SAFE ABORTION: KNOWLEDGE, PERCEPTION AND PRACTICES AMONGST URBAN POOR WOMEN IN VADODARA, GUJARAT

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SAHAJ AND COMMONHEALTH

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Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
CuT	Copper T
D&C	Dilatation and (sharp) Curettage
FGD	Focus Group Discussion
GD	Group Discussion
GNM	General Nurse Midwife
HIV	Human Immunodeficiency Virus
LHV	Lady Health Visitor
MMA	Medical Methods of Abortion
MOU	Memorandum of understanding
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NFHS	National Family Health Survey
PHC	Primary Health Centre
PIP	Project Implementation Plan
SAHAJ	Society for Health Alternatives
SRH	Sexual Reproductive Health
TBHV	Tuberculosis Health Visitors
UHC	Urban Health Centre
WHO	World Health Organization

Knowledge, Perceptions and Practices around Abortions amongst Urban Poor Women in Vadodara, Gujarat

Introduction

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[15] Globally, unsafe abortions are known to be leading cause of maternal mortality, the proportion of which varies across countries.[3]In India, abortions account for over one tenth of maternal deaths.[1] In 2010, post-abortion complications were responsible for 9% of all maternal deaths, and this proportion has not declined over the decades despite a reduction in absolute number of maternal deaths.[13]As per the WHO estimate, there are ten times more number of women who experience temporary or permanent health conditions as a result of complications from unsafe abortions, thus making it an important public health issue. A large proportion of mortality and morbidity associated with unsafe abortions can be avoided through sexuality education, access to contraceptives and provision of safe and legal abortion services including care for post-abortion care.[15] In countries such as India, where abortion is legal, awareness generation about legality of abortion and availability of safe and legal abortion too can play an important role in prevention of large extent of morbidity and mortality related to abortion.

Several studies show that in India, abortions are sought for unwanted or unintended pregnancies resulting from non-use of contraceptives rather than failure of contraception.[1,12,13]Though women from all sections of the society are known to seek abortions, NFHS-4 data shows that proportion of women seeking abortion is comparatively higher for urban residents, those with 12 or more years of schooling and those belonging to the highest wealth index category.[4]

Gujarat appears to fare worse than many states in terms of reproductive health indicators, including unmet need for contraception. NFHS-4 data shows that nationally, 13% of married women in 15 – 49 years age group had unmet needs for contraception – 6% reported unmet need for spacing and 7% for limiting the family. The unmet need for both spacing and limiting was higher than the national average among women from the poorest sections of the society (lowest wealth index). For Gujarat the unmet need for contraception was reported by 17% of women, of whom 7% reported unmet need for spacing and 10% reported unmet need for limiting. This corresponds with the high proportion of women who reported not using any contraceptive during NFHS-4 data collection period. For Gujarat, this proportion (53% of 15-49 year old currently married women) was higher than the national average of 47% (of 15-49 year old currently married women). This poor ranking of the state in terms of reproductive health perhaps reflects stronger patriarchal society, given that a higher proportion of men were found harbouring misconceptions such as 'contraception is women's business and men should not have anything to do about it' (India: 37%; Gujarat: 45%) and 'women who use contraception may become promiscuous' (India: 20%; Gujarat: 22%). The state also has poor educational status of women (Gujarat:23% women had no schooling) and early age at marriage (Gujarat: 25% women married by age 18 years).[4]

While abortion is legal in India through the Medical Termination of Pregnancy (MTP) Act since 1971; and is offered for a broad range of medical, social, economic reasons, it can be offered only by

registered allopathic medical practitioners at certified medical facilities. The National Population Policy (2000) recommended that first trimester abortion services be made available at public sector primary health care level. However, studies show that to a large extent abortion services remain limited to secondary and tertiary level hospitals in public sector.[1] Additionally, attitudes of providers, perceived lack of confidentiality in facilities from public sector and non-availability of resources, results in private sector providers continuing to be preferred by women seeking abortions.[2,6,12,13]Nationaldata shows that in 2015-16, more than half of the abortions (52%) were carried out in the private sector, about one fourth (27%) at home and public sector facilities accounted for only 20% of the abortions during the reference period. About 19% of women reported complications of abortions.[4]

Since availability of medical abortion in 2002, the demand for medical abortions in India has been increasing. Several studies have documented reasons for women's preference for medical abortions, including possibility of administration within home environments.[13]NFHS-4 data for Gujarat shows that 27% of all respondent women and 34% of women respondents from urban areas reported carrying out the abortions by themselves.[5]

Government of Gujarat has signed an MoU with IPAS India to impart trainings to public sector health care providers to safe abortion services in the state. This is expected to increase access to safe abortion services within the state. As per the official reports, 150 MTP trained doctors and gynaecologists attended 'Orientation Workshops' on 'Comprehensive Abortion Care' in all its six regions in the State. These trainings are expected to ensure that the service providers **learn** about the latest advancements in abortion technologies including MVA and MMA and refresh their understanding of the MTP Act. The State has till now trained 140 doctors adapting MMA/MVA technique.[16]

Under the State PIP, the Government of Gujarat is committed to provide affordable, safe and legal abortion services to its people and train Medical Officers from CHCs and PHCs in Comprehensive Abortion Care in the State

According to the strategies of Comprehensive Abortion Care

- The Community will be informed about the availability of these services by the Dais, ASHAs, Peer Educators.
- Pre and Post Counselling will be provided by the Counsellors /doctors
- The state will strengthen the First Referral Units, CHC and selected Primary Health Centres to Provide Safe Abortion Services.

At the city level, Urban Health Centre (UHC) is the first point of contact for women seeking reproductive health services. In Vadodara city, the UHC is staffed with one each of - Medical Officer, Laboratory Technician (who provides tests for Haemoglobin level, urine test and HIV test), pharmacist, Lady Health Visitor (LHV), General Nurse Midwife (GNM), Tuberculosis Health Visitor (TBHV), clerk and five Auxiliary Nurse Midwives (ANMs). Each UHC also has ASHA/Link Workers for 2500 to 3000 population (thus each UHC would have about 20 ASHA/Link Workers one of their key roles is reaching health information to women). The UHC provides gynaecology services through a gynaecologist who visits twice a week. Review by SAHAJ team (2017-18) showed that the list of available medicines does not include medicines required for safe abortion and management / treatment of gynaecological

conditions. As sonography services are not a part of service package provided at the primary level public sector facilities. The UHC does not offer sonography. Women who are diagnosed to be pregnant (using the urine pregnancy kit) are routinely referred to the tertiary hospital for sonography to ascertain gestational period/age of pregnancy. At the time of this exploration, it was observed that one of the two centres of tertiary care in Vadodara city (Sir Sayajirao Gaikwad Hospital and Medical College and Gotri Hospital attached to the medical college) also did not have sonography services.[10]

Background

For the past three decades, SAHAJ has been working for improvement of women's sexual reproductive health in economically disadvantaged localities (bastis) from Vadodara. Over several years, SAHAJ has trained a number of women from bastis as health workers who primarily reach SRH information from a rights perspective to their fellow resident women. Through its interactions with women and adolescent girls, the SAHAJ team has mapped the characteristics of communities that influence women's access to SRH information and services. That, almost one fourth women still prefer to carry out abortions at home or without consulting qualified health care providers is a serious cause of concern. The present study offers SAHAJ an opportunity to document and abortion related knowledge, awareness and practices of women, especially the reasons for choice of providers for abortion services from several of the bastis where it works.

Objectives of the present study

The present exploratory study was undertaken to document perceptions of women from slums and slum-like localities (referred to as bastis hereafter) of Vadodara city about abortion services.

The specific objectives of the study were –

- To document women's and adolescent girls' awareness about
    - available abortion services (including formal -- institution based, legal and informal services accessed by women and adolescent girls)
    - various methods of abortion available
    - legality of abortion
    - contraception and contraceptives
- To document women's and adolescent girls' perception of safe abortion practices
- To explore the decision-making process and autonomy of women and adolescent girls in decision making

- To document experiences of women and adolescent girls regarding the process/es pertaining to abortion

Methodology

Data for the study regarding awareness, perceptions, autonomy and experiences of women and adolescent girls regarding abortions were collected using qualitative methods.

Sample

Sample for the study was identified at two levels. First level consisted of selection of bastis where data were collected. The selection was purposive to include representations of various communities residing in the city, which SAHAJ team through its earlier intervention projects, knew to have distinct views, and attitudes towards sexual and reproductive health issues. Eleven such bastis were identified. A brief profile of the bastis and distinct features regarding SRH attitudes and practices of communities included in the present study are presented below. To ensure anonymity, all bastis and communities are referred to in this report using codes. (Table 1)

Table 1: Characteristics of communities relevant to sexual reproductive health

Basti-Community code	Characteristics of the community relevant to sexual and reproductive health
1A	Early age at marriage, low levels of literacy, migrants from different parts of the country, rigid cultural beliefs. High prevalence of domestic violence. Negative beliefs associated with menstruation and post-pregnancy period.
1B	Culturally rigid, low status of women, cultural practices force women to remain unmarried against their wishes. Pre-marital sexual relations are common in this community. Higher prevalence of hysterectomies, users of government tertiary hospital as well as a gynaecologist at a private hospital.
1C	Long term migrants from various parts of the country. Low status of women, early marriages, prevalence of violence against women, community uses services of local private doctors, blind faith in doctors they consult, poor awareness about reproductive health.
2A	Has been a SAHAJ area for the past 15 years. Tribal community with very low literacy levels but not orthodox.
2B	Tribal community. Very poor, low level of education, pre-marital sexual relations are not a taboo, low awareness about sexual and reproductive health, high turnover of population. Has been a SAHAJ work area for last 10 years
3ABC	Community A: Relatively higher educational level among girls*, better awareness of reproductive health issues, proximity to government tertiary hospital, SAHAJ work area for past 10 years Community B: Extremely poor, high prevalence of alcoholism, low level of education, SAHAJ work area since last 10 years. This part of the basti is not recognized by Municipal Corporation. Basic health services not available. Community C: Locality is overcrowded, surrounded by extremely unhygienic conditions,

	low levels of literacy, migrant communities from other parts of India, community regularly uses government primary and tertiary health care facilities.
4A	Culturally rigid, conservative society, several taboos related to sexual and reproductive health, prevalence of early marriages.
5A	New area for SAHAJ (included six months before the present study)
6A	Religious minority community. High rate of fertility due to abortions not accepted in religion, early marriages.
7A	Religious minority community. Rigid religious beliefs, believe that abortions are a sin, totally a new area for SAHAJ, not a part of community it works with.
8A	Predominantly scheduled caste population. Very poor, low levels of education, relatively good awareness of reproductive health issues, main source of information is the link worker who also is associated with SAHAJ. Has been SAHAJ area since past 5 years.
9A	Mixed caste community. Households belong to OBC and general caste categories. Has been a SAHAJ area for the past seven years, medium literacy level, relatively better awareness about reproductive health issues among young women who were associated with SAHAJ in the past.
10A	Predominantly OBC community. Has been a SAHAJ area for the past ten years. Relatively better awareness about reproductive health among girls as well as women. Frequent users of government tertiary hospital.

The second level of sample selection consisted of selection of women and adolescent girl participants for participation in the study. Group discussions were conducted separately with groups of married and unmarried respondents.

Efforts were made to include participants from age groups 15 – 24 (unmarried), 18 – 35 (married), 36 – 45 (married) in order to get a representation across the reproductive age groups. A group of recently married (married in the past two years) women too was included in the sample.

Respondents for the interviews (women who had undergone an abortion in the recent past) were selected purposively.

Method of data collection

Data for the present study were conducted through group discussions (GDs) separately for married women and unmarried adolescent girls/women. A total of 15 GDs were conducted. Group strength varied from 6 – 10 participants. (Table 2)

Table 2: Distribution of sample for group discussions over localities and age groups

Basti-Community code	Participants	Age group (years)	Number of participants
1A	Unmarried adolescents and young women	18-24	6
1B	Married women	25 – 38	9
1C	Married women	23 – 44	8
2A	Married women	24 – 56	9
2B	Married women	33 – 50	8
3A	Unmarried adolescents and young women	18-22	8
4A	Married women	18 – 55	10
5A	Newly married – married in the past 2 years	20 – 24	9
6A	Married women	23 – 36	10
7A	Married women	25 – 56	7
8A	Married women	25-38	7
9A	Married women	25 – 35	10
10A	Married women	41 – 45	7
			110

Interviews were conducted with 15 women from across nine bastis, who had undergone abortion in the past 18 months to get a deeper understanding of their experiences. The women were identified with help from anganwadi workers in areas where SAHAJ does not have an intervention project and with help of field workers who are local resident women in areas where SAHAJ has an intervention project. (Table 3)

Table 3: Distribution of sample for interviews

Basti code	Number of interviews (n=15)
1	2
3	1
4	2
5	1
6	3
7	1
9	2
10	1
11	2

Tools used for data collection

The GDs were conducted using a pre-tested guide. The tool explored following broad areas -

- Awareness about available legality of abortion, methods of abortion, contraceptives and effects of abortion on a woman's health
- Preferred methods and care providers – who, why, criteria used for selection of providers and methods
- Perception of safe abortion
- Decision making processes – who is informed, who is involved, who makes the decision on whether to seek abortion, place, service, method; whether and the extent to which the girl/woman seeking abortion has a say in this process
- Experience of abortion – when, method used, reasons for choosing particular method or service or health care provider, experiences during the processes of consultation and procedure, and aftercare

The GDs were facilitated by a SAHAJ field officer trained in conducting qualitative research and with an experience of working in the identified communities. Notes were made by the recorder – also a trained member of SAHAJ team – during the group discussions. The notes were then expanded to write up on individual group discussions. Quotes were retained where relevant to support the point being discussed. The interviews were conducted using a semi-structured tool. The tool was administered by the same field officer who facilitated the group discussions. Case-stories were constructed based on the reports of interviews and discussions in the group discussions.

Period of data collection

Data for this study were conducted over a period of two and a half months (February 1st – April 10th, 2018).

Ethical concerns

Participants were selected randomly to participate in the group discussions. The participants were informed about the objectives of the study, assured of confidentiality and anonymity and given a choice of participating in the study. Verbal consent was sought before each of the group discussion. Written consent was sought before each interview. Those who were not comfortable with participation in the study were not included in the groups.

The adolescent girls involved in the study were members of the adolescents' groups formed under an intervention programme by SAHAJ. These groups are formed after seeking consent from the parents of adolescents. However, consent for participation in the present study was sought from the girls only. Though initially it was planned to include adolescent girls in the age group of 15-18 into the sample, during pilot testing of the tool for GD, it was realized that girls from this age group could not contribute to the discussion. They were then asked to leave the discussion. For the subsequent group discussions, girls aged 18 to 24 were included in the sample of unmarried women for group discussion.

Women who were interviewed, were identified through anganwadi workers or SAHAJ field workers. The anganwadi workers and SAHAJ field workers were informed about the purpose of the study and asked to identify women who fulfilled the inclusion criteria. The anganwadi workers or SAHAJ field workers then contacted the women and asked consent for inclusion in the study. The names and addresses of women who agreed for participation in the study were informed to the SAHAJ field officer, following which the field officer visited the women at their homes. The women were informed about source of information (how they were identified) and purpose of the study before seeking consent for participation in the study. Written consent was sought on a form with information written in local language (Gujarati) that all women were comfortable with and understood. For those who could not read the form the investigator read it out to them before getting written consent. Interviews were conducted at the time and place convenient for both the respondent and the interviewer.

While efforts were done to adhere to the pre-decided age groups for group discussions, in some cases women who did not fit into the desired age group joined in and it was not possible for the facilitator to ask them to leave. They were allowed to be part of the group. In some other situations where the discussion was planned with members of a particular community, older women were allowed to join in as group strength could not reached otherwise.

In all cases, the facilitator focused on engaging and eliciting information from women belonging to the desired age group.

In case of specific communities, the women who participated in the group discussion may have been distant relatives of each other, but facilitators ensured that only one woman per family was invited to participate in the group discussion.

Names of all respondents / participants are changed in the report.

SAHAJ team will use the information arising from this study for planning awareness generation interventions for the specific communities.

Limitations

The sample for the study is small and findings may not be extrapolated to the larger population. The researchers noted that participants of group discussions had to be encouraged and probed for responses. While the data hints at many issues, only few could be explored in detail. Presence of older women may have influenced the discussion by younger women in some cases.

Since the sample of participants for group discussions was drawn in such a way to document awareness, knowledge and practices of specific community groups, in some cases the team found it difficult to find adequate number of women in the desired age group. In two places, the group discussion had to be cancelled and re-scheduled in order to ensure that participants were as close to the inclusion criteria as possible.

Despite SAHAJ team's familiarity with most of the areas, only partial privacy could be ensured during group discussions. While the team ensured that the group discussions were conducted in closed rooms that participants were comfortable with, the researchers found it difficult to turn away older women who did not fit the inclusion criteria who joined in out of curiosity.

Findings

Findings from the 13 group discussions with married women and unmarried girls/women, as well as from interviews with 15 married women who had had an abortion in the recent past are presented here. For each of the key issue explored, findings from married / unmarried women are presented separately. Findings from interviews are included among those from group discussions with married women. Parts from the group discussions and interviews are presented as quotes, narratives where relevant to support the point being made.

Profile of the sample

A total of 110 women participated in the 13 group discussions conducted in ten bastis. Ages of participants ranged from 18 – 56. Distribution of participants over age groups is presented in table 4. Of the 13 groups, two groups were of unmarried girls/young women in the age group of 18 – 24. While the other 11 groups consisted of married women.

The unmarried girls/young women had higher educational level compared to married women participants, especially from those in the older age groups of more than 45 years.

Ten of the 15 women interviewed were 20 – 30 years old; the rest five were older than 30 years.Half of the women interviewed had primary education. One third of them were married before 18 years of age. Nine of the 15 women had undergone abortion in the year preceding the study while two had had an abortion more than 12 months before the interview.

Table4: Profile of respondents interviewed (women who had undergone abortion)

Variable	Number of respondents
Age (years)	**(n=15)**
20 – 25	4
26 – 30	6
More than 30	5
Education	**n=15**
Std 1 – 5	2
Std 6 – 8	6
Std 9 or more	7
Age at marriage (years)	**n=15**
Less than 18	5
18 – 25	10
Duration of marriage (years)	**n=15**
Up to 5	3
6 – 10	6
11 or more	6
Composition of children	**n=15**
Do not have children	2
Have at least one son	8
Have only daughter/s	5
When was abortion sought?	**n=15**
Within six months before the interview	4
7 – 12 months before the interview	6

13 months or longer before the interview	5
Gestation / duration of pregnancy at the time of abortion	**n=15**
Upto3 months (first trimester)	12
More than 3 months (second trimester)	3
Approximate age in years at which abortion was sought (calculated)	**n=15**
Upt0 20	1
21 – 25	4
26 – 30	7
31 or more	3

Objective 1: Women's awareness about abortion services

Awareness and source of information

Unmarried adolescent girls/women who had been members of adolescent girls' groups formed under an intervention project by SAHAJ over the past eight years had information about abortion – methods, and its adverse effects on woman's health. They reported having received this information through sessions conducted by the field workers. Young women from bastis where SAHAJ works or has worked in the past for projects on sexual reproductive health rights of women; too were aware of these. They received this information from pre-marriage workshops organized by SAHAJ.

The unmarried girls/women participants from the group discussions were aware that "*abortions are done at hospitals where deliveries take place*". Abortion pills too were mentioned by participants. The participants from one of the groups said that "*the pills are available at medical stores but are sold only to girls. IF a boy goes to buy them, he will not get these*".

Women from one basti where SAHAJ has been working for many years and has a field worker said that the field worker whom they referred to as 'Nurse Ben' conducts sessions during MamtaDiwas. There also are two other women who attend trainings and educate their peers. Women from this basti were less hesitant in discussing methods and effect of abortion on women's bodies.

However, most other women, had obtained this information from informal sources such as friends or other women relatives who may have experienced abortion or from media. Or as participants from one group said, women find out about these (where to access, what are different methods, what is done, etc.) only when they themselves undergo abortion.

Methods used for abortion

Most of the participants from the group discussions mentioned buying abortion pills from the medical shop for terminating the pregnancy. Few participants said that it is necessary to go to the doctor first and get the pills prescribed. But majority of the participants of group discussions said the pills are available at medical stores. The participants however were aware of other methods used by health care providers. Curettage – commonly referred to as 'curetin or kreatin or kiryatin' in the community was mentioned most often across the groups. The participants used the term 'cleaning the uterus' for abortion. Different methods used by doctors / health care providers mentioned by the participants included use of injection, use of intravenous fluid to induce abortion, putting medicine directly in the uterus, curettage, or if the foetus is of higher gestation then inducing like delivery with medicines. Women from some of the groups shared that at the government hospital pills are not available. The

doctors from government hospital advise 'operation for cleaning the uterus' – which the participants believed to be good advice. Some of the participants talked about procedures with and without anaethesia – 'medicine for making women unconscious'. Details for some of the methods mentioned by participants could not be explored.

Participants from one of the groups specifically mentioned that 'uterus can be cleaned only till four months of pregnancy'. (Group discussion with women atbasti-1)

Awareness about legality of abortion

The unmarried participants from one group believed that abortion is not legal. The participants from the other group believed that it is 'sometimes illegal'. However, the participants from both the groups believed that "abortion is a girl's right – if she wants an abortion then it is legal".

Among the women's groups, participants of two groups unanimously said that abortion is legal. Participants from one of these groups knew that abortion after sex selection is illegal. In case of two other groups, some participants believed it to be legal while the others thought it to be illegal. In rest of the group discussions participants believed abortion to be illegal.

Half of the interviewed women who had undergone abortion in the recent past (7/15) said it to be illegal. Two respondents did not know if abortion is legal or not. Remaining six women believed it to be legal. These included four women who had used abortion pills without consulting a doctor.

Table 5: Distribution of respondents over perception about legality of abortion

Perception about legality of abortion	Number of women (n=15)
Yes	6*
No	7
Do not know	2
***Includes four women who used the abortion pills without consulting the doctor**	

It is important to note that at least some participants from all religious groups included in the study (Hindus, Muslims, Christians) said that abortion is a sin and that 'God does not look favourably on people who do it'. This strong belief may have implications in terms of practices regarding and morbidity following the procedure. (However, this aspect was not explored during the present exploration.)

Awareness about prevention of unwanted pregnancies

Some participants believed women to be responsible for unwanted pregnancies. Fewer women said that the couple together is responsible for unplanned pregnancies. Largely the participants both unmarried and married; reported abstinence as a way of preventing unwanted pregnancies. Some participants mentioned temporary methods of contraception such as condom, oral contraception pills, injection or insertion of CuT. However, a smaller proportion of women did mention feeling helpless to prevent unwanted pregnancies.

Table 6: Distribution of respondents over steps taken to avoid unwanted pregnancy in future

Prevention to prevent unwanted pregnancies	Number of women (n=15)
Use of temporary contraceptives (condom, mala D, copper T)	5
Underwent female sterilization	3
Planning to go for female sterilization	3
Abstinence (Not sleeping with husband, avoid sexual intercourse)	1
Nothing	3

Objective 2: Perceptions about safe abortion /good quality abortion care

Perception of safe abortion and good quality abortion care

Of the 15 women interviewed for the study, 10 believed that safe abortion is a right of a woman.

Table 7: Women's perception about safe abortion as a woman's right

Is safe abortion a woman's right?	Number of women (n=15)
Yes	10
No	4
Do not know	1

The criteria for good quality abortion care to some extent overlapped with the reasons for choosing health care providers. These included trust in the doctor, perception of competence of the doctor, availability of in-patient facilities such as bed, nursing care, medicines, food and cleanliness at the facility, and perception of attentive listening by the doctor. Additionally, participants from some of the groups mentioned that good quality abortion care includes a follow up with the doctor eight days after the procedure and if required subsequent follow ups at regular periods. The women stressed that it is important that there are no complications after the abortion. Women listed a number of complications including systemic and life-threatening ones such as problems with blood pressure / bleeding (veins) and reproductive ones such as regular menstruation, complicated subsequent pregnancies or infertility. Irregularity in menstruation – periodicity and flow – was mentioned by participants from almost all group discussions.

> *" …Safe abortion means there is no complication afterwards. That there is no problem in the veins (dhamni, shira), woman's blood pressure should not increase and she should not get tetanus."* (Participants from group discussion at basti-4)

> *"Periods should be regular…Periods should be normal. If menstrual flow is less or does not come on time, then something is wrong."* (Participants from group discussion with women at basti-2)

The women also articulated the concept of complete abortion. Participants from many groups highlighted that the most important criteria for safe abortion is that 'nothing should be left behind in the uterus'.

"(Safe abortion means) no pain, proper cleaning – that is, nothing should be left behind in the uterus and no sickness after the abortion." (Participants from group discussion with women at basti-1)

Women also gave a thought to methods of abortion while defining safe abortion. Participants from the group of women from basti-6 elaborated on this. They mentioned that investigations before the procedure as good practice. Medicines / pills which do not always succeed in aborting the pregnancy were mentioned as an unsafe method.

"…sonography test, urine test with the patti (pregnancy confirmation test) are important…There is no guarantee with medical pills. They cannot be always called safe abortion. Curreting is safe. …Safe abortion means full (complete) cleaning of uterus, regular periods (afterwards) and no bodily changes such as feeling giddy etc." (Participants from group discussion with women at basti-6)

Other women categorically mentioned that abortions done by doctors are safe abortions.

"Safe abortion is abortion done by the doctor and by using medicines. (Other factors are) good treatment and that periods should be regular." (Participant from group discussion with women at basti-5)

Box 1: Women's perception of safe abortion

- Procedure carried out after required investigations
- Done by doctor
- By using pills
- Complete – nothing should be left behind in the uterus
- Painless
- Should not result in subsequent health problems / sickness
- Should restore reproductive health – menstruation should be regular, and flow should be normal (not less, not too much)

Perception about adverse effects of abortions

Women from all groups believed that abortion adversely affects a woman's body. Commonly mentioned adverse effects included weakness, anaemia, aches and pains including pain in pelvic and vaginal area, swelling / inflammation of uterus, formation of ulcers or lumps in/on the uterus necessitating subsequent surgeries, irregular menstruation and symptoms suggestive of psychological distress such as loss of appetite, 'feeling loose', not feeling well, etc. Reporting of these did not vary over age group and educational status of participant women.

Three of the 15 interviewed women did not think that abortion has any adverse effect on a woman's body. One of these three was the woman who had been advised by the doctor to undergo abortion due to defects in the foetus.

Table 8: Adverse effects of abortion on the woman's health

Adverse effect on health	Number of group discussions where the adverse effect was mentioned		Number of respondents from individual interviews who mentioned the adverse effect
	Married (n=13)	Unmarried (n=2)	(n=15)
Less blood, anaemia	5	2	3
Increased susceptibility to diseases	4	1	--
Uterus becomes thin, problems with uterus, infection in uterus, gaanth in uterus, swelling on uterus	6	1	2
Pain in lower abdomen	2	--	--
Body ache, pain in arms and legs	1	--	--
Pain in vaginal area	1	--	--
Infertility	1	--	1
Weakness	7	2	4
Giddiness	--	1	--
Loss of weight	2	--	1
Loss of appetite	1	--	--
Irregular menstruation	1	--	2
Bleeding	1	--	1
White discharge	1	--	--
Psychological – do not feel good, feel loose	1	--	--
Other (kidney is affected, swelling of body, there can be a problem if there is no rest)	--	--	3
Do not know	--	--	1
No adverse effect	--	--	3

Objective 3: Decision making process

Sharing of pregnancy related information

Discussion with the groups as well as the interviews showed that most married women inform their husbands about the pregnancy. Some also shared that they inform the mother-in-law or members of natal family. Participants from one of the bastis (basti-2) said that they do not find it necessary to tell anyone about it (if they want to terminate the pregnancy).

In the group of unmarried girls/ women participants said that in case of unwanted pregnancy, girls often inform their friends or someone (usually a female relative) "they trust". Some participants said

that the girls would tell their mothers – but discussion showed that a girl would tell her mother about the unplanned / undesired pregnancy only if the mother was 'friendly' with the girl. Some participants said that the girls may also talk to their boyfriends about it.

> *"…a girl only tells her mother if she is 'friendly' otherwise the girl would be beaten up…unmarried girls are scared. They fear society (society's reactions), the family is boycotted and many times even the boyfriend does not support her in such a case."* (Participants from a group discussion with unmarried girls, basti-3)

> *"(An unmarried girl confides in her friends as) a friend keeps it to herself, she does not spread it into the society."* (Participants from group discussion with unmarried girls, basti-1)

Table 9: Who do women disclose unwanted pregnancy to?

Person pregnancy was disclosed to	Number of respondents (n=15)
Husband	12
Mother -in-law	1
Husband and Mother -in-law	1
Members of natal family	2

Decision about termination of pregnancy

From the group discussions it emerged that the decision to terminate the pregnancy is often made jointly by the woman and her husband. However, in some cases the decision to terminate the pregnancy is by either the husband or the mother in law without involvement of the woman. A few women respondents / participants also said that the decision to terminate the pregnancy was theirs alone.

The respondents who had undergone abortion in the recent past were asked during the interview about whose decision it was to seek an abortion. The women respondents were involved in decision making in 8/15 cases. Three of these eight women said that the decision was theirs alone. In rest of the cases husbands and mothers in law of the women had made the decision to terminate the pregnancy – in one case, against the wishes of the woman herself.

In case of unmarried girls, the decision to abort is often of the girl or sometimes the girl's mother makes this decision. Some participants said that sometimes it is the boyfriend who decides that the pregnancy should be terminated.

Table 10: Distribution of respondents over decision making for seeking abortion

Decision maker	Number of women (n=15)
Self	3
Husband	3
Mother in law	3
Both husband and self	5
Husband and mother in law	1

Reasons for decision

The participants talked about fear of social repercussions that often influence the actions taken by unmarried girls. According to the participants, the unmarried girls are often worried about 'being responsible for dishonoring the family name' and scared of reactions from family members. This according to the participants is the main reason for unmarried girls with unwanted pregnancies leaving homes or even committing suicide. The fear of society's reaction and likelihood of ending life was mentioned in the group discussion with unmarried girls/women from the migrant tribal community from bast-1 where awareness about sexual reproductive health as well as status of women is low and cultural practices pose challenges for girls in making decision about marriage, partner or even employment.

Choice of method

Participants from the group discussions were asked about what girls/women do once they find out about unwanted pregnancy and decision is made about terminating it. The discussion brought out various methods women choose and providers they approach for abortion.

Unmarried girls from the culturally rigid community said that girls from their community would directly approach a doctor for an abortion. This was reiterated in many other groups. Participants – married and unmarried - said that once the decision for abortion is made, girls/ women approach doctors irrespective of gender of the doctors. Some married participants said that women purchase pills for abortion directly from the chemists / pharmacists. Some others mentioned women first using a pregnancy detection kit to ascertain whether or not they are pregnant and then using pills for abortion.

Using pills for abortion was mentioned in all group discussions. Women reported purchasing them directly from the chemists either by using old prescriptions from doctors or without them. According to participants of a group this has made abortion very accessible and helps protect the woman's privacy as well.

> *"…It is so easy nowadays that if a woman undergoes abortion, even her neighbours would not know about it."* (A participant from group discussion)

Participants from some groups mentioned home remedies for inducing an abortion such as consumption of hot foods. However, some women also said that in case of an unwanted pregnancy "the woman would do anything others would suggest".

Box 2: Home remedies reported by participants for inducing an abortion

- Raw papaya
- Papaya seeds
- Pepper
- Ukalo (a strong spicy brew)
- Jaggery syrup
- Nutmeg (jaiphal)

Choice of provider

Group discussions highlighted various factors that married and unmarried women consider while seeking services for abortion. The choices of providers and reasons for choosing them varied across groups / communities but were directly associated with the participants' perception of 'good quality care' as well as their past experiences.

The unmarried girls/women from the culturally rigid tribal community knew that for abortion one needs to 'go to the hospitals where deliveries are conducted'. They said that most of the women and girls from their community go to the government hospital for abortion as *"the doctors there do not ask too many questions, do not ask for any proof and abortion is done free of cost*". The private doctors according to them, on the other hand ask for 'details' such as 'address', 'how did it happen' etc.

Unmarried participants from another group discussion were of the opinion that confidentiality is of prime importance while selecting a health care facility for abortion. According to them unmarried girl would not choose a doctor in the vicinity of her basti as there are chances of people from the basti knowing about it. These girls seemed to prefer providers from private sector over the public sector ones.

> *"There are many tests (advised) in the government hospital, there are too many people around. The doctors are learners (students) themselves. Government hospitals also file a case if the girl is young (less than 18 years of age). The services in private hospitals are good."* (Participant from group discussion at basti-3)

Among the groups of married women too, there appeared to be a preference for private sector providers. Women from the minority community prefer to seek services at private facilities as they feel discriminated against at the government hospital.

> *"They are very suspicious about us. They look at us very strangely. We feel awkward…Lot of time is spent but less money is required."* (A participant from basti-6)

Women from this group also mentioned that at government hospital anaesthesia – 'medicine to make woman unconscious' is not used. This was one of the deciding factors in choice of private hospitals for the participants from this group.

Participants from other groups that did not include women from minority community believed services at government hospital were 'not good'. Long waiting time and need for repeated visits was mentioned by a number of participants from various groups. The 'hassles' at government hospital especially if the doctors suspect sex selective abortion too are deterrent for women using the services. Availability of free services was the only positive aspect of government services reported by the women.

> *"…have to make multiple visits (at the government hospital). It saves money but no one over there is ready to listen to our problems. One has to wait for one's turn (for a long time)."* (A participant from group discussion at basti-4)

> *"…have to go repeatedly. One has to go from one place to another. The woman has to stay at the hospital for two days. But one does not have to pay for the services. Medicines too are free."* (A participant from group discussion at basti-2)

"There are too many queries, especially if one has one or more daughters…long queues. Women do not have so much time. They have work to do."

Some of the participants also said that when in-laws make the decisions (about place of abortion) they take the women to the government hospital. Some others said that if they had financial problems they go to the government hospital otherwise opt for a private hospital/doctor.

Relatively easy accessibility of private hospitals was reported to be the main reason for opting for them for abortion for many women.

"There is no need for frequent visits. This (unwanted pregnancy and abortion) is an emergency. So we do not have a problem even if the services are expensive. There is no need for anyone to accompany the woman. The hospitals are also clean." (A participant from group discussion at basti-2)

Possibility of medical abortion at home, without having to go to the doctor and without any investigations (which are believed to be causes of delays) was another reason that came forth for preference for private sector.

"…The doctor is very close by. Even the husband of the woman can get the prescription (for abortion pills). He brings the medicine and explains to his wife how to use it…" (A participant from basti-8)

Other factors women considered while choosing the provider for abortion services were perceived competence of care provider, need for an accompanying person, satisfactory in-patient facilities. Some participants mentioned that in private hospitals doctors perform the procedures while in government hospitals either student-doctors or student-nurses perform these. For these respondents, status of the care provider was the deciding factor for choice of health care facility. Availability of 'cot' while admitted to the hospital, being looked after by nurses (hence not need for accompanying relatives), cleanliness of the facility were other factors mentioned by the women participants. Familiarity with (and possibly trust in) the provider was another factor for choice of facility where women sought abortions. Three-fourth (8/12) of the women interviewed had opted for private facilities that were suggested by friends and family members or where the woman knew the doctor or a staff member at the hospital.

In some areas where SAHAJ had worked in the past, women reported consulting the gynaecologists that were then associated with the project or still followed the advice of the health workers to seek services from recognised centres.

Box 3: Reasons for choice of facility summarized

Reasons for choosing public sector facilities

- Free of cost services
- Proximity
- Anonymity (according to some participants of GD, others had different opinion)

Reasons for choosing private sector facilities

- Proximity
- Confidentiality
- Non-judgmental attitude of care providers
- Perceived competence of doctor (good doctor)

	• Familiarity with the doctor • No need to visit the doctor for the woman (in some cases), doctors give prescriptions to husbands • Delays / time spent is lesser than in public sector facilities (shorter waiting time, no need for repeated visits, all facilities available at one place, no need for admission / hospital stay or very short hospital stay) • No need for an accompanying person • Good nursing care, other facilities (e.g. food if admitted) • Good quality of facility (cleanliness, availability of hospital bed, efficient support staff, provision of food) • Use of sedation/ anaesthesia to make the woman fall asleep (as reported by respondents)

Eight of the 15 women interviewed for the study, had sought services at private hospitals, two went to the government tertiary hospital and four others chose to buy medicine (pill for abortion) from private pharmacy (chemist) shop and use it at home without consulting the doctor. Reasons for choice of particular provider were similar to those shared by participants of group discussions.

Table 11: Distribution of respondents over choice of facility for abortion

Facility of choice	Reason	Number of women
Private clinic/hospital		(n=9)
	Located close by / convenient location	2
	Good doctor / Good services	3
	Know the doctor	3
	Female doctor	2
	Doctor prescribes pills	2
	Suggested by neighbours / friends	2
	To keep from family members	1
	Emergency (It was a Sunday and this was the only clinic open)	1
Government tertiary hospital		(n=2)
	Regular user	1
	Free services	1
	Decision of family members	1
Used pills at home		(n=4)
	Knew about medicine from previous experience	2
	No specific reason provided	2

Box 4: Factors that influence choice of health care provider

- Distance
- Delays / Number of visits / Waiting time
- Perceived competence of care provider
- Physical conditions at the hospital – cleanliness, availability of bed
- Polite behavior of health care providers (attentive listening, non-judgmental attitude, nursing care while admitted to the facility)
- Perceived convenience (length of stay at the hospital-shorter stay or no stay are preferred, flexibility of accessing abortion pills without visiting the doctor, not asking too many questions about the pregnancy, not asking for details of the woman)
- Familiarity with / trust in providers
- Costs (for a few participants)
- Confidentiality (especially for unmarried girls/women)

Accompanying person

In GD the unmarried participants said that generally the girls go for abortion with either their mothers, friends or boyfriends.

Of the 15 women interviewed, 11/15 reported approaching a clinic or a hospital for abortion while the rest (4/15) purchased abortion pills directly from pharmacies. Of the 11women who visited a clinic/hospital for abortion, 6/11 reported that their husbands accompanied them for the procedure, while 4/11 were accompanied by their mothers-in-law or other members of the family. Only one woman reported being unaccompanied / having gone alone for the procedure. She said that the doctor was familiar to her and she had gone there to get a prescription for abortion pills. Remaining 4/14 women purchased the abortion pills from the chemists directly. None of the woman who had surgical abortion reported being unaccompanied for the procedure.

Table 12: Person who accompanied the woman to the clinic / hospital

Who accompanied the woman to the clinic / hospital	Number of women (n=11)
Husband	6
Mother in law or maternal family members	4
Nobody	1

Method used

All 15 women who were interviewed and had undergone an abortion in the recent past said that they had had a safe abortion. Two-thirds (10/15) of the interviewed women had opted for medical abortion using pills. Three of these had purchased the medicine directly from the medical store / chemist without consulting the doctor. 5/15 reported having undergone curettage – two of them had undergone the procedure at the government hospital. Of the three who underwent the procedure at private sector hospitals, one woman reported her abortion as a spontaneous abortion (miscarriage) and she had to undergo the procedure as per the advise of the doctor.

Table 13: Methods used for abortion

Method used for abortion	Number of women (n=15)
Medical (pills either used after consultation with a doctor, with a prescription or without a valid prescription)	10*
Curettage	5
***Includes three women who used the abortion pills without consulting the doctor**	

Objective 4: Experiences of seeking abortions

The women who had undergone abortion were asked about their experiences of seeking care – whether they could access abortion services with ease. While 14/15 women said that they had no difficulties in accessing / availing of abortion services, one woman who had a spontaneous abortion / miscarriage had a harrowing experience. She could avail services only after over 24 hours, and after visiting five different health care facilities.

> *About three months into her pregnancy, 24 years old Daya experienced red watery discharge. She went to the government tertiary hospital where she had registered for ANC. She was told that she would need a sonography which was not available at the government hospital and referred to a private sonography clinic. After a long wait, Daya could no longer bear the bladder pressure and relieved herself. She was told to return for sonography four days later. By this time, she had been having vaginal bleeding. She then went to a private gynaecology clinic/hospital nearby. The doctor was not available; and she was turned away. Desperate to seek a consultation, she approached yet another private gynaecologist, who gave her tablets to stop the bleeding. Exhausted, Daya returned home. She took the tablets, but the bleeding continued. In the morning she started having pain in lower abdomen. She went to yet another private gynaecologist who examined her and told her that she had partially aborted and needed to undergo curettage. She spent Rs 8000/- on the procedure.* (Case story reconstructed from the interview notes. Name changed to protect the identity of the respondent.)

One of the women participants from a group discussion with women from basti-6 shared an experience of her failed attempts at seeking an abortion.

> *About nine years back, then 19 years old Gouriben became pregnant within a few months of delivering her first child. She and her husband decided to abort the pregnancy as they did not want another child just then. On suggestions from friends and acquaintances, Gouriben went to a gynaecologist located pretty far away from her house. She was one-and-a-half month pregnant at that time. The doctor prescribed her a medicine for abortion. She took the medicine but it did not work. A few days later she consulted another gynaecologist as per suggestions from some other friends. This doctor too gave her pill for inducing abortion. Gouriben experienced some bleeding after taking this pill but she still was not convinced that the foetus had been completely aborted. She then went to the government tertiary hospital. She was scared that if she told the true reason for her anxiety to the doctor, she would be scolded for having tried abortion in the first place. She therefore lied to the doctor – said that*

she had a fall and experienced bleeding and therefore had come for a check up. The doctor examined her and told her not to worry, that the foetus was alright. Gouriben was now worried. She felt that because of her taking two pills for aborting the foetus, the foetus may have developed abnormalities / deformities. She went back to the government tertiary hospital and told the doctor that because she had a fall, experienced bleeding she did not want to continue the pregnancy, she also said that she was worried that there would be deformities in the child. The doctors took Gouriben for an advanced sonography and reassured her that the foetus was unharmed and counselled her to continue the pregnancy. Gouriben gave birth to a healthy son, who is currently studying in third standard.(Case story reconstructed from narrative during a group discussion)

Discussion

This was an exploratory study that documented abortion related awareness, perceptions, practices and experiences among the low-income group women from Vadodara city. Group discussions with women from bastis showed a high awareness about availability of abortion services. Women seemed to have a fair understanding of safe abortion – according to the participants complete removal of uterine contents, and no health problems for woman afterwards were the main criteria for safe abortion which is similar to that documented elsewhere.[8]Most of the women participants believed abortion to have adverse effects on women's health including infertility. Other health effects mentioned by women included weakness/ anaemia, possibility of infections in uterus / ulcers in uterus and susceptibility to illnesses/diseases. Some participants also mentioned effects like loss of appetite.

For the participants of group discussions friends and family members were the main source of information. Some women even mentioned that one got information about methods of abortion, adverse effects on woman's health etc only through personal experiences. Difference was noted in this regard in bastis where women field workers / health workers trained over the past decade by SAHAJ under various projects on women's reproductive and sexual health worked. In these areas women followed the advice of the health workers to seek services from recognised centres.

Most women preferred private sector providers. Overall, these findings are similar to those from many studies conducted over the past decade across India that show a preference for private sector where providers are believed to have better services, better communication with patients, provide confidentiality, do not insist on long hospital stay.[11] The reasons given by the participants from the present study were similar. For some of the respondents, the choice of provider was influenced by family and friends as has been noted in earlier studies. Analysis of DLHS-3 data for 13 states with high proportion of induced abortions (Gujarat was not one of these) by Maharana (2016) showed that women from rural area, who were non-literate, had low standard of living, had an ultrasound and had pregnancy terminated in private sector facility were more likely to depend on 'others' for decision making.[6]Pattern of help seeking and choice of providers as mentioned by participants of this study is similar to that documented elsewhere in India.[1, 12]Similar reasons for choosing providers (provider of gynaecological / reproductive services, clean large hospital equipped with modern amenities, team of trained personnel, polite, empathetic behaviour of doctor and staff) were documented in a qualitative study from southern India.[8] This same study also documented that sometimes women chose providers who were not the most qualified if their clinics were more accessible or fees more affordable

compared to the ones they classified as safe and qualified. This concern for proximity and costs too has been reported by sample of women from the present study.

Availability of abortion pills has expanded the reach of the abortion services and it has remained a preferred method of abortion for women across India. The women in the bastis of urban Vadodara are no exception. Two-thirds of these women had chosen to have a medical abortion. Additionally, most of these women participants from this study had had an early (first trimester) abortion. This could suggest an ease of access to abortion services but must be regarded with caution as 3/10 women chose to self-prescribe the abortion pills. This is an issue of concern as self-administration of abortion pills is known to be associated with severe complications.[12] Early abortion also suggests awareness about recognition of pregnancy, awareness about possibility, methods and providers of abortion.

Despite the WHO and national guidelines, D&C appears to be a commonly used method where medical abortions are not opted for or not feasible. 'Curetin' was mentioned by participants in group discussions as well as by five women who had experienced an abortion. Since the study did not explore the source of this information (how did the woman know that the doctor performed 'curetin') it is not possible to comment on practices in medical sector in the city.

An area of concern that emerges from this study is low acceptance of contraception subsequent to abortion. Induced abortions among younger / adolescent unmarried girls in India are directly related to access to contraceptives and poor recognition of sexual reproductive health needs and rights of adolescents. The limited available literature suggests very low use of contraceptives among younger unmarried women and hence a risk of repeated abortions.[12]In a community where women have little say in deciding about abortions, those who have not accepted contraception seem to have very little (lesser than the others) say in either abstinence or selection of a method, thus face a possibility of further unwanted pregnancies. In communities included in this study where proportion of unmarried women is high, or among the communities where pre-marital sex is not a taboo, understanding their access to contraceptives would help designing more specific interventions.

Conclusion

In terms of reasons for abortions, methods and providers preferred; the data from the present study are similar to those conducted across India over the past one decade. It is important to note that SAHAJ health workers were mentioned to be the only source of information on abortion and women from these areas were more aware compared to others about legality of abortion. Most of the women still believe abortion to be illegal. While pills for abortion is preferred by women, it is not provided through the government tertiary hospital in the city. The women thus chose the private sector providers who provided the abortion pills.

Low acceptance of contraceptives and almost one-fifth of interviewed women's expression of helplessness over making decisions about it, are a cause of concern. This is indicative of the strong patriarchal community where women have lower social status, lower access to resources and lower decision-making power even about their own bodies. Women reporting not being involved in decision making about abortion is another indication of it.

Poor awareness about legality of abortion needs to be addressed to ensure women can access only safe abortion services.

It is also important to systematically explore and document practices followed in public sector and private sector facilities. This information needs to be shared with women to enable them to make better choices for abortion services.

The overall findings suggest partial retention of information received through interventions. The women who as adolescents were exposed to the SRHR information were observed to be more aware and articulate about it. This highlights the importance of such interventions which need to be repeated or continued till a mass awareness is created through generations of women being aware of the issues related to sexual reproductive health.

Way forward

Information obtained from the present study points to the urgent need for addressing the information gap at several levels. Following are some of the activities / interventions SAHAJ could initiate in the area to address this need.

Evidence generation

- Mapping of available services to get information about recognised / certified facilities providing abortion services along with types of services provided (medical abortion, MVA, D&C, etc).
- Procedures followed in public sector facilities that provide abortion services (information recorded, use of this information, investigations asked for, choice of method, etc)
- Documentation of men's perceptions and perspectives on safe and unsafe abortion.

Awareness generation among community women

- Contraception – available methods, advantages and disadvantages of these
- Abortion – legality (conditions under which it is legal, gestation period for which it is legal, who can provide it, where, etc)
- Abortion – available methods

Creating enabling conditions

- Sensitisation of men and women to the concepts of gender, patriarchy, women's right to their own bodies, shared responsibility of reproduction and related events, laws regarding role of husband/partner/parents regarding sexual and reproductive health related services such as contraception, abortion etc.
- Creating spaces for women and girls to seek information about SRH including contraception and abortion.
- Advocacy with public sector to ensure empathetic service provision to girls and women for sexual and reproductive health related conditions.

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SAHAJ (Society for Health Alternatives) works with communities by spreading awareness about their rights and empowering them to claim their entitlements in the Health and Education sectors. Our interventions involve direct action in the communities as well as action research and policy advocacy.

Vision

A society where there is social justice, peace and equal opportunity for all

Mission

- To strive for health of poor communities – health defined in a broad sense to encompass the social, spiritual, economic and political
- To strive for the practical relevance to the poor in all the work undertaken
- To be innovative and creative and try and break new ground in work undertaken

CommonHealth, (Coalition for Reproductive Health and Safe Abortion) is a national group of individuals and institutional members.

Vision

A society that ensures the human right to the highest attainable standards of reproductive and sexual health for all, especially women and marginalized communities in India

Mission

To promote the reproductive health of women and girls by identifying drivers and pathways of reproductive mortality and morbidity, including low access to services, especially safe abortion, and mobilising advocates to adopt a rights based and gender justice perspective.

Websites

www.sahaj.org.in www.commonhealth.in