



Unwanted Pregnancy and Induced Abortion in Rajasthan, India: A Qualitative Exploration



This report is the result of a collaborative project between the Population Council and Ibtada, conducted as part of a Council programme of research on unwanted pregnancy and induced abortion in Rajasthan, India. Designed as a complement to service-delivery activities being undertaken in Rajasthan by the Indian non-governmental reproductive health service provider Parivar Seva Sanstha, the programme of research aimed to provide a multi-faceted picture of the on-the-ground realities related to unwanted pregnancy and abortion in six districts of Rajasthan.

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Ibtada is a non-profit, non-governmental development organisation working to uplift the rural poor and deprived in Rajasthan and adjoining states. The organisation was registered in 1997 when the founder Executive Director was conducting a benchmark survey of the Mewat region for the Government of Rajasthan which highlighted the backwardness of the region and thus led to the initiative called *Ibtada*, an Urdu word meaning *the beginning*.

Parivar Seva Sanstha is a national non-governmental organisation providing reproductive health services with an emphasis on family planning. Registered in 1978, the organisation today has a strong network of 40 reproductive health clinics, a contraceptive products marketing and distribution system, and numerous projects and outreach activities located in 21 states of India.



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Acronyms

BAMS	Bachelor of <i>Ayurvedic</i> Medicine and Surgery
DGO	Diploma in Gynaecology and Obstetrics
MBBS	Bachelor of Medicine and Bachelor of Surgery
MD	Doctor of Medicine
MS	Masters of Science
MTP	Medical Termination of Pregnancy
RMP	Rural Medical Practitioner

Abstract

As part of a Population Council programme of research on unwanted pregnancy and induced abortion in Rajasthan, the Population Council and Ibtada conducted a qualitative exploration of attitudes and behaviours surrounding unwanted pregnancy and induced abortion in one village and one town in Alwar district, Rajasthan. The study was intended to lay the groundwork for two quantitative studies on abortion that were undertaken subsequently in six districts of Rajasthan. Five different qualitative methods — social mapping (n=14), body mapping (n=12), focus group discussions (n=20), key informant interviews (n=68) and in-depth interviews (n=59) — were used to gather detailed data from women, men, community leaders, and informal and formal providers. Both study sites were 15-20 kilometres from Alwar, the district headquarter.

This qualitative exploration shows that women, particularly those who are poor, turn to a number of largely untrained community-level providers for abortion services. These include female *dais* and auxiliary nurse midwives, as well as male chemists, *vaidhs*, and rural medical practitioners, among others. Most of these informal providers offer oral allopathic and *ayurvedic* treatments, and when these treatments fail, some use invasive procedures. Additionally, women use a number of home remedies in an often unsuccessful attempt to terminate unwanted pregnancies.

Information about abortion methods and providers, even those operating in the formal sector in Alwar, diffuses relatively easily through family, friends and local health providers. When selecting an abortion method and/or provider, our data suggest an important bifurcation based on financial resources. Women with greater financial means — generally those who have the support and involvement of their spouses and other family members — go directly to Alwar and obtain surgical services from a private gynaecologist. The remaining women are left with little choice but to avail of services from informal providers that they often recognise to be unsafe and/or to carry unwanted pregnancies to term. Other factors that are taken into consideration when selecting an abortion provider are convenience, perceived quality of care, privacy and the sex of the provider.

Based on these findings, we encourage innovative means to improve access to legal, safe and effective abortion services at lower levels of the public health system. Given the prevalence of informal providers documented in the study area, the feasibility of training certain of these providers to offer safe abortion services, particularly at early gestations, should be explored at the policy, programme and research levels.

Introduction

Background

In India abortion has been legal for over 30 years following the enactment of the Medical Termination of Pregnancy (MTP) Act in 1971. The MTP Act permits abortion for a broad range of social and medical reasons, including to save the life of the woman, to preserve physical or mental health, or to terminate a pregnancy resulting from rape or one that will result in the birth of a child with physical or mental abnormalities. Abortions must be performed within the first 20 weeks of pregnancy and no spousal consent is required (Government of India 1971).

In addition to liberalising the circumstances under which abortion may be provided, however, the MTP Act also includes several provisions regarding the delivery of services that have had the effect of severely constraining access to safe and legal abortion services. First, abortions can only be performed by gynaecologists, or non-gynaecologists who have six months of training in gynaecology or have undergone abortion training and certification at a government-approved training facility. Providers trained in Indian systems of medicine, nurses and midwives are not permitted to provide abortions. Additionally, abortions can only be provided at public-sector facilities (at the primary health centre level and above) or at private clinics that have received certification from the government. Finally, abortions performed between 12 and 20 weeks' gestation require approval from two providers certified to provide abortion.

Due in part to these provisions, the MTP Act is widely considered to have failed to ensure meaningful

access to safe and legal abortion services for the bulk of women in India. Upto 90 percent of the six million induced abortions estimated to occur annually in India are illegal — provided in uncertified settings and/or by uncertified providers (Chhabra and Nuna 1994; Chhabra 1996). While some of these illegal abortions are safe, many are unsafe and result in morbidity or mortality. A hospital-based study conducted in Delhi, for example, found that all women presenting with illegal abortions had septic shock and pelvic inflammatory disease and almost one-third required blood transfusions (Sood et al 1995). In a community-based study conducted in rural Maharashtra, over two-thirds of respondents said they experienced at least one post-abortion problem that was severe enough to affect routine household work and nearly six percent reported symptoms suggestive of sepsis (Ganatra 2000). While estimates of the proportion of all maternal deaths due to abortion range from five to 20 percent depending on the study methods and sample (Ganatra et al 1998; Johnston 2002; Sood et al 1995), the Indian Survey of Causes of Death attributes nearly 18 percent of maternal deaths nationwide to abortion-related causes (Johnston 2002).

As one of the less-developed states in India, Rajasthan has high rates of unwanted fertility and unmet need for family planning, coupled with low contraceptive prevalence rates and pervasive son preference. The latest total fertility rate of 3.8 children per woman remains roughly 30 percent higher than the national figure and suggests that on average

women are having one child more than they desire (IIPS and ORC Macro 2000). About 18 percent of women of reproductive age (15-49 years) in Rajasthan who are not pregnant or breastfeeding wish to postpone or avoid having another child but are not using contraception (IIPS and ORC Macro 2000). Despite efforts by the government, there has been little change in the contraceptive prevalence rate over the past 15 years with about 40 percent of married women of reproductive age using a method of contraception. The bulk of contraceptive users reside in urban areas and have adopted sterilisation (IIPS and ORC Macro 2000).

Women who have an unmet need for family planning are among those most likely to have unwanted pregnancies and, in turn, seek abortions. Yet with a per capita availability of legal abortion services of one per 157,354 individuals, access to safe abortion in Rajasthan is limited (Johnston 2002). One study suggests that nearly all of the estimated 352,000 induced abortions that are performed every year in Rajasthan are performed illegally by uncertified medical or non-medical practitioners (Chhabra and Nuna 1994). Thus, by implication, Rajasthan is among the states where increased access to safe abortion services is most urgently needed.

Recognising this situation, Parivar Seva Sanstha, an Indian non-governmental reproductive health service provider, launched an initiative to prevent and respond to unwanted pregnancy in Rajasthan in early 2001. Their intervention focuses on increasing access to safe, affordable and high-quality family planning and abortion services, and conducting community outreach to inform men, women and providers about the availability of such services. As a complement to

these service-delivery activities, the Population Council undertook a programme of research on unwanted pregnancy and induced abortion in Rajasthan. The Council's programme was comprised of both qualitative and quantitative studies and was intended to provide a multi-faceted picture of the on-the-ground realities related to unwanted pregnancy and abortion in Rajasthan. The qualitative exploration described in this report is among the first studies conducted as part of this programme of research.

Study objectives

The Population Council and Ibtada collaborated on a qualitative exploration of attitudes and behaviours surrounding unwanted pregnancy and abortion in Alwar district, Rajasthan. This study was designed to lay the groundwork for several community- and facility-based quantitative studies on abortion that were undertaken subsequently in six districts of Rajasthan (Barge et al 2004; Elul et al 2004). The specific objectives of the qualitative exploration were to:

- Examine how the notion of unwanted pregnancy is crystallised at the community level;
- Learn with whom women discuss their pregnancies and abortion;
- Document the process of decision-making surrounding pregnancy termination; and
- Identify the various types of abortion methods and/or providers available and explore the reasons why women and decision-makers select a specific method and/or provider.

To this end, we examined the pathways that women undergo from the moment they recognise

they are pregnant until they identify and seek pregnancy termination services from a provider.

Study sites

The study was conducted in two sites, a village and a small town, in Alwar district, Rajasthan. Both sites are about 15-25 kilometres from the district headquarter and thus the study village and town residents have access to better educational and economic opportunities and health-care services than in more rural areas. Nonetheless, the area is characterised by low literacy levels, particularly among women, and agriculture remains an important source of livelihood. As in other parts of Rajasthan, women in the study sites tend to marry at an early age, but generally do not co-habitate until after a *gauna*, or return marriage ceremony, which is performed approximately 12 months after marriage.

The village site, to the south of Alwar city, is easily accessible by road, and both potable water and electricity are available to most residents. In 2001 the village had a population of just over 3,800, mainly Hindus with a small number of Muslims. Most of the population works in agriculture-related occupations. The village has several government and private schools. A primary health sub-centre has also been established there and is staffed by an auxiliary nurse midwife. At the time of the study, three *anganwadi* workers provided maternal and child health outreach services under the central government's Integrated Child Development Scheme. In addition, about ten trained and untrained *dais* and a handful of chemists, *vaidhs* and village health practitioners, some with training in *ayurvedic* medicine, provide both allopathic and non-allopathic treatment.

There were no formally trained allopathic doctors living in the village site at the time of the study although there was a provider with a BAMS degree. Additionally, a doctor with a MBBS degree made weekly visits to the village from Alwar. Formal-sector health services are also available at the community health centre in the nearby town of Malakhera.

The town site is located to the east of Alwar city, along the Delhi-Alwar highway. In 2001 the population was estimated at approximately 11,000, mainly upper-caste Hindus, as well as a significant number of Muslims and a few Jains and Sikhs. As in the village site, agriculture is the predominant occupation. In recent years, however, small private industry has grown and has contributed to substantial in-migration from neighbouring villages. At the time of the study, there were over 25 schools in the town. There is a community health centre in the town, but in 2001 it served primarily as a referral centre because of continual staff and/or equipment shortages. One female and four male doctors with either MBBS or BAMS degrees are officially posted at the centre, together with a lady health worker. However, at the time of the study, the female doctor's post had been vacant for several months, as had the town's auxiliary nurse midwife post. There are also nine *anganwadi* centres in the town, several trained and untrained *dais*, and a large number of *vaidhs*, village health practitioners and chemists or compounders.

Study team

A team of one male and two female interviewers was responsible for data collection at each of the study sites. All interviewers were fluent in Hindi and had atleast a college degree. Several had experience

conducting social science or health-related field research and/or detailed familiarity with Rajasthan. A one-week training course was held for both study teams together in Alwar. The training covered basic reproductive health concepts, qualitative data methods and supervised field practice. During the data collection process, the two teams met daily to discuss progress and problems with the fieldwork. One or more interviewers per team shared field notes for peer review at those meetings. The study managers, which included a public health researcher, a social scientist and a doctor, also reviewed incoming data on a regular basis and at least one of them met weekly with the interviewers. Translators and data entry staff were based in the city of Alwar and interacted frequently with the interviewers.

Data collection and analysis

All fieldwork was conducted between September and December 2001. Qualitative methods were used as they are particularly suitable for collecting information on sensitive topics such as abortion and can provide detailed data on both community perceptions and practices. In total five different qualitative research methods were employed:

- *Social mapping exercises (n=14)*. In this participatory research method, community members created a visual representation of their village/town, highlighting housing arrangements and religious, educational and health facilities.
- *Body mapping exercises (n=12)*. In this participatory research method, women collectively drew a diagram of a female body, identifying the reproductive system and defining key terms related to pregnancy and abortion.
- *Focus group discussions (n=20)*. Focus group discussions were conducted with individuals who had either participated in the social and/or body mapping exercises or had been recommended by community members as individuals who were particularly knowledgeable about women's health issues in order to gather information about community attitudes and norms related to unwanted pregnancy and abortion.
- *Key informant interviews (n=68)*. Key informant interviews with community leaders, community residents who appeared to have an above-average knowledge of abortion, and formal and informal health-care providers were used to obtain additional information about normative attitudes and behaviours. Included among community leaders were individuals involved in local governance, religious leaders and school teachers.
- *In-depth interviews (n=59)*. In-depth interviews documented personal attitudes, behaviours and experiences with regard to unwanted pregnancy and abortion. In general, individuals who participated in in-depth interviews were married women who had experienced an unwanted pregnancy or induced abortion in recent years or married men whose wives had had an unwanted pregnancy or abortion. We identified most of these individuals through either the focus group discussions or the key informant interviews.

Additional information on the data collection methods is provided in Table 1.

Table 1
Data collection methods by study site

	Number of sessions/interviews			Average duration
	Village	Town	Total	
Social mapping				
Unmarried adolescent girls	1	1	2	2h 13m
Unmarried adolescent boys	1	1	2	
Young married women (≤ 25 years)	1	1	2	
Young married men (≤ 25 years)	1	1	2	
Older married women (>25 years)	1	1	2	
Older married men (>25 years)	1	3	4	
Total	6	8	14	
Body mapping				
Adolescent girls	1	2	3	1h 45m
Young married women (≤ 25 years)	2	2	4	
Older married women (>25 years)	1	1	2	
Anganwadi workers	1	1	2	
Dais	-	1	1	
Total	5	7	12	
Focus group discussions				
Unmarried adolescent girls	1	-	1	1h 25m
Unmarried adolescent boys	2	1	3	
Young married women (≤ 25 years)	1	3	4	
Young married men (≤ 25 years)	3	3	6	
Older married women (>25 years)	3	3	6	
Older married men (>25 years)	-	-	-	
Total	10	10	20	
Key informant interviews				
Community leaders	5	9	14	2h 05m
Community residents	9	11	20	
Health-care providers	16 ^a	18 ^b	34	
Total	30	38	68	
In-depth interviews				
Young married women (≤ 25 years)	5	8	13	1h 45m
Young married men (≤ 25 years)	-	3	3	
Older married women (>25 years)	19	13	32	
Older married men (>25 years)	10	1	11	
Total	34	25	59	

^a Includes three providers based in Alwar who provide services to village residents.

^b Includes five providers based in Alwar who provide services to town residents.

Purposive and snowball sampling techniques were used to select study participants across a range of important sub-populations (i.e. age, caste and religion). For the social and body mapping exercises, as well as the focus group discussions, relatively homogenous groups of individuals were selected. Due to the strong stigma associated with premarital sexual activity in the study area, we collected very little information from unmarried adolescents. As the selection of study participants was purposive and non-random, the study findings are not generalisable to other parts of Alwar district, Rajasthan or India, and no measures of abortion incidence or prevalence are calculated.

Pre-tested discussion guides were used to facilitate data collection in the focus group discussions, key informant interviews and in-depth interviews. As the interviewers participated in the drafting and pre-testing of these guides, they were familiar with them before the main phase of data collection began and used them primarily to initiate discussion, redirect discussion when digressions occurred and to probe for additional details. Each data collection exercise took approximately between 1.5 and 2.0 hours.

The interviewers worked mostly in pairs, one facilitating the data collection exercise or interview and the other taking hand-written notes. Whenever possible, the sex of the interviewer, note-taker and respondent(s) was matched. Referrals for physical, psychological or legal assistance were provided to

study participants if requested or if deemed appropriate by the interviewers.

In an effort to maintain confidentiality, all interviews were conducted in a setting that afforded as much privacy as possible. Oral informed consent was obtained from participant(s) before the start of any mapping exercise, focus group discussion or interview. In the case of focus group discussions and interviews, interviewers also requested permission to take hand-written notes of the conversation and to tape-record it. The vast majority of participants permitted both note-taking and tape-recording. Transcripts were prepared by the interviewer on the same day that the focus group or interview took place, using the hand-written notes and, when available, the tape-recording. Transcripts were later translated into English and entered into a word processor. Interviewers reviewed the translated transcripts and made any necessary corrections before the text was finalised for coding and analysis.

Once the fieldwork was completed, the data from the focus groups and interviews were coded and analysed using ATLAS.ti Version 4.2. The findings in this report draw mainly from the key informant and in-depth interviews, as they are believed to describe the practice of abortion most accurately. Findings are generally presented for both study sites together, although important differences are highlighted as appropriate.

CHAPTER 2

Findings

Participant characteristics

Tables 2 and 3 present background characteristics of the key informants in both sites. Overall, 14 community leaders and 20 community residents with above-average awareness of abortion participated in key informant interviews (Table 2). These respondents were largely female and Hindu.

Key informant interviews were also conducted with ten formal providers (including eight in Alwar who provide services to residents of the village and town sites) and 24 informal providers in both study sites (Table 3). All five of the gynaecologists interviewed provide surgical abortion. Most of the informal providers use oral indigenous treatments, although several use invasive treatments as well.

Table 2

Background characteristics of non-provider key informants by study site

	Village	Town	Total
COMMUNITY LEADERS			
Age			
<35 years	1	2	3
≥ 35 years	4	7	11
Sex			
Female	2	5	7
Male	3	4	7
Religion			
Hindu	5	6	11
Muslim	-	3	3
Total number of participants	5	9	14
COMMUNITY RESIDENTS			
Age			
<35 years	6	9	15
≥ 35 years	3	2	5
Sex			
Female	5	8	13
Male	4	3	7
Religion			
Hindu	9	7	16
Muslim	-	4	4
Total number of participants	9	11	20

Table 3
Background characteristics of provider key informants by study site

	Alwar	Village	Town	Total
FORMAL PROVIDERS				
Training				
Gynaecologist (MD/DGO)	5	-	-	5
Sonographer (MBBS)	3	-	-	3
Community health centre doctor (MBBS)	-	-	1	1
<i>Ayurvedic</i> doctor (BAMS)	-	1	-	1
Sex				
Female	5	-	-	5
Male	3	1	1	5
Total number of participants	8	1	1	10
INFORMAL PROVIDERS				
Training				
Chemist/compounder	-	1	3	4
<i>Vaidh</i>	-	-	3	3
Auxiliary nurse midwife/ <i>anganwadi</i> worker	-	5	1	6
<i>Dai</i> (trained and untrained)	-	4	2	6
Registered medical practitioner/village health provider	-	1	2	3
Sex				
Female	-	9	3	12
Male	-	3	9	12
Total number of participants		12	12	24

Key informants or focus group participants who experienced or whose wives experienced an unwanted pregnancy and/or induced abortion were invited to be interviewed in further detail. In total, 59 individuals participated in in-depth interviews. In several cases, we interviewed both members of a couple. Characteristics of the individuals who participated in in-depth interviews are presented in Table 4. Of the 59 women and men interviewed in-depth, 32 reported that they or their wives had experienced at least one unwanted pregnancy.

Many had multiple unwanted pregnancies, including one woman from the village site who reported that nine of her 12 pregnancies were unwanted. Thirty-four respondents noted that they or their wives had attempted to terminate one or more pregnancies and 22 of them were successful. Repeat abortions were not uncommon; a few women reported having had four or five abortions. Ten more respondents indicated that they or their wives had desired an abortion but had not attempted it. Only six respondents claimed to have had one or more sex-selective abortions.

Family size norms and sex preferences

Male and female respondents in both sites articulated strong preferences regarding family size and sex composition. Most agreed that the ideal family is comprised of three children, preferably one girl and two boys. Sons are considered essential for inheritance purposes, providing financial support for parents or female siblings, performing parental funerary rites

and conferring higher social status on the family. In contrast, as a woman from the town site with eight daughters suggested:

Girls are somebody else's wealth. See I have only girls. They do not have any brothers. Now who will look after them? Who will help them in their marriage? (37-year-old married Hindu woman, in-depth interview, town site)

Table 4
Background characteristics of in-depth interview participants by study site

	Village	Town	Total
Age			
<25 years	5	4	9
25-34 years	13	12	25
≥ 35 years	16	9	25
Sex			
Female	24	21	45
Male	10	4	14
Religion			
Hindu	34	19	53
Muslim	-	6	6
Number of living children			
1-2	6	1	7
3-4	12	9	21
5-6	11	9	20
≥ 7	5	6	11
Experiences with unwanted pregnancy and induced abortion^a			
Had unwanted pregnancy	16	16	32
Attempted induced abortion	23	11	34
Had successful induced abortion	18	4	22
Desired induced abortion but did not attempt	5	5	10
Had sex-selective abortion	5	1	6
Total number of participants	34	25	59

^a Respondents may be included in more than one category.

Pressure to meet these childbearing ideals comes not only from family members, but also from neighbours and the community at large. As one respondent explained, the pressure to bear male children is particularly acute at later parities:

In the beginning everybody wants a child. It doesn't matter whether it's a boy or a girl. When the first child comes . . . then it means the husband is fertile. If one or two children come, then it is fine. If it is a girl or boy, it doesn't matter. After the third child, though, it matters . . . girls are not meant to be kept. (27-year-old married Hindu woman, in-depth interview, village site)

Several factors were identified that could influence individual family size, including the health of one's own living children and the sex composition of children in other family units sharing the same joint household. A 31-year-old mother of three girls and one boy in the village site, for example, reported that her in-laws had welcomed her first daughter because her sister-in-law had already produced a son for the family.

Given the pressure to produce a son, many women expressed dismay when they only gave birth to girls. A few women felt they had "bad luck," "some disease" or were "cursed." A woman from the village site with eight daughters spoke eloquently of how "love lessened" when she continued to give birth to girls:

Neither anyone cares for the mother, nor looks after her because she had produced so many girls . . . That is why I used to feel sad. Because so many girls have come, nobody talks to me. If a boy had come then everyone would have loved me. (32-year-old Hindu married woman, in-depth interview, village site)

Pregnancy identification, reaction and disclosure

Women reported recognising they were pregnant from as early as 10-15 days from the expected date of menses to as much as four or five months later. A delay in or cessation of the menstrual cycle commonly served as the first sign of pregnancy. Other symptoms that women associated with pregnancy include vomiting, loss of appetite, giddiness, nausea, insomnia, food cravings, fatigue, headaches and irritability. Usually two or three symptoms together led women to conclude that they were pregnant. A few women, however, were so unfamiliar with the signs of pregnancy that they did not recognise their pregnancy until it was brought to their attention by other women in their household or in the community. Almost no women reported seeking confirmation of a suspected pregnancy by visiting a doctor or taking a pregnancy test.

Women described experiencing a range of emotions upon realising they were pregnant. Those who were happy or elated were, in most cases, discussing their first pregnancy. Those who had unwanted pregnancies felt sadness, irritation, anger or distress upon discovering that they were pregnant.

Unwanted pregnancies were attributed to a number of economic, social and health factors. Most commonly, pregnancies were considered unwanted when the desired number and sex of children had already been obtained or when they followed a birth or marriage too closely. Unwanted pregnancies also occurred as a result of pre- or extramarital sexual relations or when the couple had older children who were already parents themselves. Other reasons given for unwanted pregnancies include poverty, marital discord and the poor health of the mother.

Regardless of their own feelings about the pregnancy and desire for abortion, women often shared information about their pregnancies with their spouses, other female family members and friends. Most commonly, women first shared the news that they were pregnant with their spouses and did so shortly after they became aware that they were pregnant. Women reported in some cases that their husbands realised on their own that their wives were pregnant. A few women, particularly in the town site, reported being too shy to tell their mothers-in-law directly about the pregnancy and thus waited for them to recognise it on their own.

Far more rarely, women kept the pregnancy secret from their spouses and/or in-laws. In a few cases, women shared the information with their spouse, but the couple did not disclose the pregnancy to more senior family members. In general, this scenario occurred when women or couples desired to terminate the pregnancy and anticipated strong opposition from any/other family members.

Abortion decision-making

The decision to have an abortion is a complex process that often involves a woman's spouse and in-laws. Many respondents argued that social norms dictate that the decision to have an abortion or carry a pregnancy to term rests solely with a woman's spouse and in-laws and that the woman herself has little say in the matter. Indeed, a fair number of female respondents described being pressured by family members to have abortions although they desired an additional child:

Sister, to tell you the truth, I did not want to abort the girl. It is a sin to kill a child, but my husband decided it should be aborted . . .and got it done forcibly. (27-year old married Hindu woman, in-depth interview, village site)

Others reported not pursuing abortions despite their wish to do so because their husbands and/or in-laws had decided they should continue the pregnancy:

I did not want such a big family. But what could I do? I kept getting pregnant and . . . kept listening to my husband and mother-in-law. (45-year-old married Hindu woman, in-depth interview, village site)

As a male key informant explained, however, the involvement of extended family members in the decision to have an abortion often hinges on a couple's economic autonomy:

A joint family system still exists here and so the decision to have an abortion cannot be made by the couple only. The senior family members are the decision-makers. If they don't agree, it's impossible to get an abortion. . . . But if [the husband] is able to bear the expenditures on his own without depending upon the joint family income, the woman can get an abortion without even asking the senior household members. (26-year-old married Muslim man, key informant interview, village site)

Only in a handful of cases did women report attempting abortion or carrying pregnancies to term in direct opposition to their spouses' and/or in-laws' wishes. Women who attempted abortion in such situations generally relied on (ineffective) home

remedies or traditional medicines, as they were unable to obtain funds for formal-sector services. Those who reported refusing to get abortions when their spouses or in-laws decided that the pregnancy should be terminated often did so because they were fearful of the health risks and complications associated with abortion.

Traditional methods of abortion

Knowledge of home remedies to induce abortion was pervasive across the study sites, regardless of the sex, age or marital status of the respondent.

These traditional methods of abortion generally entail the consumption of a hot concoction made from one or more of the following ingredients: black tea, jaggery, carrot seeds, radish seeds, anise seeds, fenugreek seeds, cumin, turmeric, *garam masala* (spice mixture), cloves, cardamom, black pepper, dry ginger, lady fingers, milk, clarified butter, tobacco and buffalo fodder. Other "heat producing" foods or drinks mentioned as possible abortifacients include eggs, coffee, *bajra roti* (bread of coarse millet), maize, ground berries and the roots of red wild berries.

In addition to these home remedies, many informants in the town site were aware of inexpensive pills or medicines believed to have abortifacient qualities. While most study participants in the village site were also familiar with these products, they reported that they could be procured only in Alwar or the nearby town of Malakhera. Chemists, *vaidhs*, *dais*, and auxiliary nurse midwives in both sites, however, confirmed that *ayurvedic* medicines are available locally and were able to provide samples of well over a dozen such products including Mensuline, Mensunorm, Mensurite, Pregnil and Pregno (Table 5).

Despite widespread knowledge of these products, few women reported success with them and most considered them, as with the homemade remedies, to be unreliable. As one female focus group participant put it:

If abortion happened this way [by eating or drinking something], no one would spend 3,000 [Indian Rupees] on a cleaning [dilatation and curettage]. (24-year old Hindu woman, focus group participant, town site)

Many were also concerned about the safety of these products and considered them risky. In some cases, women were so concerned about complications following the use of these products that they carried unwanted pregnancies to term:

Many times I thought of taking hot things at home only, but did not. Now suppose I had drunk kada [a concoction], eaten carrots seeds and some disease then occurred. If the child does not come out completely, excess bleeding occurs. This happened to my sister's daughter-in-law . . . She was in great distress. Then I thought that an incomplete child causes problems to one's health. It is better then to have the child. (43-year-old married Hindu woman, in-depth interview, town site)

Informal-sector providers

A number of local abortion providers were identified in both study sites. These informal providers range from female government paramedical staff, such as auxiliary nurse midwives, nurses and *dais*, to male chemists, compounders and *vaidhs*. While a few of them provided only oral herbal remedies and

ayurvedic products, they most commonly offered oral allopathic treatments such as Arga and Ergacap (Table 5). While the chemists in our study generally recognised that many of these products, particularly the *ayurvedic* ones, are indicated for the treatment of secondary amenorrhoea and not pregnancy termination, they were candid about their motivation for continuing to sell them:

It is not like this [medicine] will work and that one won't work. It's all about making money. We look at the patient and determine whether she will spend money or not. (35-year-old male chemist, provider key informant interview, town site)

Several informal providers offered these products through the mid second trimester, while others were more cautious, rarely recommending them beyond

Table 5
Abortifacients collected from study sites

Ingredient	Preparation	Method of use
Buffalo fodder	Boil with jaggery	Ingest
Carrot seeds	Grind seeds, mix with jaggery and then boil in water.	Ingest
Cotton seeds	Grind seeds and mix with cow's milk	Ingest
Root of cotton plant	Boil with water	Ingest
Root of <i>biskhaphra</i> herb	Grind and mix with roots and herbs	Insert in cervix
Arga, Amorex, Ergacap, EP Forte, IB Forte, Mala Forte, ME Forte, Mensuline, Mensuline Forte, Mensunorm, Mensurite, Pregnil, Pregno, Quinine		Ingest
Anin-500, Botropaste, oxytocin		Inject
Foetex Paste/Prostodium		Insert Foetex Paste in cervix via makeshift catheter and follow with injection of Prostodium
Glycerin/Prostodium		Insert glycerin in cervix via makeshift catheter and follow with injection of Prostodium

the first few weeks of pregnancy for fear of complications or possible side effects.

When these oral hormonal treatments failed, most of the informal providers reported repeating the treatment, often at a higher dose. In some cases, when the initial oral treatment proved ineffective, informal providers offered injections of allopathic products such as Prostadine or Prostdium, often together with Foetex Paste or glycerine administered in the cervical canal through a makeshift catheter:

I go to the woman's house and give the injection and apply the paste. It takes 3-4 hours. There are some mysteries behind abortion, like profuse bleeding that might turn out to be fatal. Hence, the bleeding needs to be stopped. . . [profuse bleeding] needs to be cured by injections like Strepdinol or by Cadisper tablets. When the abortion is not done properly, when the placenta or remains of the foetus are inside, then bleeding does not stop. Then we have to do it again. An injection of Methergine is also given to make part of the placenta come out.
(40-year-old male rural medical practitioner, provider key informant interview, village site)

A few *vaidhs* and chemists also acknowledged inserting the root of a local herb or a chemical irritant into the cervix to provoke an abortion, when other treatments failed. While none of the female informal providers we interviewed admitted performing invasive abortion procedures, several of the gynaecologists interviewed in Alwar indicated that most of the paramedical government staff, including auxiliary nurse midwives and lady health workers, provides such abortions, sometimes using dilatation and curettage.

Formal-sector providers

Formal-sector abortion services were not available in either study site and many respondents who had desired to terminate a pregnancy in the past but had not done so expressed frustration over this.

In contrast, services staffed by doctors formally trained in allopathic medicine were relatively easily accessible in Alwar. Indeed, when asked about the options for a woman who desires to terminate her pregnancy, study participants overwhelmingly responded that she would have to go to either the government hospital or a private nursing home in Alwar. We identified at least 19 formal-sector facilities that provide abortion services in Alwar, all but one of them in the private sector. While no such services were available in Malakhera at the time of the study, reportedly they had been available in the past both at the community health centre and in the private sector.

While many key informants indicated that services for pregnancy termination were available at the government hospital in Alwar, several reported that doctors there refuse to conduct the procedure in the hospital, preferring to do it in their homes for a fee. A few also indicated that providers working in the government hospital do not abort pregnancies resulting from pre- or extramarital relationships. While the doctor from the government hospital that we interviewed indicated that staff shortages had affected the provision of abortion services from time to time, he reported that the hospital performs three or four terminations per day on average. This doctor expressed some reluctance to provide abortions beyond the first trimester, considering all such abortions to be for sex-selective reasons, but noted

that second-trimester abortions are provided when the pregnancy results from a permanent or long-term contraceptive method failure or puts the mother's life at risk.

While community respondents suggested that private providers offer abortions regardless of the reason, the private-sector gynaecologists we interviewed indicated otherwise. Two insisted that they do not provide abortions for sex-selective reasons. All the gynaecologists working in the private sector reported requiring the presence and consent of family members, although this is not mandated by law.

Key informants in both study sites also reported that private providers offer abortions upto seven or eight months' gestation. All the gynaecologists we interviewed, however, stated that they do not provide abortions beyond the late second trimester. Most women who reported having undergone a surgical abortion in the private sector did so in the first two months of the pregnancy. Those who reported terminating a pregnancy of three or four months' gestation generally also acknowledged having undergone an ultrasound to determine the sex of the foetus. Many respondents recognised that the risk of complications increases as gestational age increases.

Regardless of whether they work in the public or private sector, all the formal providers we interviewed use dilatation and curettage, usually under general anaesthesia, for first- and early second-trimester abortions. Extra- or intra-amniotic Emcredil is reportedly used for later second-trimester abortions. All formal-sector providers believed manual vacuum aspiration to be ineffective. While one gynaecologist was aware of mifepristone medical abortion, which

was approved for use in India several months after we completed data collection, he indicated that it was not available in Alwar.

Most respondents who had obtained abortions in the formal sector, presumably dilatation and curettage, had a limited understanding of how the procedure was done. A few were aware of the use of anaesthesia and mentioned that instruments such as scissors, tongs and forceps were used. Others, however, argued that the doctor removed the foetus with his or her hands. A young unmarried male focus group participant in the village site suggested that abortions are completed using sonography.

Both non-provider and provider respondents reported that the cost of an abortion in the formal sector varies depending on a number of factors aside from whether treatment was sought in the private or public sector, including the pregnancy duration and the marital status of the woman. While most women who had undergone abortions reported paying between 1,000 and 2,000 Indian Rupees, the private-sector gynaecologists we interviewed maintained that the cost was somewhat lower, usually between 500 and 1,000 Indian Rupees. While the government doctor reported that the procedure is usually available for free at the district hospital, when faced with "supply" problems, clients are asked to purchase all required drugs (i.e. tetanus toxoid, antibiotics, anaesthesia).

Identification and selection of an abortion method/provider

Information about abortion methods and providers disseminates relatively easily among community members. Women reported learning about home

remedies by asking other female household members and friends. Informal providers residing in the study sites were well known to women and men alike. As one woman who had visited a village health practitioner to obtain *ayurvedic* abortion medicines explained:

Everybody knows [about these doctors] . . . these days even unmarried girls also know these things.
(35-year-old married Hindu woman, in-depth interview, town site)

Formal facilities and providers in Alwar, while less familiar to women and men in the study sites, were generally identified without too much trouble through referrals either from relatives or friends, informal providers or sonographers. One female gynaecologist who ran her own private nursing home in Alwar reported that she was well known to women and paramedical staff in both study sites and other adjacent rural areas as she had completed over 20 years of government service in several primary health centres in the district. One village health practitioner referred patients to specific doctors along caste lines, which he believed clients prefer. While informal providers in both sites who referred women to one or more formal-sector providers in Alwar insisted that they do not receive a commission, private providers in Alwar suggested otherwise:

At some places, doctors say, "Bring patients and we will give you something." In such cases, these RMPs take [money] both from the doctor and the patient.
(39-year-old female gynaecologist, provider key informant interview, Alwar)

A few male key informants and one female *anganwadi* worker suggested that one might learn about formal-

sector facilities through newspaper advertisements or pamphlets that are distributed by private clinics. None of the individuals we interviewed in-depth, however, identified a provider in this way.

Abortion methods and providers were chosen based on a range of factors including cost, convenience, perceived quality of care, privacy and the sex of the provider. Even when aware of services in the formal sector, women with very few financial resources — generally those seeking abortions without the input of their spouses and/or in-laws, or those coming from poor families — relied largely on ineffective home remedies or *ayurvedic* products purchased from informal providers.

Those who could afford services in the formal sector had strong preferences for a private facility over a government one. Private facilities were considered cleaner, better equipped and the treatment there more respectful. They were also associated with fewer aggravations, including bribery, which some respondents reported occurs in the public sector.

Many respondents considered abortion to be risky, even in the formal sector, and thus avoided providers they perceived to be incompetent. For example, one respondent from the village site reported that she sought services in Alwar instead of Malakhera, which was closer to her home, because she had heard that a woman had died following an abortion conducted by a doctor in Malakhera.

Concerns about privacy led women to seek services outside their communities or to have their spouses serve as intermediaries when interacting with local providers. Several women who had attempted to

terminate pregnancies using traditional medicines without the knowledge of their spouses and/or in-laws said they travelled to Alwar or other nearby towns or villages to obtain the products even though they knew they were available in their own community. Similarly, a *vaidh* working in the town site reported that his primary abortion clients were either local men procuring abortion treatments for their wives or women from other towns or villages. Among the options available in the formal sector, private providers were generally viewed as more discrete than those in the public sector.

While few women expressed concern about the sex of the provider, some indicated that their spouses and/or other family members preferred female providers. One woman relayed the following reaction from her husband after suggesting they seek services from a male doctor:

Is the doctor your friend? . . . He is going to do all wrong things with you. (43-year-old married Hindu woman, in-depth interview, town site)

We found surprisingly little evidence of women making multiple attempts to terminate their pregnancies. Those who had the financial means to seek services from the formal sector generally did so shortly after the decision had been made to terminate the pregnancy. Most often accompanied by their husbands or other family members, they went directly to a provider in Alwar and obtained a surgical abortion. Those with few financial means attempted abortion using home remedies or the services of a local provider. When these treatments failed, they often repeated them but rarely could afford to seek services from a formal provider. Indeed, in only a few

cases, did women report using home remedies and/or inexpensive local products first and then seeking services from a formal-sector provider in Alwar when those products failed.

Knowledge and attitudes regarding the legality of abortion

Both provider and community participants had limited and often incorrect knowledge of the legality of abortion in India. When discussing the legal status of abortion, community respondents most commonly spoke in terms of the marital status of the mother, arguing that abortions among widows and unmarried girls were illegal. While some community respondents had a more nuanced understanding of the abortion legislation in India, they generally were ill-informed, explaining that all abortions performed in private facilities or beyond 14 weeks' gestation are illegal. Most respondents, whether provider or non-provider, also believe that a husband's consent is required by law before the abortion can take place.

When asked about the acceptability of abortion, however, community respondents rarely considered its legal status, speaking instead largely about what they believed to be morally right or wrong. While some reasoned that abortion is more acceptable if done in the early stages of pregnancy, most referred to it as a sin or equated it with murder. For a few women and men, the idea of abortion was so morally reprehensible that they or their wives carried an unwanted pregnancy to term. Most community respondents, however, clearly indicated that abortion was the lesser of two evils and often unavoidable. One woman, who decided together

with her husband to have an abortion after giving birth to two children, put it succinctly:

Abortion is not a good thing. It is the biggest sin to kill a child. There is a saying that seven generations get offended when a child is killed. But, Sister, what can we do? Having a child die from starvation is also a big sin. A government might pass a law to restrict abortion, but those who have to do it will get it done anyways. (34-year-old married Hindu woman, in-depth interview, village site)

Both provider and community respondents also endorsed abortion for unmarried girls who get pregnant. In fact, most argued that the only solution for unmarried girls who become pregnant is abortion, preferably one performed as secretly as possible. Respondents associated premarital pregnancies with humiliation, social stigma and ineligibility for marriage.

While community respondents were rarely aware of the legality of abortion, most were more familiar with the government legislation curtailing sex determination and often assumed that legislation restricted their right to abortion. Community respondents had differing opinions as to whether the restrictions on the use of sonography to detect the sex of the foetus had affected the frequency of sex-selective abortions. While several women remarked that the government legislation had reduced the number of such abortions in government hospitals, others suggested that the practice continued in both the public and private sectors. Most concurred, however, that the government campaign against sex-selective abortion had led to an increase in the price of second-

trimester abortions in the formal sector. Indeed, a few of the poorer respondents interviewed in-depth indicated that although they had undergone a sonogram and learned they were carrying a female foetus, they were unable to afford an abortion in the formal sector and thus relied on less expensive, traditional methods of abortion or carried the pregnancy to term.

Sex determination and sex-selective abortion

Study participants identified a number of traditional methods or treatments used to ensure the birth of a son and identify the sex of the foetus. Women consumed traditional or *ayurvedic* preparations, received massages from local *dais* or sought treatments from religious leaders to guarantee a son. Once pregnant, a woman's dreams, food preferences and physical attributes are taken as indications of the sex of her foetus (Table 6). For example, craving sweets, walking quickly, and dreaming of lemons, tomatoes or potatoes are all thought to be signs that a woman is carrying a male foetus.

Study participants were also aware of more technical methods for determining foetal sex, including the "TV" or ultrasound. While sonography services were not available at either site at the time of the study, they were readily available and highly visible in both Alwar and Malakhera. As with the traditional methods of sex determination, however, several respondents expressed concern about the accuracy of ultrasound and suggested that sonographers, driven by financial motives, might purposefully misreport the sex of the foetus:

We didn't believe them. Another woman who had undergone sonography was told that [the] foetus was female but she didn't get an abortion. Later she gave birth to a boy instead of girl. Doctors get lots of money if they report that the foetus is a girl instead of boy and then [the couple] get an abortion.
(33-year-old married Hindu woman, in-depth interview, village site)

Despite such concerns, several women interviewed in-depth reported having had

ultrasounds to assess foetal sex and a few expressed a desire to do so in the future. Both the provider and non-provider key informants we interviewed suggest that the practice is common across all socio-economic groups:

Even the lower classes, the poor and farmers they do it [sonography]. Here, if we ask them to buy an injection, they're unable to purchase it, but they do sonography. (50-year-old male doctor, provider key informant interview, Alwar)

Table 6

Traditional indicators of foetal sex

Indicator	Foetus is believed to be female	Foetus is believed to be male
Eating habits of pregnant woman	Desires sour foods	Desires sweet foods
Physical changes and activity level in pregnant woman	Facial tone lightens. Abdomen feels warm. Feels energetic and healthy. Walks slowly.	Facial tone darkens. Abdomen feels cold. Feels tired and weak. Walks quickly.
Food-related dreams of pregnant woman or family member	Carrot, chilli, gourd, radish	Apple, banana, eggplant, lemon, onion, potato, tomato

Summary of Findings and Conclusion

This report provides a description of a range of attitudes and practices related to unwanted pregnancy and induced abortion at the community level in one village and one town in Alwar district, Rajasthan. As the study was qualitative in design, the results are not generalisable to other parts of Alwar district, Rajasthan or India. By describing the process women undergo from the moment they recognise they are pregnant until they identify and seek services from a provider, we highlighted some of the problems women encounter when faced with unwanted pregnancies.

- While many women recognised their pregnancies within one or two months of a missed menstrual cycle, some remained unaware of their pregnancies for several months. Doctor's visits and pregnancy tests to confirm a suspected pregnancy were virtually unheard of. Efforts should be made to increase the availability of and access to methods of pregnancy confirmation as early abortions are undoubtedly safer than those performed later in the pregnancy.
 - Women often lack the autonomy to make decisions about their pregnancy outcomes. As is the case with many other areas of reproductive health, husbands and mother-in-laws appear to be the primary decision-makers with regard to abortion in the study area. In many cases, this decision-making structure appears to be driven by women's lack of economic independence. Indeed, access to the most effective services was highly dependent on the involvement of influential family members.
 - Informal abortion providers were widely known to men and women in both study sites.
- Surprisingly many women were aware of the risks associated with the products and/or services obtained from these providers. Poor women determined to terminate unwanted pregnancies, however, were often left with little choice but to avail of services from informal providers as the costs of formal-sector services, even those from the public sector, remained prohibitive. In some cases, when women feared complications following an abortion from a local provider they carried unwanted pregnancies to term.
- The proximity between both study sites and the district headquarter rendered formal-sector services in Alwar easily accessible to those who could afford them. Private providers were generally perceived to be more competent and discrete and to offer more humane services than their public-sector counterparts.
 - Abortion treatment-seeking behaviours appear to be determined by one's financial resources. Women with the means to obtain pregnancy terminations in the formal sector generally went directly to private gynaecologists in Alwar. Those with fewer financial resources most often relied on the less expensive and also less effective products obtained from informal providers. When those treatments failed, they were often repeated. Only in the rare case did women first use locally available services and then seek services in the formal sector.
 - While almost no community participants were aware of their right to abortion, most were familiar with the restrictions curtailing sex determination and often assumed that legislation limited their right to abortion. Details regarding

the MTP Act must be disseminated widely at the community level. Similarly, efforts must be made to distinguish between the legality of abortion and government restrictions regarding sex determination.

Conclusion

The data collected in this qualitative exploration point to a need to investigate innovative means of getting better methods of pregnancy confirmation and

abortion services to poor rural women. Access to legal, safe and effective services clearly needs to be improved at lower levels of the public health system. Given the prevalence of informal providers documented in the study area, the feasibility of training certain of these providers to offer safe abortion services, particularly at early gestations, should be explored at the policy, programme and research levels.

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