women were valid in all cases of foetal abnormality; the doctor who had reservations felt that an abortion may be performed only if the abnormality were confirmed by an ultrasound scan.

On terminating a pregnancy resulting from marital rape, only two out of the six providers said it should be provided; of the other two, the private doctor said it depends on the woman's situation and the government doctor stated that the woman should continue her pregnancy. Likewise, for contraceptive failure, two government providers were of the view that an abortion should not be provided. One of the ANMs felt that an abortion should not be provided under any circumstances for married women whose pregnancy was the result of spousal sexual violence or condom failure. In other words, some of the government providers believed that abortions should not be provided for unplanned and unintended pregnancies in married women, although these are the main reasons why most women seek an abortion.

Providers' views varied on the termination of pregnancies of unmarried girls below 18 years. In the case of incest or non-consensual sex almost all were of the view that an abortion may be provided in all circumstances with guardian or parents' consent. However, two government providers had reservations about abortions for an unmarried woman with a lower limb disability – they thought she could be a surgical risk for a D&C.

7.5 Consequences of the limited availability of and access to safe abortion services

As a result of the limited availability of services, denials, delays and negative attitudes of providers in public health facilities, many women from the marginalised sections and unmarried girls were forced to seek the services in private facilities. They had to incur very high out-of-pocket expenditures for obtaining an abortion, which many of them could ill-afford. Many abortion seekers faced various levels of humiliation and abuse; unmarried girls faced humiliation and stigma even in private facilities.

The failure to obtain an abortion could have extreme consequences for unmarried women. We heard stories of suicides and instances where young women were ostracised from society as single mothers.

For unmarried girls (not getting) an abortion is a big problem. There are chances that the girl may opt for suicide because of society's attitudes (women leader KII 5-SHG leader).

Ann unmarried girl will be kept apart, no one will mingle with her. She will face problems at home and also in society. She cannot live and people will not allow her to lead a peaceful life (FGD with unmarried women).

I will share one incident: a girl was working in a company and she used to talk with a boy. They entered into a relationship and the girl became pregnant, she was 18 years old. The girl's family came to know about the relationship and asked the girl not to go to work and the boy went back to his native place. People from the village took the girl to his native place, and they came to know that he was already married and had cheated the girl. The girl delivered a baby and is staying with her mother now. If she had had an abortion, she could have married, and her life would be different. She was from a poor family and there was no one to support her …. now she is struggling alone and stays with her mother (women leader KII-4, SHG leader)

7.5.1 Unsafe abortions and their negative consequences

Unmarried women and many married women who cannot afford private abortion services opt to visit either the informal providers who may use medical or surgical abortion methods or cruder techniques, with serious negative health consequences:

People who need abortion services first go to registered practitioners or the RMOs, get a scan and all the reports. Some women are told that an abortion cannot be done, so they go to the informal providers, which may lead to their death. In a nearby village named P…. two or three women died due to unsafe abortions, the police even arrested the informal service provider, but it continues and there is no end to such practices. This incident was even highlighted in the media, but it is of no use, these practices still continue (KII CSO leader-3)

I read in a study that almost all unmarried girls in a village near Thirupporur who are working in factories have had abortions. The doctor (informal provider) there is providing only abortion services. Young women work in companies and for unintended and unplanned pregnancies they have abortions from this doctor, but I feel that 99 % there is no safety (KII CSO leader-4).

7.5.2 Self-induced abortions

With the availability of MMAs, women have been spared these extreme options. Those who cannot afford private abortion services can now access the medical abortion drug pack containing mifepristone and misoprostol from a local pharmacy and self-induce an abortion at home. When women use the pack for an early abortion and have accurate information on how to use the drugs, the abortion process and what to do in case of complications, the method can be perfectly safe. Unfortunately, most women do not have access to such information. As a consequence, many use the method beyond the period of gestation for which the pack may be effective, or use it inappropriately, and may not know what to do to confirm that the products of conception have been completely expelled.

Medical abortion drugs are freely available and self-induced abortions are common; every month we get two or three cases of missed abortion, and I am handling these. (The drugs are) taken during the second trimester, and continuing the pregnancy is dangerous, but many women are not aware of it (Provider KII 1- gynaecologist).

In many instances, it is not certain if the drug dispensed was a MMA or some other drug used to induce an abortion. The descriptions merely state that some drugs from a pharmacy were taken:

A poor woman in my village had self-medication for an abortion as her previous child was one-and-half year old. Her husband bought the drugs from a pharmacy and after taking it she had excessive bleeding and approached me. She was very anaemic, and we sent her to the government hospital where she was saved. She was hospitalised for more than a week (provider KII-5, ANM).

It is unfortunate that in a state such as Tamil Nadu, well-resourced in human resources and infrastructure in health, a service that women need badly is not available, leading to these consequences.

8 SUMMARY AND THE WAY FORWARD FOR ADVOCACY

8.1 Key findings from the study and reflections

This baseline research study had three major objectives. The first was to obtain an overall picture of the extent of support for safe abortion from the government and CSOs and to understand the perspectives of CSOs, community leaders, local women leaders, women, and healthcare providers at various levels, on abortion as a women's rights issue. The second was to generate evidence on the availability of affordable, safe abortion services in public and private health facilities, and the consequences for women. The study was carried out in one district each in the states of Bihar and Tamil Nadu, two states with vastly differing socio-economic, demographic and health-system contexts.

In terms of support from the government for safe abortion services, there are indications of a commitment to improve services. The Bihar government has implemented a public-private partnership (Yukti Yojana) to provide low-cost first-trimester abortion services through empanelled private hospitals. However, in Nawada, the study district, none of the study participants had heard of this scheme. There are no comparable initiatives by the Tamil Nadu government to promote affordable access to safe abortion services, although the government had formulated a Comprehensive Abortion Policy (CAP) as early as 2011 and has allocated resources for training in MVA techniques for medical officers and staff nurses and for the distribution of MMA kits to CHCs.

How does this compare with the scenario in other states or at the national level? There are few Indian studies that have analysed the extent of government support for safe abortion services. Two key documents were produced by the national Ministry of Health and Family Welfare: the first (in 2010) issuing guidelines on comprehensive abortion care, and the second (2015) provided guidance on not compromising safe abortion services for the prevention of gender-biased sex-selection (Government of India 2010; Government of India 2015b). Seemingly, there is some policy and planning commitment to making safe abortion services accessible, although this is nowhere near being an important priority.

In Bihar, civil society engagement in safe abortion information, services and advocacy is constrained. This is because many are bound by the global 'gag rule' which prohibits organisations from working on abortion services, even with their own funds or funds from non-Indian sources. As a consequence, many field-based NGOs working on MCH/FP are not allowed to engage with safe abortion information, advocacy or provision. The impact on access to safe abortion for Indian women of this rule, which was expanded in scope under the Trump administration, has been the subject of several news stories. Some have pointed out that to restrict NGOs from providing services that are legal in India was tantamount to interfering with national sovereignty. US government sources fund governments and NGOs in some of India's least-developed states in India with weak health infrastructure, and their negative role would affect the most vulnerable groups of Indian women (Pasricha 2017, Rao 2017).

Many local NGOs and CBOs in Bihar are active in monitoring the implementation of the Pre-Conception and Pre-natal Diagnostic Techniques (Prevention of Misuse) Act (PCPNDT Act, for short) to prevent abortions for gender-biased sex-selection. The history of female infanticide in selected districts of Tamil Nadu has influenced the women's movement's involvement in its prevention and, subsequently, in the prevention of sex-selective abortions, including through campaigns to ban second-trimester abortions. These phenomena are not unique to Bihar and Tamil Nadu. The 'inappropriate linking' of the Medical Termination of Pregnancy (MTP) Act and the PCPNDT Act was pointed out almost 15 years ago (Hirve 2004). A number of other articles and even a guidance document by the Indian government have remarked on how conflating the two Acts had created confusion among the public on the legal status of abortion in India and affected attitudes to safe abortion (Prasad 2015, Gulati 2016, Government of India 2015b). One commentary described an instance where pro-life groups had used this confusion to attack the act of abortion per se, with slogans such as 'one life is taken and another harmed' (Prasad 2015).

Despite the limited government and CSO support for safe abortion in the two states, there have been some positive trends. The presence of a large number of local CSOs and CBOs and their engagement at the community level are important factors in both states, while in Tamil Nadu the strong government health infrastructure and government's resource allocation for MMA and MVA hint at possibilities for expanding availability and access to these methods.

The availability of abortion facilities was below the recommended norms in the sample districts of both states: 1 facility per 370,000 people in Nawada, Bihar and 1 facility per 70,000 in Kancheepuram, Tamil Nadu. Our study shows a far lower availability than comparable figures from the Guttamacher studies in Bihar and Tamil Nadu, which were 1 facility for a little over 67,000 population and 1 per around 29,000 population, respectively[11] (Stillman et al. 2018, Alagarajan et al. 2018).

The facilities tended to be concentrated in urban locations in both states, and abortion services were predominantly provided by the private sector. However, while in Nawada private providers were mainly unqualified non-medical providers, in Kancheepuram the vast majority of private providers were MTP-trained professionals. These are in line with recent studies on the two states (Stillman et al. 2018, Alagarajan et al. 2018), and earlier studies for Bihar and Jharkhand (Aich et al. 2011a, 2011b).

Second-trimester abortions were reportedly highly restricted especially in public institutions, but also in private, in both Nawada, Bihar and Kancheepuram, Tamil Nadu. In Kancheepuram this was despite the presence of 6-9 trained gynaecologists in the hospital and operation theatre facilities. Other studies have reported that 24 per cent of public facilities and 28 per cent of private facilities in Bihar provided second-trimester abortions, with comparable figures for Tamil Nadu being 17 per cent and 15 per cent, respectively (Singh et al. 2018).

Respondents in our study reported that government hospitals often refused to provide abortions to unmarried young women or subjected them to abusive and disrespectful care. Married women reported having to make multiple visits in order to obtain an abortion in a government health facility. HIV-positive women in Tamil Nadu found it especially difficult to negotiate the government health system because

11 Population estimates for 2018 for the two states were divided by the number of estimated facilities providing induced abortion services (total facilities minus those providing only post-abortion care) from the Guttmacher studies (Stillman et al. 2018, Alagarajan et al. 2018) to arrive at these figures.

of their health status. The delays would often result in women exceeding the legal gestational limit for an MTP, in which case they would be denied the service. In both states, public facilities insisted on both married and unmarried women being accompanied by their husbands or 'guardians' who had to consent to the procedure. Moreover, abortion services appeared to be provided conditional on women's acceptance of post-abortion contraception. Other studies corroborate women's preference for private facilities and the existence of barriers such as the need for consent from the husband or guardian, even for adult women (Singh et al. 2018, Sebastian et al. 2014). However, very few studies have documented the abuse and humiliation faced by unmarried women and the specific difficulties encountered by HIV-positive women.

The costs of private abortion services by a qualified medical professional were very high. In Bihar, it was almost equal to the per capita average daily income for about 77 days; the comparable figure for Tamil Nadu was a little over 30 days' of the per capita income. Private services would be unaffordable for women from low-income groups and marginalised sections in both states, although much more so in Bihar.

Unable to access affordable services in public or private facilities sector, many women resorted to self-medication with drugs dispensed by pharmacists. Some women, usually from the most vulnerable sections, resorted to unsafe abortions with serious negative health consequences. In extreme scenarios, unmarried mothers denied abortion services were ostracised by their community or, according to stories shared by respondents, even took their own lives.

The availability of MMA combi-pills in pharmacies offers women some respite in these extremely difficult situations and indicates why the Guttmacher studies in Bihar and Tamil Nadu (2015) found a majority of abortions taking place outside health facilities (Stillman et al. 2018, Alagarajan et al. 2018). However, important concerns remain. One is the finding from other studies (Ganatra et al 2005) that when asked for drugs to induce an abortion, pharmacists dispensed a wide range of drugs other than MMA not considering that these may not only be ineffective but also unsafe and harmful to women, causing complications that would require medical attention.

The second is the finding from our study that most women respondents had only heard about MMA but did not know how to use it safely and effectively. A systematic review of self-medicating women using mifepristone and misoprostol found that only about a third took the pills as prescribed (Sharma et al. 2018). The Guttmacher study in Bihar and Tamil Nadu reported that 51 per cent and 33 per cent, respectively, of all women seeking care from health facilities for post-abortion complications did so for incomplete abortions following the use of MMAs (Stillman et al. 2018, Alagarajan et al. 2018). The women may or may not have experienced incomplete abortions, but because of the lack of information panicked and sought medical help when bleeding continued for several days. On the other hand, it is also possible that many women used the drug incorrectly or for gestational periods above nine weeks of pregnancy. The incorrect or inappropriate use of MMAs which led to hospitalisation would, even if the complications were not severe, result in considerable OOP expenditure which many women can ill-afford. The review by Sharma et al. (2018) found that 68 per cent of the women who had self-medicated had to undergo a surgical abortion subsequently, while 14 per cent required a blood transfusion and about 4 per cent needed a laparotomy.

People's awareness about the legal status of abortion was limited overall. There was also confusion between sex-selective abortions being illegal and all abortions being illegal, as has been reported by other studies and cited earlier in this section.

Abortions appeared to be strongly stigmatised in both states, with some differences. In Tamil Nadu, there was strong support from local leaders and older women for abortion, but younger women across castes considered an unintended pregnancy as completely within the power of a woman to avoid, and an abortion to terminate an unintended pregnancy as unjustifiable. Community leaders in both states thought that women seeking abortions were likely to be humiliated, gossiped about, and considered immoral, and unlikely to receive any support from their peers and family members.

Not many Indian studies have focused on the stigma of abortion, factors influencing it, and its consequences. A few studies make a passing mention of some issues related to the stigma. A 2007 study from Madhya Pradesh noted that most women who sought post-abortion care had relied on unsafe providers or induced abortions themselves mainly because of the social stigma related to the termination of a pregnancy (Banerjee et al. 2012). One study cited the stigma related to abortions as a reason why women preferred to self-medicate (Sharma et al. 2018). It is possible that fear of stigma keeps women away from the few public facilities that perform abortions. There have been news features and blogs that vividly describe women's experiences of the stigma around an abortion, and how these create formidable barriers to accurate information and timely services (Suresh and Kurian 2018, Youth Ki Awaz 2018).

The attitudes of providers towards abortions were most disconcerting. They generally opposed abortions for married women with an unplanned or mistimed pregnancy, and seemed to believe that if the father is the woman's husband there was no reason for her to opt for an abortion. Attitudes towards providing abortions to unmarried girls were mixed, with some willing and others unwilling to do so. Their overall attitude towards women with an unwanted pregnancy was one of disdain for not having used contraception to avoid the situation. Providers did not seem to be aware of the gendered circumstances that lead to unintended pregnancies.

Studies from Kerala and West Bengal report that 60 per cent and 38 per cent of providers, respectively, had a negative attitude towards providing abortion services and were willing to provide abortions mainly in the case of a foetal anomaly or rape, or under life-threatening circumstances for the woman (Chowdhury 2012, Pyne 2015). Another study remarked that because of stringent government action to prevent gender-biased sex-selection, 'providers are gripped by fear of prosecution,' and thus unwilling to provide abortion services (Sebastian et al. 2014). These negative attitudes contribute to legitimising a stigma towards abortion, and burdening women with unnecessary guilt, in addition to being denied the services (Suresh and Kurian 2018, Youth Ki Awaz 2018).

8.2 The way forward for advocacy

In this section, we draw on the findings from this study to outline priority areas, potential target audience and strategies for advocacy for safe abortion services over the next few years (2019-22). CommonHealth would aim to implement these in selected states in the country, including the two covered by this study.

8.2.1 Priority areas

- A key priority for advocacy would be to improve the availability of abortion services in all public facilities. The focus should be on providing quality medical abortion services to all women, including those from marginalised communities (HIV-positive, poor, and Dalits) in PHCs and CHCs, so that services are available closer to their homes.
- Another priority would be to enhance people's knowledge and awareness about the legality, public health importance, and the availability of various abortion options and services.
- To address the stigma and negative attitudes towards abortion, a third priority would be to work towards creating champions who advocate for women's right to safe abortion among key constituencies at all levels (local, state and national). The special focus would be on creating champions among health professionals and students training to be health professionals.

8.2.2 Target audiences and potential strategies

Increasing the availability of abortion services in public-sector facilities

This would require legal and policy review and state-level advocacy with three key groups: health personnel and policy-makers; professional bodies such as the Federation of Obstetricians and Gynaecologists of India; and SRHR advocates who can influence key decision-makers and service-providers.

At the district and local levels, advocacy would also help make health administrators and qualified healthcare providers aware of the barriers to safe abortion services and address these so as to enhance access.

Strategies that could potentially influence these advocacy audiences are:

- Documenting and publicising best practices by state governments to promote safe abortion services;
- Working with health facility managers and healthcare providers to creating model safe abortion service facilities at PHCs and CHCs;

- Presenting evidence documenting the absence of safe abortion services, and its impact on women's health and their lives; and
- Continuing to generate evidence on women's lived realities and their experiences with unintended pregnancies and accessing safe abortion services.

Enhancing the levels of knowledge and awareness

The audience for this would be key constituencies at the community level and the general public. Examples of community-level audiences include members of local government, women members of SHGs, school teachers, members of adolescent and youth groups, and front-line health workers such as ASHAs, ANMs and anganwadi workers who run adolescent SRH education programmes.

Community-level work may be led by CommonHealth members in selected states, through workshops, meetings and public education materials in various formats. Knowledge and awareness among the general public could be enhanced through a multi-pronged approach using print, electronic, visual and social media that reaches across various population sub-groups.

Facilitating the emergence of champions for women's right to safe abortion services

The audience for this would be community leaders and representatives of community groups mentioned in the previous section, CSO leaders at the state level, the media and, most importantly, health professionals and students of medicine and other health professions. CommonHealth could leverage its work with CREA and work with like-minded NGOs and technical agencies to organise value-clarification workshops for community and CSO leaders, the media and health professionals/ students in health professions. Through these workshops and through networking, champions for women's right to safe abortion services may be identified. A portfolio of activities may be developed for each category of champions, to be carried out over two to three years.

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ANNEXURE: STUDY TOOLS

RFSU-ARROW Project on Claiming the Right to Safe Abortion: Strategic Partnerships in Asia

Study on availability of safe abortion services and perspectives of actors on right to safe abortion in the state of Bihar and Tamil Nadu, India: CommonHealth, India

OUTLINE FOR SITUATIONAL ANALYSIS OF ABORTION IN BIHAR AND TAMIL NADU

SECTION 1: BACKGROUND INFORMATION ABOUT THE STATE

1.1 **General information and indicators:** Location; Number of districts, Population[12], SC and ST Populations, Proportion of youth and young population by sex, rural-urban; Literacy rates by sex, State Domestic Product and economic growth rate over the past few years

1.2 **Health indicators:** Prevalence of anaemia among married women, adolescent girls and children. Life expectancy at birth, IMR, U5MR, MMR, % institutional deliveries, doctor/population ratio, bed/population ratio, per capita spending on health: total, public and private, OOPE on delivery care; (normal, c- section) by public and private. Prevalence of gender- based violence against women.

1.3 **Indicators related to need for abortion:** Total fertility rate, wanted fertility rate, Contraceptive prevalence rate -spacing and limiting methods; unmet need for contraception both spacing and limiting, birth intervals, % whose most recent pregnancy was mistimed or unwanted, son preference. OOPE on abortion by public and private.

1.4 Availability of various spacing methods of contraception in the public health facilities; for example non availability of oral pills and EC pills in TN

SECTION 2: THE MACRO SCENARIO – POLICIES, PROGRAMMES AND ADVOCACY

2.1 Government policies and programmes, and NGO/INGO/ private sector activities and initiatives related to safe abortion services; betibachao and other programmes to save the girl child; PC/ PNDT implementation

2.2. Inclusion of abortion in recent PIPs, allocation of budget, any specific initiatives such as PPPs

2.3. Is there active support for, or opposition to safe abortion, implicit or explicit, from any constituency (including medical professionals, religious or caste-based groups, Civil society groups)

2.4. Who is involved and what has been done over the past few decades? What can we say about the positions of different players w.r.t. abortion, sex-selection?

12 All data should preferably be disaggregated as Rural M and F/Urban M and F/ Total M and F

SECTION 3. STUDIES AND REPORTS ON ABORTION (Look for studies also on specific vulnerable groups)

3.1. What do we know about: abortion rates and ratios? Changes over time?

3.2. Profile of abortion users (age, education, rural/urban location, parity, month of pregnancy)

3.3. Reasons for abortion

3.4. Decision-making processes and barriers to seeking services

3.5. Abortion stigma

3.6. Proportion of first versus second trimester abortions

3.7. Average number of induced abortions/ woman, Proportion had two and above abortions, or undergone repeated abortions, Post abortion complications and care seeking behaviours

3.8. Whether accepting contraception after MTP

3.9. Where are services received? (Government versus private, formal versus informal)

3.10 Method of abortion: medical, MVA, D&C, D&E

3.11. Availability of facilities and providers for provision of safe abortion services Pre and post abortion counselling

3.12 Any reports on provider attitudes to abortion provision, provider refusal to provide abortions etc.? Examples of good practice?

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Facility checklist

Instruction:

The information should be sought from the medical officer or senior resident in the facility. The researcher should move around the facility to observe the physical standards. Three PHCs that are geographically dispersed and are most functional should be selected. The hospitals at the taluka and district level should also be selected. One private facility in the district to be included too.

Code number of the facility:

State/ District/ Taluk / Village:

Name of the respondent:

Designation:

Age:

Marital Status:

Years of experience:

Date of visit to facility:

1. How far is the facility from main road? Note down the distance and time required from main road to reach the facility.
2. What is the kind of public transport is available? (bus, train, auto)
3. Are MTP services available at the facility? If no why?
4. If MTP services are available, does the facility have trained & registered medical officer to perform MTP? How many providers have been trained to provide MTP services? What are their qualifications? (Medical Officers, Gynaecologists)
5. What are the methods for MTP available at the facility? (Medical Abortion, MVA, D and C, D and E,)
6. Are medical abortion drugs available at the facility? Or are women expected to buy from outside.
7. Until what stage of gestational age are MTP services available at the facility? (8 weeks, 12 weeks, 20 weeks)
8. Observe and describe the place where MTP is provided- is there a waiting area for women? Where is post abortion care provided? What kind of privacy is available - audio, visual? What are the procedures for protecting confidentiality and seeking informed consent?

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Guidelines for KII with Health Care Providers

1. Location of facility – Rural/ Urban
2. Type of facility
3. Date of interview
4. Name of interviewee
5. Age of interviewee
6. Gender of interviewee
7. Religion of interviewee
8. Area of upbringing Rural Urban
9. Marital status – Married /Single
10. Professional qualification
11. Have you undergone MTP training? Where? For which methods? (MA, MVA, D&C, D&E, etc.)
12. If trained, are you providing MTP?
13. If yes, how many have you provided in last 3 months and which methods?
14. What are the formalities for women seeking abortion- consent, method and so on
15. If not providing MTP, what are the reasons?
16. What are the reasons for which women seek abortion in this area?
17. Are you aware of any instances of unsafe abortion? Can you describe these?
18. Some studies have reported that women present with self-induced abortion. Do you also receive such cases? (Also probe for medical abortion) what are the reasons for this?
19. What are the consequences of unsafe abortion?
20. Can MTP services be provided when women in these circumstances seek it?

Statements

		Should be provided under all circumstances	Should be provided under some Circumstances Explain	Should be provided under no circumstances
1	A 20 weeks pregnant married woman, first time pregnant, whose mental health will be affected if the pregnancy is continued			
2	A 16 weeks pregnant married woman who has a serious heart condition and had been advised against getting pregnant			
3	A 16 weeks pregnant unmarried woman with a lower limb disability indicating a complicated pregnancy			
4	A 22 weeks pregnant 10 year old whose pregnancy is a result of incest			
5	A 19 weeks pregnant seventeen year old girl whose pregnancy			
	is because of consensual sex			
6	A 19 weeks pregnant married woman whose USG has shown evidence of a congenital disorder, trisomy 18			
7	A 16 weeks pregnant woman whose pregnancy is the result of rape by husband			
8	A 16 weeks pregnant married woman who is pregnant because of the failure of oral pills used inconsistently by her			
9	A 6 weeks pregnant married woman who is pregnant because of the failure of the condom used by her husband			

		Should be provided under all circumstances	Should be provided under some Circumstances Explain	Should be provided under no circumstances
10	A 16 weeks pregnant married woman who is pregnant and an			
	USG has showed evidence of fetal anomaly			
11	A 16 weeks pregnant married woman who is pregnant when her husband has been abroad for a year			
12	A 16 weeks pregnant married woman who is pregnant for the third time has two daughters and USG shows a female fetus			

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GUIDELINES FOR KIIS WITH WOMEN LEADERS

(Anganwadi workers, TBA and SHG women)

I. Background Information

1. Name of the village/locality name, Panchayat/ Municipality and taluk
2. Whether it is Rural/ Urban
3. Respondent Reference number/ Name
4. Age in completed years
5. Religion
6. Caste
7. Number of years of schooling
8. Occupation
9. Marital Status
10. Total number of pregnancies that you had, no of children born; male, female, surviving children; male, female.
11. For TBA. Did you undergo training for conducting delivery? If yes when and where?
12. For Anganwadi worker, how long have you been working in the department, and in this centre?

II. Guidelines for interview

Availability and utilisation of Maternal Health care facilities:

1. What are the most common health problems experienced by people in this area and where do they seek treatment for these problems?
2. What are all the health problems of women in the area? What are the health facilities used for treating these problems? (Probe regarding - general health, pregnancy, other gynaec problems for example RTI, Uterine prolapse). Do they go to government or private facility. Is there any preference and why. .If private, is it doctors or informal providers.
3. What kind of contraceptive services are available in your area? Where are contraceptive services available? What are the commonly used methods ? Why? (Probe for poor utilisation of spacing methods).

4. Which are the government health facilities near your area? How far are the facilities? Which government facilities are more used by women for maternal health? Which facilities are used for gynaecological problems? What is the basis for this choice?

5. What are all the private health facilities that provide maternal health and gynaecological care services in your area? (Probe for private nursing homes, medical colleges, and others). Which of these is more used by women in your area. Why?

III. Availability and utilisation of Abortion services

1. As we all know there could be times when a pregnancy is not wanted/not planned. What do women do in such circumstances? Who decides what should be done?

2. Why do women end up with unwanted pregnancy- what are the common reasons?

3. Is this pathway different for married and unmarried women? Please describe in what ways it is different and the reasons for the same.

4. Are abortions legal? Probe- gestational limit, reasons, marital status, consent

5. Which are the government facilities in your region that provide abortion services and which are more accessible to women? Why?

6. Up to how many weeks/months of gestation MTP are done in each of these facilities? What methods of abortion are done to terminate 1st & 2nd trimester pregnancies?

7. Which facilities are predominantly used by women? (Probe separately for PHC, CHC Taluk and District hospitals; private; formal and informal providers).

8. In earlier days there were informal providers who provided abortion services using herbal medicines, sticks, applying pressure etc. Are there still such persons in this area? If yes how many. What method of abortions are used by them to terminate first trimester and second trimester ?.

9. What is your opinion about the availability and accessibility of abortion services in the public and private sectors in your area?

10. According to you, is there any difference in the nature of the abortion services provided in the public and private sectors? If yes what ways they are different?.

11. Do women ask your advice on where to seek abortion services? If yes, where do you suggest they go?

12. Are there instances of abortion not provided for women who want it? If yes, which group of women and why?

13. What do you think are the most important barriers to women in accessing safe abortion services?

14. What are your recommendations to the government for improving access to abortion services?

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Guide for FGDs with women

Instruction:

Before beginning the group discussion, the researcher should have contacted individual women and sought their informed consent. Once the group has been formed, introduce the purpose of the study to the entire group, read the informed consent letter to the entire group and explain to the members that they may withdraw participation now or at any stage of the discussion.

Participant profile

Age

Marital Status

Education

Occupational Status

No of pregnancies

No of living children

Use of contraception

Place

Date

State

FGD Group

Guideline questions

1. What are the most common health problems experienced by women here?
2. Which health care facilities do women go to for treatment of these problems? (Probe regarding - General health, Pregnancy related , other gynaec/women's health problems)
    a. Do they go to government or private facility? If private, is it doctors or informal providers?
    b. What is the basis for choice of facility? (Probe- Cost of treatment, distance to facility, type of women's health problems)
3. What are the services available for pregnant women?
4. What kind of contraceptive services are available? From where are they available? What are the commonly used methods?

5. As we all know there could be times when a pregnancy is not wanted/not planned. What are the reasons that women end up with unwanted/unplanned pregnancies? (Probe: for married and single women)

6. What do women do in such circumstances? (Probe: Who decides what should be done? Is abortion an option? Is this pathway different for married and unmarried women? Please describe in what ways it is different and the reasons for the same.)

7. How common is abortion in this community? What is the perception about abortion in community, family? What are the reasons for these perceptions? (Probe- abortion within marriage /outside marriage, what are the reasons acceptable for abortion?)

8. Where are abortions sought? What kind of abortions (methods) women go for? What is cost of MTP services? (Probe for formal and informal providers)

9. Have you heard of abortions using tablets? What do you feel about it?

10. How safe is abortion for women? Have you heard of any health problem arising out of abortion?

11. Do you think abortion services are easily available? What are the consequences of lack of availability or difficulty in accessing

12. Have there been instances where women went to heath facilities and they did not get it? What are those circumstances? (Probe for government and private)

13. Have methods for abortion changed over the years? In some places, there were instances of use of herbal paste, insertion of sticks, and so on. Does this happen in your area?

14. Have you heard of any deaths or health problems due to unsafe abortion? (Any example they know of or heard of without revealing identity)

15. Are abortions legal? (Probe- gestational limit, reasons, marital status, consent, coercion)

16. What are your recommendations to the government for improving access to abortion services?

17. Should safe abortion services be available to women without any restrictions? (Probe reasons for Yes or No) What are the consequences for women who don't want to continue with the pregnancy?

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Draft agenda for Meeting of Community Leaders

(Panchayat members, SHG leaders, Teachers and youth Leaders)

Time	Session Topic	Content	Method
10.00-10.30 AM	Registration		
10.30-10.45 Am	Introductory Session	• Welcome address • Introduction to Participants Background of the meeting • Aim and objectives and expected outcome • Overview of the issue on safe abortion	
10.45- 11.30 AM	Understanding the Social Values about abortion	• Social and family values on abortion; • How decisions are taken in the family • How it is women's rights; adolescent girls, married and single women' s right	Small group work Using real life stories from "Women's voices" workshop Large group discussion
11.30-11.45	Tea Break		
11.45- 12.00 PM	Attitude assessment	• Attitudes to women's rights abortion	Self-administered Attitude scale

12.00 -12.30	Availability of safe abortion services	• Mapping of facilities and abortion methods used	• Using area map, mark facilities that provides MTP services; Public sector • Private sector (formal/ Informal) • What type of abortion is done in each facility
12.30- 1.15	Barriers in access to safe abortion	• Group Discussion • Family and social level • Availability and accessibility- Provider level • Government and private providers • Formal and Informal providers • Etc…	Open Discussion
1.15-2.15 PM	Lunch Break		
2.15- 3.15	Awareness and knowledge about Abortion	• Legal status- start from basic question on Is it legal in India • Under What circumstances/ conditions abortion is legal • Consent • Who are certified providers • Up to – months of gestation • Methods of abortion	Quiz Two or three groups Four rounds; first round very basic, second and third round moderate and final round detail questions 10 questions; At the end we will provide materials; video shows as a part of education.
3.15-3.20	Conclusion and Thanks note		

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COMMUNITY ATTITUDES SCALE FOR USE IN COMMUNITY LEADERS' MEETING

In our community, a woman who seeks abortion

		Never	Sometimes	Often	Always
1.	Worries that other people may find out about it	0	1	2	3
2.	Fears that people may suspect her character	0	1	2	3
3.	Stands a high chance of being humiliated	0	1	2	3
4.	Will be subjected to gossip by the community	0	1	2	3
5.	May be judged by people as having sinned	0	1	2	3
6.	Can talk about her abortion to someone close to her	3	2	1	0
7.	Can trust that people close to her will not divulge the information to anyone else	3	2	1	0
8.	Will feel supported by people close to her about the decision to have an abortion	3	2	1	0
9.	Will feel confident that she made the right decision	3	2	1	0
10.	Will not feel ashamed of herself because of having the abortion	3	2	1	0

Guidelines for KII with CSO leaders

Guidelines for KII with CSO leaders

Name of the organisation:

Location: (State, district/ city)

Geographic area of operation

Name of person interviewed

Position in the organisation

Date of interview

1. Can you give a brief description of your professional background, nature of work in the organisation and number of years you have been associated with the organisation?

2. As an organisation working on (women's rights / health / rights of specific marginalized groups, as the case may be), what are the thrust areas of your work?

   (If abortion or sex-selection is not mentioned, then probe to find out if they are engaged in any activities related to a) preventing sex-selection b) promoting women's access to safe abortion)

(If working on safe abortion access, or both prevention of sex-selection and safe abortion access)

3. Can you describe the objectives of your work, and the nature of your activities, target groups that you work with, strategies you employ related to (sex-selection/ safe abortion / both)

4. What have been some major events and achievements related to these in the past year?

5. Have you faced any challenges in implementing these activities?

6. Who are the other major organisations that work in this (subject) area?

7. Are there any joint activities or events that you have carried out with any of them?

8. What is the extent and nature of support from government for your work?

9. What are some recommendations that you would like to make to the government for improving access to safe abortion services?

(If working only on sex-selection but not on safe abortion access)

10. Can you describe the objectives of your work, and the nature of your activities, target groups that you work with, strategies you employ related to prevention of sex-selection?

11. What have been some major events and achievements related to this area of work, in the past year?

12. Have you faced any challenges in implementing these activities?

13. Who are the other major organisations that work in this (subject) area?

14. Are there any joint activities or events that you have carried out with any of them?

15. What is the extent and nature of support from government for your work?

16. Has your organisation considered working on access to safe abortion services at any time? Are there any specific reasons why it is not engaged in this issue?

(for all respondents)

1. What is the scenario in your state w.r.t. safe abortion? Is there a demand for safe abortion services?

2. Are services available to women who need it? Are they mainly in the public sector, or in the private sector? What methods of abortion do they provide?

3. Are there informal providers (modern / traditional) of abortion services? What methods of abortion do they provide?

4. Is unsafe abortion a problem in the geographic area where you work?

I would to ask you now about important tasks related to prevention of sex-selection of promoting access to safe abortion that your organisation plans to undertake in the immediate future?

Any other comments or observations that you would like to make

Thank you for your valuable time.

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INFORMATION SHEET AND INFORMED CONSENT FOR SURVEY FGDs WITH WOMEN

Namaste, my name is _____, and I am part of a research team engaged by CommonHealth, a National Coalition working on reproductive health and safe abortion.

In this research study we are trying to understand what women do when they are faced with an unplanned pregnancy, how decisions are made on whether or not to continue with the pregnancy, and whether women have access to information and services for safe termination of pregnancy, if they choose not to continue with the pregnancy. We are talking to women in different villages about these issues and have invited a group of you here to participate in a group discussion.

No personal benefits will be gained from participating in this study. But this study will contribute to advocacy with the government to improve access to safe abortion services for all women. Participation in this discussion will take about one hour. We also seek your consent to audio-record the discussion.

Whether to participate or not in this study is completely voluntary. If you decide to participate, you could also decide to stop participating at any time. You are not required to answer questions that you are not comfortable with. The answers will be kept confidential and you name will not appear anywhere. You are not expected to share any personal experiences in the discussion. If you are sharing the lived experience of another woman, please do not share her identity.

The information that we collect from this research project will be kept confidential. Background information about the interviewee and the health facility that we collect in the field will be detached from the transcripts and stored in a file that will not have any name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the principal investigator. Data and transcripts will be entered in the computer with unique code number no identifiers will be presented in the document. The computerised data will be protected with password protection.

No individual names/ facilities or identifiers, will be presented in the report, only consolidated figure/ responses will be provided. The data will be thoroughly analysed and the results will be published. The findings of the study will be mainly used to advocate with different stakeholders for promoting the availability of safe abortion services in India. The study results will be released in a form of research report and article. The published report will be shared with key policy makers and other stakeholders and we also plan to conduct dissemination meetings with the key persons in the respective states. The results will help the NGO's in the state and CommonHealth to prioritise their work on safe abortion.

You are free to ask us, if you have any questions about this study. We will do our best to answer. For any further clarifications, you may also contact the person from CommonHealth responsible for this study: Professor Sundari Ravindran, at ravindransundari@gmail.com or mobile number: 09447757974

The institutional review board of Rural Women's Social Education Centre, Thirukazhukundrum, Tamil Nadu has reviewed and approved the study.

DECLARATION

We hereby declare that we have been given the above information regarding the study *"Availability of safe abortion services and perspectives of actors on right to safe abortion in the state of Bihar and Tamil Nadu, India."* We also understand that my participation is entirely voluntary, and that we are free to discontinue the study at any time. We understand that our identities and the given information will be kept strictly confidential. We do agree to take part in this study, and for the discussion to be audio-recorded.

S.No.	Respondent's name	Age	Signature

Date:

Place: Village:
Taluk
District

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INFORMATION SHEET AND INFORMED CONSENT FOR IDIs WITH TBAs, ANGANWADI WORKERS AND SHG LEADERS

Namaste, my name is _____, and I am part of a research team engaged by CommonHealth, a National Coalition working on reproductive health and safe abortion.

In this research study we are trying to understand what women in the community do when they are faced with an unplanned pregnancy, whether women have access to information and services for safe termination of pregnancy; which are the health facilities they go to and why, and what difficulties they may face in terminating an unwanted pregnancy. We are talking to knowledgeable women in different villages about these issues and seek your participation in this capacity.

No personal benefits will be gained from participating in this study. But this study will contribute to advocacy with the government to improve access to safe abortion services for all women. Participation in this interview will take about 30-45 minutes. I would like to audio-record the interview with your permission. If audio-recording is not acceptable to you, I shall take notes of the interview.

Whether to participate or not in this study is completely voluntary. If you decide to participate, you could also decide to stop participating at any time. You are not required to answer questions that you are not comfortable with. The answers will be kept confidential and you name will not appear anywhere.

The information that we collect from this research project will be kept confidential. Background information about the interviewee and the health facility that we collect in the field will be detached from the transcripts and stored in a file that will not have any name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the principal investigator. Data and transcripts will be entered in the computer with unique code number no identifiers will be presented in the document. The computerised data will be protected with password protection.

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The institutional review board of Rural Women's Social Education Centre, Thirukazhukundrum, Tamil Nadu has reviewed and approved the study.

Participant's name:

Age:

Address:

I …….. hereby declare that I have read the above information regarding the study Availability of safe abortion services and perspectives of actors on right to safe abortion in the state of Bihar and Tamil Nadu, India". I also understand that my participation is entirely voluntary, and I am free to discontinue the study at any time. I understand that my identity and the given information will be kept strictly confidential. I do agree to take part in this study. I also agree that my interview may be audio-recorded (strike-off this sentence if permission for audio-recording is not given)

Respondent signature/ Thumb impression: ……

Interviewer signature: ……

Witness' signature (in case of thumb impression):……

Date:

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INFORMATION SHEET AND INFORMED CONSENT FOR IN-DEPTH INTERVIEWS WITH HEALTHCARE PROVIDERS

Namaste, my name is _____, and I am part of a research team engaged by CommonHealth, a National Coalition working on reproductive health and safe abortion.

In this research study we are trying to understand what women in the community do when they are faced with an unplanned pregnancy, whether women have access to information and services for safe termination of pregnancy; which are the health facilities they go to and why, and what difficulties they may face in terminating an unwanted pregnancy. We are also interested in understanding healthcare providers' perspectives on abortion. As a healthcare service provider serving women in this area, your insights will be of great value to us in understanding women's realities.

The in-depth interviews will take about 30-45 minutes. You can specify the time when you would like the interview to take place. I would like to audio-record the interview with your permission. If audio-recording is not acceptable to you, I shall take notes of the interview.

No personal benefits will be gained from participating in this study. But this study will contribute to advocacy with the government to improve access to safe abortion services for all women. Whether to participate or not in this study is completely voluntary. If you decide to participate, you could also decide to stop participating at any time. You are not required to answer questions that you are not comfortable with. The answers will be kept confidential and you name will not appear anywhere.

The information that we collect from this research project will be kept confidential. Background information about the interviewee and the health facility that we collect in the field will be detached from the transcripts and stored in a file that will not have any name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the principal investigator. Data and transcripts will be entered in the computer with unique code number no identifiers will be presented in the document. The computerised data will be protected with password protection.

No individual names/ facilities or identifiers, will be presented in the report, only consolidated figure/ responses will be provided. The data will be thoroughly analysed and the results will be published. The findings of the study will be mainly used to advocate with different stakeholders for promoting the availability of safe abortion services in India. The study results will be released in a form of research report and article. The published report will be shared with key policy makers and other stakeholders and we also plan to conduct dissemination meetings with the key persons in the respective states. The results will help the NGO's in the state and CommonHealth to prioritise their work on safe abortion.

You are free to ask us, if you have any questions about this study. We will do our best to answer. For any further clarifications, you may also contact the person from CommonHealth responsible for this study: Professor Sundari Ravindran, at ravindransundari@gmail.com or mobile number: 09447757974

The institutional review board of Rural Women's Social Education Centre, Thirukazhukundrum, Tamil Nadu has reviewed and approved the study.

Participant's name:

Age:

Address:

I ……..hereby declare that I have read the above information regarding the study Availability of safe abortion services and perspectives of actors on right to safe abortion in the state of Bihar and Tamil Nadu, India". I also understand that my participation is entirely voluntary, and I am free to discontinue the study at any time. I understand that my identity and the given information will be kept strictly confidential. I do agree to take part in this study. I also agree that my interview may be audio-recorded (strike-off this sentence if permission for audio-recording is not given)

Respondent signature/ Thumb impression: ……

Interviewer signature:……

Witness' signature (in case of thumb impression):……

Date:

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INFORMATION SHEET AND INFORMED CONSENT FOR IN-DEPTH INTERVIEWS WITH CSO LEADERS

Namaste, my name is _____, and I am part of a research team engaged by CommonHealth, a National Coalition working on reproductive health and safe abortion.

In this research study we are trying to understand the scenario with respect to availability of and access to safe abortion services in your state, and your organisation's work related to sex-selection, or safe abortion, or both. As a person with considerable experience in the area of women's rights and/ or health and holding a leadership position in a leading NGO in the state, your perspectives will be of great value to us in understanding women's realities.

The in-depth interviews will take about 30-45 minutes. You can specify the time when you would like the interview to take place. I would like to audio-record the interview with your permission. If audio-recording is not acceptable to you, I shall take notes of the interview.

No personal benefits will be gained from participating in this study. But this study will contribute to advocacy with the government to improve access to safe abortion services for all women. Whether to participate or not in this study is completely voluntary. If you decide to participate, you could also decide to stop participating at any time. You are not required to answer questions that you are not comfortable with. The answers will be kept confidential and you name will not appear anywhere.

The information that we collect from this research project will be kept confidential. Background information about the interviewee and the health facility that we collect in the field will be detached from the transcripts and stored in a file that will not have any name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the principal investigator. Data and transcripts will be entered in the computer with unique code number no identifiers will be presented in the document. The computerised data will be protected with password protection.

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You are free to ask us, if you have any questions about this study. We will do our best to answer. For any further clarifications, you may also contact the person from CommonHealth responsible for this study: Professor Sundari Ravindran, at ravindransundari@gmail.com. or mobile number: 09447757974

The institutional review board of Rural Women's Social Education Centre, Thirukazhukundrum, Tamil Nadu has reviewed and approved the study.

Participant's name:

Age:

Address:

I ……..hereby declare that I have read the above information regarding the study Availability of safe abortion services and perspectives of actors on right to safe abortion in the state of Bihar and Tamil Nadu, India". I also understand that my participation is entirely voluntary, and I am free to discontinue the study at any time. I understand that my identity and the given information will be kept strictly confidential. I do agree to take part in this study. I also agree that my interview may be audio-recorded (strike-off this sentence if permission for audio-recording is not given)

Respondent signature/ Thumb impression: ……

Interviewer signature:……

Witness' signature (in case of thumb impression):……

Date:

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INFORMATION SHEET FOR FACILITY SURVEY

Namaste, my name is _____, and I am part of a research team engaged by CommonHealth, a National Coalition working on reproductive health and safe abortion.

In this research study we are trying to understand what women in the community do when they are faced with an unplanned pregnancy, whether women have access to information and services for safe termination of pregnancy; which are the health facilities they go to and why, and what difficulties they may face in terminating an unwanted pregnancy. We are also interested in understanding the availability of abortion services in the public sector. As a public sector health facility in this area, it would of great value to us to have information about the services provided here.

The survey will take about 30 minutes. I will be observing and making notes and will also be requesting for access to some of your records. Permission has been obtained by us to seek data from your facility. No personal benefits will be gained from participating in this study. But this study will contribute to advocacy with the government to improve access to safe abortion services for all women.

Whether to participate or not in this study is completely voluntary. If you decide to participate, you could also decide to stop participating at any time. You are not required to answer questions that you are not comfortable with. The answers will be kept confidential and you name will not appear anywhere.

The information that we collect from this research project will be kept confidential. Background information about the interviewee and the health facility that we collect in the field will be detached from the transcripts and stored in a file that will not have any name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone except the principal investigator. Data and transcripts will be entered in the computer with unique code number no identifiers will be presented in the document. The computerised data will be protected with password protection.

No individual names/ facilities or identifiers, will be presented in the report, only consolidated figure/ responses will be provided. The data will be thoroughly analysed and the results will be published. The findings of the study will be mainly used to advocate with different stakeholders for promoting the availability of safe abortion services in India. The study results will be released in a form of research report and article. The published report will be shared with key policy makers and other stakeholders and we also plan to conduct dissemination meetings with the key persons in the respective states. The results will help the NGO's in the state and CommonHealth to prioritise their work on safe abortion.

You are free to ask us, if you have any questions about this study. We will do our best to answer. For any further clarifications, you may also contact the person from CommonHealth responsible for this study: Professor Sundari Ravindran, at ravindransundari@gmail.com. or mobile number: 09447757974

The institutional review board of Rural Women's Social Education Centre, Thirukazhukundrum, Tamil Nadu has reviewed and approved the study.

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