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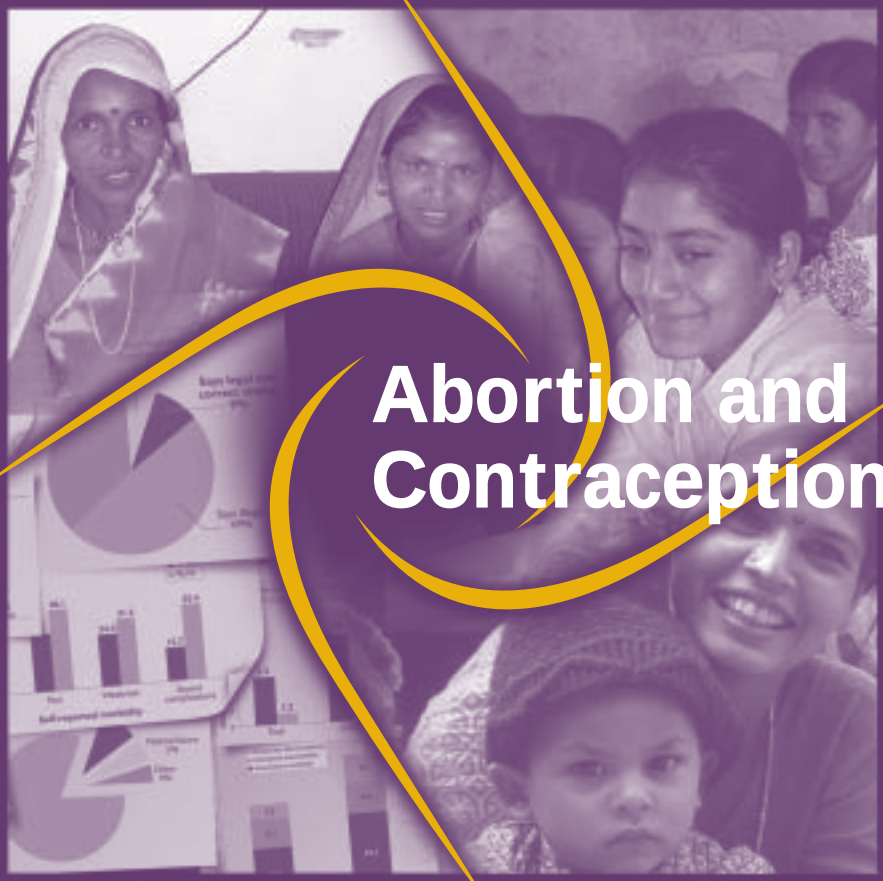
Realizing Reproductive Choice and Rights



Abortion and Contraception in India

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Dedication

We dedicate this report to all the women in Madhya Pradesh who so willingly shared their lives with us.

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Executive Summary

Women's control over their own childbearing is a key component of reproductive rights as defined by the Cairo agenda. To the extent that the *de facto* interpretation of reproductive rights and choice has come to be identified with the legal right to abortion, policy and advocacy efforts have failed to address the full range of factors that are critical in defining women's options regarding childbearing in poor countries. For women in developing countries, abortion is often a choice that is derived from a lack of alternatives: the extent to which they resort to unsafe or safe abortions is fundamentally determined by the realistic options they have for preventing unwanted pregnancies in the first place. If reproductive rights are to be realized for women in developing countries, therefore, it is important to ensure that women's basic need for access to appropriate contraceptive options is addressed along with the need for safe abortion.

The International Center for Research on Women designed and implemented an innovative, large-scale, household-based study in India in order to better understand the interrelationships of contraceptive options and abortion prevalence for women in developing countries. This study explores the domestic, societal, service-related, and policy-related context of the occurrence and resolution of unwanted pregnancies among a sample of approximately 2400 women. It was conducted from 1999-2002 in the state of Madhya Pradesh, in partnership with the International Institute for Population Studies, Mumbai and the Government Medical College, Nagpur. The central questions motivating the research were:

- How are women's reproductive rights and choice manifested in the decision-making processes that determine contraceptive use, the occurrence of unwanted pregnancies, and the resolution of unwanted pregnancies?
- Under what circumstances are the actions that women take—or fail to take—indicative of their ability to formulate and act upon reproductive choices?

The study shows that the vast majority of Indian women have limited reproductive rights and choices despite the fact that abortion has been legal in India through the Medical Termination of Pregnancy (MTP) Act, passed in 1972. In India, the lack of safe, effective, accessible temporary methods of contraception is as much a barrier to the realization of reproductive rights and choice for women as the ineffective and poor implementation of the abortion law.

Findings from the study show that abortion rates in Madhya Pradesh, India are considerable, with almost one-fourth of currently married women 15-39 experiencing at least one abortion by their late thirties. Demand for abortion is even higher and failure rates at attempted abortions are substantial. Women's knowledge of their legal right to abortion, at less than 10%, is abysmal. Despite the provisions of the MTP Act, women incur significant

financial costs and exert much effort to get an abortion. Rural, poor, and marginalized women are especially disadvantaged in access to adequate and safe abortion services. The majority of abortions in rural areas were through dubious and potentially dangerous means, and self-reported morbidity from abortion attempts is high.

Women's limited mobility and decision-making power also means that influential family members play a significant role in women's ability to get abortions.

The data from the study also point to the unequivocal link between contraceptive access and abortion. Despite the fact that demand for spacing methods is very high, contraceptive use among women in Madhya Pradesh is very low, and mostly accounted for by sterilization. Women used temporary methods of contraception in only 8% of the intervals where they had wanted to space their childbearing. The most important reasons for non-use are lack of information and access and opposition from the family.

The rate of contraceptive use was nearly the same for women who attempted abortions and those who did not. Yet, many women who attempt abortions are pioneers in that they are making a concerted effort to use temporary methods of contraception in an environment where sterilization is the norm. Among women who did try temporary methods and then resorted to abortion, 75% had either discontinued due to health concerns or experienced method failure. The current system is failing women at more than one level. Over three-quarters of the women who had an abortion did not get follow-up advice on contraception from a medical provider.

The most significant policy message emerging from the findings of this study is clear: Temporary methods of contraception must be made a viable option for Indian women. The rhetoric for informed choice must be translated into a serious, committed, and energized effort to provide women safe and effective forms of temporary contraception. This effort requires addressing not only the supply side factors of service provision, but also the demand side factors of women's perceptions, knowledge, health concerns, and family constraints. This approach is also necessary for restructuring abortion services. Misinformation, poor knowledge, limited decision-making ability, and poor health consequences are currently a significant part of women's experience with abortion.

Government providers of abortion services need to be more plentiful, better trained, and better equipped, especially in rural areas. Since the vast majority of abortions are currently provided through the private sector, the role of the private sector must be acknowledged and adequately addressed. A campaign to inform and educate women, their families, and service providers regarding the legal right to abortion must be a first step in ensuring the enactment of this right. Additionally, the MTP Act itself requires revision to make it more transparent and easily implemented.

Perhaps the most significant contribution of our work is in highlighting the extent to which contraceptive use (or non-use) and abortion are interconnected. In women's lives, these two issues do not exist independently of each other, and their separation in the health infrastructure does not serve women well. Our findings demonstrate that in order to realize reproductive rights and choice for women in the developing world, it is essential to consider issues beyond the legalization of abortion. While most (although not all) women in the Western world may consider basic access to effective contraception a given, this is yet to be the case in many countries of the developing world, India being an important case in point. Similarly, the passage of a law legalizing abortion is a necessary, but not a sufficient condition for ensuring access to safe and effective abortion services. It is equally important to ensure that women are apprised of their legal rights, service provision reaches a significant majority of women, and social, gender-based, and health-related barriers to accessing services are addressed adequately.

I Introduction

Addressing Rights and Choice Internationally

In the last decade, national and international stakeholders have struggled to operationalize women's empowerment, rights, and choice, as articulated in the Cairo agenda. This has not been an easy task, given the difficulties in reshaping health and family planning systems, social and economic conditions, and policy action to more adequately reflect women's needs. For women in developing countries, moreover, the progress on rights has been constrained by the *de facto* identification of reproductive rights with the legal right to abortion. This has meant that programmatic, policy, and advocacy efforts have not always addressed the full range of factors that are critical in defining women's options on reproductive matters in poor countries.

In this work, we argue that women's control over their own childbearing is a key component of reproductive rights as defined by the Cairo agenda, and that all effective and safe means for ensuring this control must be on the policy and programmatic agenda. The legal right to abortion is certainly one important component to ensuring that women are able to control their childbearing destinies. However, large proportions of women in the world lack not only access to safe abortion, but also access to safe and effective contraception. For these women, abortion is often a choice that is derived from a lack of alternatives: the extent to which they resort to unsafe or safe abortions is fundamentally determined by the realistic options they have for preventing unwanted pregnancies in the first place. If reproductive rights are to be realized for women in developing countries, therefore, it is important to ensure that women's basic need for access to appropriate contraceptive options is addressed along with the need for safe abortion.

An important reason why the connection between abortion and contraception for women in developing countries has not been addressed adequately is because it is poorly understood. Although large scale surveys such as the Demographic and Health Surveys (DHS) have provided valuable data on rates and trends in contraceptive use across a number of countries, they provide only limited information on factors underlying women's reproductive behavior, such as motivations for childbearing, decision-making processes regarding contraception or abortion, or barriers to accessing services. They also do not provide reliable data on abortion prevalence. Thus far, depth of knowledge regarding reproductive choices and behavior from women's own perspective has come mostly from small scale, community-based, qualitative studies; yet, these are difficult to generalize. Higher quality, large-scale survey data on these issues are essential, not only for better estimating the number of women who are practicing abortion, but also for adequately understanding the context in which women make contraceptive choices, experience unwanted pregnancies, and resort to abortion.

In order to better understand the interrelationships of contraceptive options and abortion prevalence for women in developing countries, the International Center for Research on Women designed and implemented an innovative, large-scale, household-based study in India. This study explores the domestic, societal, service-related, and policy-related context of the occurrence and resolution of unwanted pregnancies among a sample of approximately 2400 women. It was conducted from 1999-2002 in the state of Madhya Pradesh, in partnership with IIPS, Mumbai and the Government Medical College, Nagpur.

The central questions motivating the research were the following:

- How are women's reproductive rights and choice manifested in the decision-making processes that determine a) contraceptive use; b) the occurrence of unwanted pregnancies; and c) the resolution of unwanted pregnancies as either abortion or unwanted births?
- Under what circumstances do the actions that women take—or fail to take—indicate their ability to formulate and act upon reproductive choices?

The primary goal of this study is to provide the documentation needed for policy action to promote women's reproductive health and rights more effectively. In particular, it aims to provide data to facilitate policy action that increases women's ability to formulate decisions regarding the number of children they want to have; prevent unwanted pregnancies; and attain greater control over the timing and circumstances of childbearing. The study is also motivated by the need to implement high quality survey methodologies that are replicable in other settings and can effectively address the sensitive and complex issues related to abortion and the processes of reproductive choice more broadly. Without such information, there is sparse documentation to convince policymakers of the importance of these issues or to devise concrete recommendations for policy and programmatic action.

The Indian Context

In India, the issue of reproductive rights and choice must be seen in the context of a number of factors. These include the official policies regarding family planning and abortion and their implementation; the downward trend in family size desires and declining fertility levels, and their effect on the demand for contraception and abortion; and the social and gender-related pressures, constraints, and options for women's reproductive behavior.

In India, the Medical Termination of Pregnancy (MTP) Act made abortion legal in 1972, and the legality of abortion has not been in contention. Paradoxically, however, the vast majority of Indian women get abortions outside this legal framework. In part, this is due to the inherent restrictions regarding registered facilities and doctor consent built into the MTP Act, but it is also due to lack of services, poor implementation of the Act by providers, and an even poorer understanding among women regarding their legal rights (Gupte, Bandewar et al. 1997; Khan, Barge et al. 1999; Bandewar 2001; Johnston 2002). Unlike the U.S. where the exclusive focus with regard to "choice" has been on the continued legalization of abortion, the relevant policy debate with regard to abortion in India centers around women's knowledge of their legal rights and the adequate implementation of the MTP Act.

The stated policy and actual implementation of the government family planning program present a set of contradictions with regard to women's rights and choice in India. Since ICPD 1994, the Indian government has attempted to move from a longstanding policy of achieving specified targets on contraceptive use to greater emphasis on individual need and quality of care, but with uneven and limited success (Khan and Cernada 1996; Visaria, Jejeebhoy et al. 1999; Donaldson 2002). For example, a 1998 analysis of seven states shows that implementation of the target-free approach varies considerably across states, with some states unwilling or unable to

abandon targets (Khan and Townsend 1999; Visaria and Visaria 1999). Similarly, despite the policy's stated commitment to principles of informed choice, service providers often do not practice these principles (Baveja, Buckshee et al. 2000; Ninger 2001; Johnston 2002). Data indicate that only in a small number of highly urbanized centers are a range of contraceptive options available to Indian women. In poor, rural areas, contraceptive supplies at Primary Health Centers and sub-centers are frequently inadequate or lacking altogether (Khan, Patel et al. 1999). Data from the second round of the National Family Health Survey (NFHS-2) indicate that only 40% of women remember ever discussing family planning with a health worker; only 10% had ever discussed the pill and even fewer had ever discussed other temporary methods; and only 15% of users of modern contraceptives were informed about an alternative method (IIPS and Macro 2000).

Existing demographic data for India suggest that unwanted pregnancies may be at high levels due to declining fertility preferences and substantial unmet need for contraception. India has experienced declining fertility levels and desired family sizes throughout the last decade. The total fertility rate fell from 3.4 to 2.9 between 1992 and 1998, while the mean ideal number of children fell from 2.9 to 2.7 (IIPS 1995; IIPS and Macro 2000). This trend is accompanied by a rising demand for contraception, including spacing methods. However, permanent methods, specifically female sterilization, continue to predominate, accounting for 71% of contraceptive use. In 1998, 34% of currently married women were sterilized, but only 7% were using a spacing method, levels virtually unchanged since 1992 (IIPS 1995; IIPS and Macro 2000).[1]

The extent to which the unmet need for contraception results in unwanted pregnancies and whether these are then resolved through abortion or become unwanted fertility is a question that needs to be answered empirically. In his analysis of the fertility transition in 20 developing countries, Bongaarts (1997) has argued that during the early and middle phases of the demographic transition from high to low fertility, levels of unwanted fertility are likely to be high as family size preferences decline but the means to ensure them are not fully accessible. He suggests, moreover, that to the extent that contraceptive use is not maximized, induced abortion is likely to be the solution for implementing fertility preferences (Bongaarts 1997).

Family and gender-based constraints for women in India are also likely to be major determinants of unmet need for contraception and the practice of abortion. Research on fertility behavior in India indicates that women face a number of social and domestic constraints that limit their ability to act upon reproductive decisions. These include early marriage and the social pressure for early childbearing, poor access to knowledge regarding contraception, lack of decision-making power in the household, limited physical mobility and access to services and providers, and physical violence and coercion in sexual and family relations (Yinger 1998; Jejeebhoy 2000).

The continued strength of son preference in India is also well-documented (Arnold 1997; Arnold, Choe et al. 1998; Pande and Astone 2001; Arnold, Kishor et al. 2002). Abortion for sex selection in India receives a lot of public attention, but it is not well-known what percentage of abortions are motivated by a desire for sons (Khanna 1997). Such data are necessary because policy action required to address sex selection as a key motivator of abortion is fundamentally different from the policy action necessary to address other motivating factors for abortion.

The need to differentiate the motivating factors for abortion and to more precisely identify family and service-related constraints regarding contraceptive use is especially acute in under-served "BIMARU" (sickly) states such as Madhya Pradesh. BIMARU states are

large, Hindi speaking states within the heartland of India. They are characterized by huge populations, limited infrastructure, and a history of underdevelopment. In Madhya Pradesh (MP), a state with 60 million people, fertility levels are relatively high (TFR=3.3 per NFHS-2) and contraceptive use continues to be limited largely to sterilization (37.9%), with only 4.7% of married women using temporary methods (IIPS and Macro 2001). Lack of programmatic investment in the past has meant longstanding neglect of women's reproductive health needs and rights. Addressing these needs is one of the most critical issues confronting policy makers and program personnel in India.

II Innovating a New Methodology

The Need for Better Methodology

Although the issue of abortion is highly relevant in India, it is poorly documented. In her review of the existing literature on abortion in India, Johnston (2002) notes that "no valid data exist on the incidence of abortion in India." Most existing research on abortion in India—and elsewhere in the developing world—is sketchy in terms of confirming prevalence, while research on motivation and processes is even more limited (Jejeebhoy 1999; Johnston 2002). This is because for the most part, documentation on abortion is limited to extrapolations from official or provider-based records. Efforts at collecting primary data have been largely confined to interviews with women at clinics serving abortion needs. Household or community-based research on abortion is rare, especially using quantitative methodologies. This methodological limitation with the study of abortion is not confined to India, but is prevalent in the literature on this issue for most developing countries. In a compilation of 22 studies funded by WHO on abortion in the developing world, 20 were provider-based and only two were household/community-based (Mundingo and Indriso 1999).

Official records provide estimates of the incidence of abortion based on reporting from legal abortion providers, and in most developing countries, they underestimate the true prevalence of abortion because this information routinely excludes abortions that occur outside official settings. In their compilation and review of abortion rates worldwide, Henshaw, Singh, and Haas (1999) state that India is one of four prime areas in the world (along with China, Japan, and the former Soviet Union) contributing most heavily to the underreporting of abortion prevalence. Official records indicate approximately 550,000-600,000 induced abortions per year, yielding a rate of about 2.7 per thousand women of reproductive age, a gross underestimate by most accounts (Chhabra and Nuna 1996; Henshaw, Singh et al. 1999). This is because the vast majority of abortions are performed by private providers who are not registered at MTP centers. Many women go to qualified private physicians, who are preferred over official government centers or clinics but are outside the official system. Others, however, go to a range of unsafe providers out of ignorance of the law, lack of access, or lack of money (Chhabra and Nuna 1996; Koster-Oyekan 1998; Ganatra, Hirve et al. 2000).

Indirect estimation techniques are often used to correct the underestimation of poor official data on abortion. Estimation techniques typically rely on records from hospitals and other healthcare facilities on women admitted for abortion-related complications or deaths. Assumptions are then made on the number of abortions that are not captured because they occur without complications requiring medical attention, or because women with complications go to non-official facilities for treatment, never access care, or die. For India, estimates indicate anywhere from 1 million to 7 million

induced abortions per year; the higher number yields somewhere between 55-60 per thousand women of reproductive age, a rate that is 20 times higher than the official rate (Chhabra and Nuna 1996; Khan, Barge et al. 1999). Clearly, numbers on the incidence of abortion based on estimation techniques are rough estimates at best, based on extrapolation and numerous assumptions (Figa-Talamanca 1989; Alan Guttmacher Institute (AGI) 1999). Moreover, both official and estimated prevalence data capture little more than the number of abortions that occur in a given time period. They cannot offer information on process, motivations, or access.

Provider or clinic-based studies attempt to capture a wider range of factors through interviews with or recorded information on women who have come in for an abortion, undergone one, or have complications from a failed abortion. Such studies can provide significant information on the service conditions and processes within the clinic setting. However, several researchers have found it difficult to overcome the sensitivity surrounding the discussion of abortion when respondents were interviewed in healthcare settings. Additionally, provider-based studies suffer from a major limitation due to the lack of a control or comparison group. By definition, clinic-based studies cannot compare women who are **not** getting an abortion with those who are, and therefore, cannot adequately examine the determinants and dynamics of how and why women get abortions.

Household-based studies focusing on the issue of abortion are rare, and existing survey data that include questions on abortion suggest that methodologically, the subject matter poses significant challenges. As abortion is often a sensitive and taboo topic, women are reluctant to discuss their experiences in a formal interview setting. Surveys such as the Demographic and Health Surveys end up providing unrealistically low prevalence rates through questions such as "Did you ever have an induced abortion?" For example, less than one percent of the women in Madhya Pradesh answered "yes," to this question for the Indian National Family Health Survey in 1993 (IIPS 1995).[2] Qualitative approaches that allow interviewers to build rapport with the respondents have been utilized to overcome the sensitivity associated with questions on abortion as well as for capturing detail on related contextual, process, and motivational factors. However, this approach allows for only small case studies within geographically limited areas. Qualitative studies cannot measure prevalence, nor can they be generalized to larger populations.

A New Approach: Methodology for the Study

Given existing challenges and gaps, the ICRW team developed a methodological approach that blends the best of quantitative and qualitative techniques to build a household-level instrument that offers the scale, consistency, and widespread applicability of a quantitative survey, but also the complexity, depth, and flexibility of the qualitative technique. This has meant the alteration of the traditional survey approach in fundamental ways:

1. Modifying the basic nature and structure of the survey instrument

The major strength of the survey instrument we have developed comes from the incorporation of a "narrative" technique commonly used in qualitative approaches into the quantitative survey design. While the questionnaire and the response matrix are structured, information is actually elicited through a more fluid and natural conversational flow rather than close-ended questions. This technique, which allows women to tell the interviewer "the story of their life," overcomes the taboos associated with asking abortion-related questions directly since the incidence of abortion, or any attempts at abortion, emerge naturally in the storytelling process. The narrative also allows us to cover a wide range of details and decision-making processes in a

woman's reproductive history, thus providing a wealth of information for a more sophisticated analysis covering not just one abortion incident, but the entire reproductive life course.

Additionally, the survey instrument was implemented over two visits to the respondent rather than one, allowing the interviewer to build rapport before approaching sensitive topics and to cover a larger number of questions without tiring the respondent. This structure also allowed us to include multiple related questions on the practice of abortion, with internal checks for consistency.

2. Building flexibility into the interviewing process

It was also clear that the instrument described above could not be implemented in the field through traditional interviewing techniques. Thus, an equally important component of the study design was to provide extensive training to field interviewers, allowing them to understand the subject matter and conceptual issues intimately and to master the structure of the survey instrument. The interviewers had to develop the confidence in their ability to strike the right balance between being flexible in the interview process and maintaining consistency and rigor in recording responses. Additionally, in order to overcome the sensitivity issue, we considered it crucial that the interviewing process begin with rapport-building activities, not only with the female respondents, but also with key community and family members, ensuring that the respondents would be candid and that important "gatekeepers" to women would be supportive of the interview process.

3. Blending input from social science and medicine

The study was designed with scientific input and review from the social science and the medical professions. While the main goal of the study was to document women's perceptions and experiences rather than to document medical practice, we felt that both fields had important perspectives and knowledge to contribute toward the design of a truly unique and innovative approach. Thus in addition to the social science and demographic expertise resident at ICRW, our principal partners included Ob-Gyns from the Government Medical College, Nagpur, as well as demographers and statisticians from the International Institute of Population Science, Mumbai.[3] Additionally, the research team vetted the research design with a number of scientists with special expertise on reproductive health in India and professional backgrounds in medicine, public health, sociology, anthropology, and demography.

Given both the innovation and the risk associated with our efforts, it was necessary to undertake some preliminary exploration and testing before launching the full scale survey. Therefore, data collection in the study was structured in three phases: 1) an initial qualitative phase; 2) a pilot survey phase; and 3) the full scale survey phase.

The Initial Qualitative Phase

The initial phase served two functions. First, it allowed us to explore the relevance of a range of important social, family, and individual determinants of unwanted pregnancies and their resolution within the context of Madhya Pradesh, India. We employed focus groups, key informant interviews, and in-depth interviews to discover the experiences and attitudes of not only women, but family members, community members and service providers as well. Secondly, the in-depth interviews with women during the qualitative phase utilized the narrative approach with full flexibility. This confirmed for us that when the narrative approach is used, women are comfortable sharing personal details about

their reproductive, pregnancy, and abortion histories. We used data from this phase to specify the dimensions of abortion, choice, and rights that were most critical to be incorporated into the pilot survey, which was to include a quantitative phase.

The qualitative phase was completed between September 2000 and February 2001 in one urban and two rural sites in the Chhindwara district of Madhya Pradesh. The qualitative data collection produced transcripts from 10 focus groups, 17 key informant interviews, and 41 in-depth interviews covering younger married women, more mature married women, married men, unmarried women, mothers-in-law, and key community members and providers such as panchayat leaders, anganwadi workers, traditional birth attendants, ancilliary nurse midwives, physicians, and pharmacists.

An important finding from the qualitative phase was that in the Indian setting, although the issue of abortion is less taboo than thought among married women, it is highly taboo among unmarried women. Other research on abortion and adolescent reproductive health in South Asia has also documented that premarital sexual activity for girls is so heavily stigmatized that any efforts at capturing it through surveys yield extremely unreliable results (Ganatra, Hirve et al. 2000; Mathur, Malhotra et al. 2001). Thus, although we had originally intended to study both married and unmarried women, this phase resulted in our restricting further research to only married women.

The Pilot Survey Phase

Following the data and methodological analysis from the qualitative phase, we piloted a survey among 100 (50 rural and 50 urban) randomly selected married women within the Chhindwara district of Madhya Pradesh. The purpose of the pilot was to test the transferrability of the narrative approach to a survey structure, the substantive adequacy and sensitivity of the questionnaire, and the logistical feasibility of administering a two-day questionnaire design. The research team designed an extensive two-day questionnaire covering the most relevant issues emerging from the qualitative phase, and focusing on women's pregnancy history. This survey was successfully administered in the field over a two month period. The daily logs kept by the field staff and a review of the interview schedules confirmed for us that the transference of the narrative technique from a qualitative to a quantitative medium was entirely feasible, and successfully implemented. This phase also brought to our attention several implementation details and options that required fine-tuning, including the number of interviewers required, the use of closed as opposed to open codes for responses elicited, and the overall complexity of the coding structure.

The Full Scale Survey Phase

These concerns were addressed in developing the full scale survey. Based on the pattern of responses in the pilot, we made the coding structure less cumbersome by developing closed-end response categories for most questions. Additionally, the entire survey questionnaire was trimmed and streamlined to eliminate redundancies and nonproductive questions, reducing the interviewing time from 2.5 hours (1 hour day one, and 1.5 hours day two) in the pilot phase to 1.75 hours (.5 hours day one, and 1.25 hours day two). The instrument was finalized after input from the field staff during the training process, and fieldwork was conducted between January and June 2002.

The principal investigators conducted an intensive two week training for 18 field interviewers, three of whom were from the field staff from the first two phases. The interviewers, mostly natives of Madhya Pradesh, were young women in their 20s who were selected based on their previous experience in field research and high recommendations from previous supervisors. The training process was structured around participatory principles, allowing the interviewers to not

only absorb the structure and content of the questionnaire, but also to provide considerable input in modifying it. The interviewers demonstrated great skill in understanding and communicating the complex and difficult nature of the questionnaire and gave helpful and important input for revisions. For example, based on their feedback it became clear that only the rough outlines of each question could be framed in English, whereas the specific wording must be constructed in the native language (Hindi in this case). Extensive quality control in the field was maintained through constant supervision by an experienced research officer as well as through frequent field visits by senior staff. The interviewers also relied on a training manual developed by the research team as a reference for addressing complex as well as simple issues.

Sampling

For the sample, six districts in Madhya Pradesh were purposively selected to ensure geographic and cultural representation. Within each district, the sample is stratified first by 10 Primary Sampling Units (PSUs), and then 40 eligible women per PSU, yielding a total sample of 2400 eligible women. Within this design, we oversampled urban areas to ensure enough cases for analysis by rural-urban residence since abortion and contraceptive experiences are likely to be radically different in the two areas. Eligibility was defined as currently married women, ages 15-39, having at least one child.[4] A major purpose of the cluster sampling design is to collect not only household-level data, but also community-level information. A separate, small community-level questionnaire was implemented in each PSU to gather information on family planning and abortion providers, available services, and general health, infrastructure and development conditions.

Survey instrument

The unique structure of the survey instrument developed by the research team provides a major breakthrough in abortion research. As noted previously, the questionnaire spans two days of interviewing per eligible woman. The session on the first day is administered in standard survey format where questions with precoded responses are asked of the woman regarding her:

- household composition
- socioeconomic status
- demographic characteristics
- husband's characteristics
- economic and decision-making status within the family
- family planning knowledge, opinions, and practice
- abortion knowledge, opinions, and practice
- childbearing desires and experience

As the formal session of the first day ends, the interviewer records a preliminary pregnancy history for the woman, using the birth of two successive children as an anchor for probing on any pregnancies that may have occurred between these two births. The complexity of the preliminary pregnancy history then guides the time allocated for conducting the second day interview, which can last from 1-1.5 hours, and also helps predict the level of difficulty likely to be encountered. The second day questionnaire requires a more in-depth recording of each pregnancy experience a woman has had, using structured questions with precoded responses, but also the flexibility of the narrative method of interviewing. Here, for each pregnancy, the circumstances behind its occurrence are elicited, including:

- household conditions
- decision-making power
- access, availability, desire, and decision-making ability to use contraception

Once the occurrence of a given pregnancy is recorded, the interviewer then conducts a series of probes to see if there was any desire, and/or attempt to terminate the pregnancy. The follow-up questions then record the full experience of either delivering a live/still birth, experiencing a miscarriage, or attempting a successful or unsuccessful abortion for that specific pregnancy. If for a given

pregnancy a woman attempted an abortion—successfully or unsuccessfully—then she is asked a set of questions regarding the steps taken, multiple attempts, type of provider, treatment by provider, method for inducing abortion, complications, costs, transportation, support from husband or other family members, etc. This series of questions is repeated for each pregnancy that a woman has experienced.

Data structure

The structure of the questionnaire permits analysis of the data and an understanding of the issues at several key levels: by individual women, by all pregnancies, and by the interval[5] of time between the end of one pregnancy and the beginning of the next. For example, we can examine what percent of **women** have ever experienced an abortion, what percent of all **pregnancies** ended in abortion, or whether contraception was used in the **interval of time** between the previous pregnancy and the current one. In the following sections we present the results by examining the issues at these multiple levels and therefore alternately refer to women, pregnancies, or intervals between pregnancies.

III Abortion Prevalence, Demand, and Perceptions

Abortion Prevalence

Results from the study indicate that despite some limitations and challenges, our research team's innovation in methodology clearly offers a major advance in measuring the prevalence of abortion and in illuminating the related complex and sensitive issues relevant to the reproductive choice and rights of women in developing countries. Figure 3.1 shows that a fairly significant proportion of the women in our sample—15%—had undergone an abortion at least once in their lifetime. However, since our sample consists of married women aged 15-39, the reproductive experience of the younger women is truncated; that is, these women still have several years remaining before they may experience an abortion. Thus, the experience of women in the oldest age group (those aged 35-39) presents a more accurate picture of the likelihood of a woman ever experiencing an abortion during her reproductive life course. Our data show that almost one-fourth (23%) of the women in Madhya Pradesh experience an abortion at least once by the time they reach their late thirties. Given the size of the currently married, reproductive age (15-39) female population in Madhya Pradesh, these percentages suggest that over 2.1 million women in that state are likely to undergo an abortion at least once through their reproductive lives.[6]

Since our data measure prevalence through the reproductive life course, our results are not directly comparable to official or estimated rates which attempt to measure incidence annually. Although recall issues and reluctance on the part of some respondents to discuss this sensitive issue mean that the prevalence numbers we obtained are still likely to be underestimates, they indicate a significant improvement from previous quantitative estimates that are comparable. This is most evident when we compare the abortion ratio (abortions as a percentage of live births) in Madhya Pradesh obtained by the NFHS-2 to the one obtained by ICRW.[7] As Figure 3.2 shows, across the total, rural, and urban samples, the ICRW numbers are consistently about ***five times higher*** than those obtained by NFHS-2.

Figure 3.1
Percent of women who ever had, attempted, or wanted an abortion

Demand for Abortion

A major issue of interest in this study was whether women who have the need for an abortion are actually able to act on their intentions. When assessing whether women are able to exercise rights and choices, there is considerable value to considering "the demand for abortion" in addition to the prevalence of abortion. To parallel the concept of "demand for contraception" (women who want to prevent pregnancies), we have developed the concept of "demand for abortion" to be women who want to terminate unwanted pregnancies. The "unmet demand for abortion," therefore, consists of women who could not or did not get an abortion despite an expressed desire. As Figure 3.3 shows, women comprising the "unmet demand for abortion" consist of those who actually made an attempt at abortion but did not succeed as well as those who for one reason or another did not even make the attempt.[8]

Figure 3.2
Abortion ratio in Madhya Pradesh
ICRW and NFHS-2 data comparison

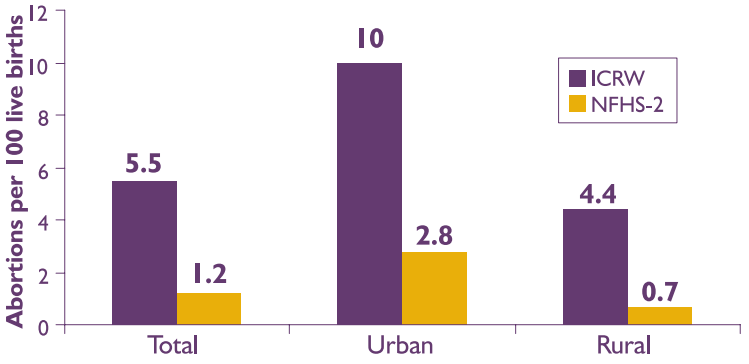
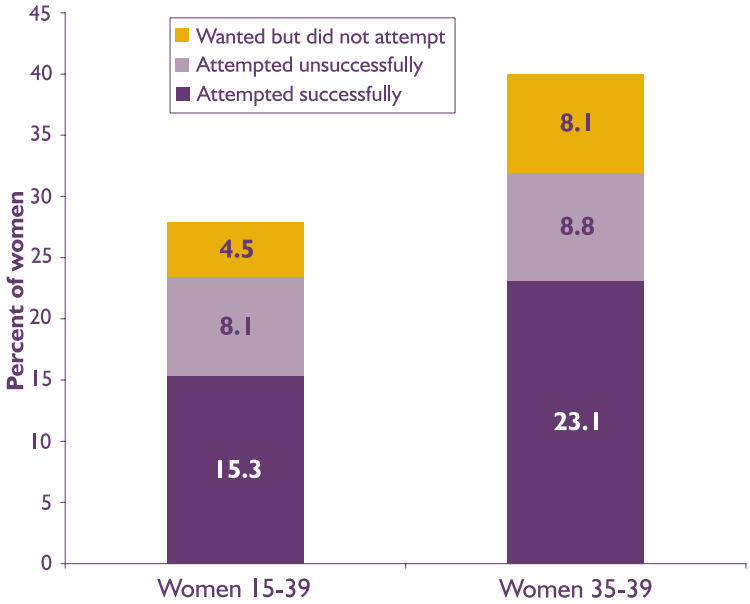


Figure 3.1 shows that although 15% of the women in our sample experienced an abortion, nearly twice as many—28%—actually wanted one and 23% made at least one attempt at terminating a pregnancy. Thus, as Figure 3.3 illustrates, the demand for abortion is "met" for only slightly more than half the women who have an expressed need. Again, if we use the reproductive experience of the older age group (35-39) as illustrating the more accurate picture, the demand for abortion (met and unmet) in Madhya Pradesh is very high, with 40% of married women wanting an abortion at least once by the time they reach their late thirties, but only 23% succeeding in terminating the unwanted pregnancies.

Figure 3.3
Met and unmet demand for abortion



The data also indicate that socio-economic and locational advantages are the biggest factors determining whether demand is met or unmet. As Figure 3.4 shows, women who have higher socio-economic status, are better educated, or live in urban areas have considerably higher rates of ever having an abortion compared to women who are poorer, less educated, or residents of rural areas. That lack of access is the major factor limiting women with socio-economic or locational disadvantages from meeting their demand for abortion is also clearly indicated by Figure 3.5: While 60% of urban women indicated that accessing abortion was easy, only 18% of rural women did so. Rural women were also much more likely to lack knowledge about where to access abortion services.

Perceptions Regarding Abortion

Knowledge of legality

As indicated before, abortion in India has been legal since 1972. Figure 3.6 shows, however, a major reason why legal rights have not translated into effective reproductive rights for women in India. In MP, women's knowledge regarding their legal right to abortion can only be classified as abysmal. ***Only 9%*** of the women in our sample knew that abortion was legal and could correctly identify the time period within which it was legal to terminate the pregnancy. Fully half (49%) of the women thought that abortion is illegal, and an additional 36% had no idea regarding its legal status.

Social and cultural perceptions

Our data suggest that misconceptions regarding the legal status of abortion are partially due to the social and cultural taboos surrounding it. However, as is the case in most societies, Indian women's perceptions regarding abortion often include a set of ideas that seem contradictory at first sight. Given that abortion may be personally and socially undesirable and at the same time a necessity under certain social, economic, personal, and medical conditions, general disapproval is often tempered with approval, depending on the circumstances. Thus, when asked a general question, only 7% of the women in our sample said that they approve of abortion, but an additional 23% said that their approval would depend on the circumstances under which abortion was sought.

In fact, as illustrated in Figure 3.7, approval rates when the circumstances are specified are much higher. An overwhelming majority of women unequivocally approve of abortion if the mother is experiencing health problems (78%) or if there are problems with the fetus (86%). Social stigma is an even more important reason for the acceptability of abortion; 95% of the women said that abortion was acceptable if the pregnancy results from a pre- or extra-marital sexual encounter. Approval

Figure 3.4
Percent of women who ever had an abortion
by rural/urban, education, and socioeconomic status

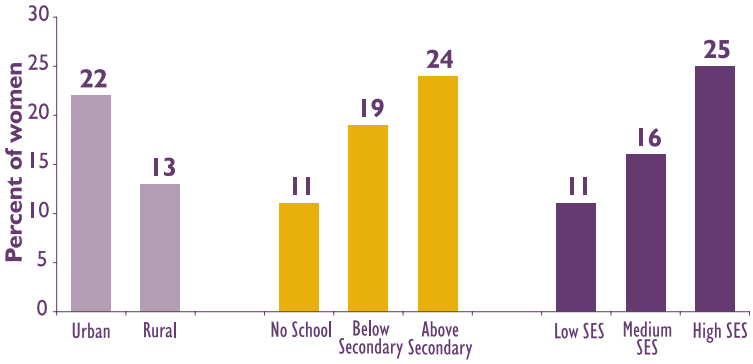


Figure 3.5
Women's perceptions of ease of accessing abortion services

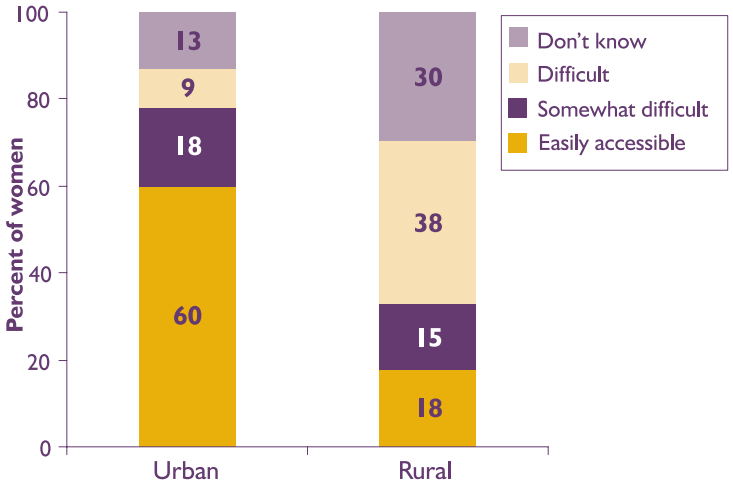


Figure 3.6
Knowledge of abortion legality

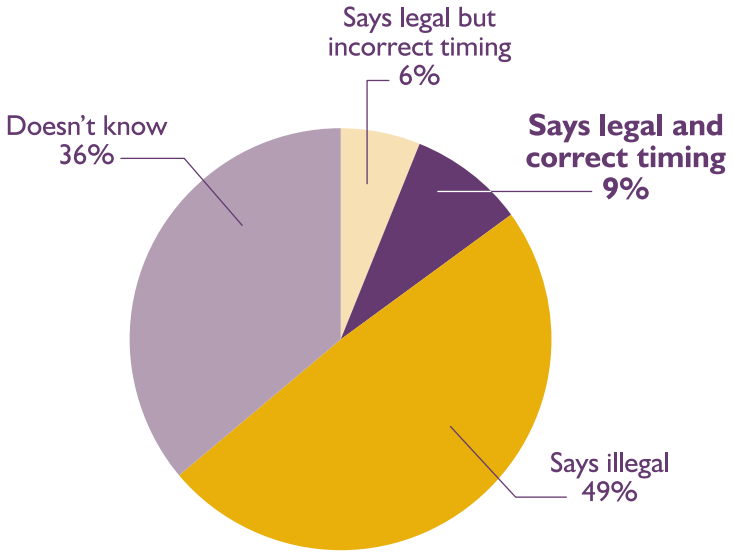
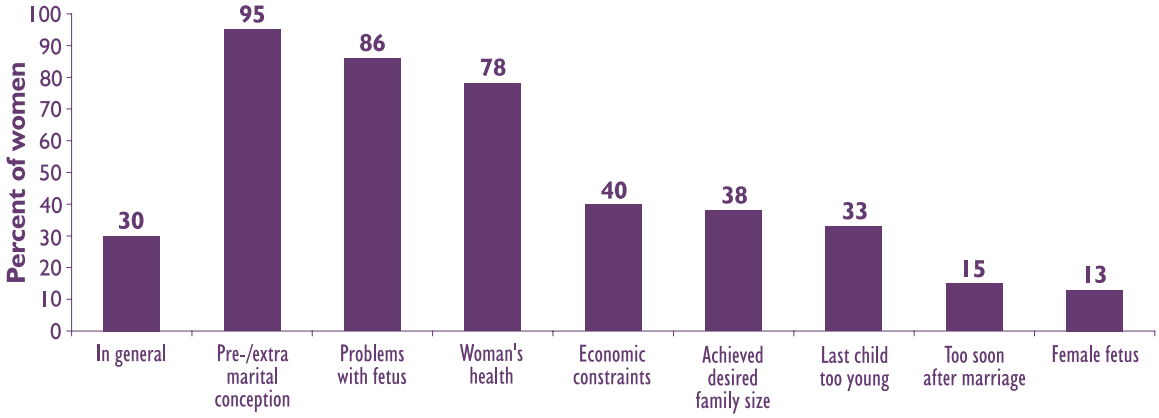


Figure 3.7
Approval of abortion
by reason



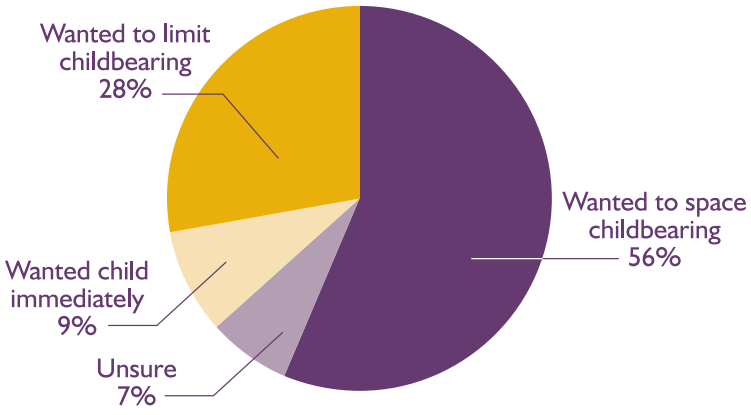
rates for abortion if a woman wants to limit (38%) or space (33%) her family, or is facing economic difficulties (40%) are lower, but still fairly substantial. In contrast, despite the fact that women frequently reported their first pregnancy as occurring too soon after marriage, only a small minority of women (15%) support abortion in such a situation. Only 13% of the women in our sample said that they support the idea of an abortion because the fetus is a girl.

IV Contraceptive Use, Unwanted Pregnancies, and Abortion

In India, it is critical to understand the role that contraceptive availability and use plays in allowing women to translate their desires about childbearing into reality. Our data allow us to map a comprehensive picture that captures the connection between a woman's views about the timing and desirability of any given pregnancy, her use of contraception preceding that pregnancy, and her follow-up actions on resolving an unwanted pregnancy.

Figure 4.1 shows that in only 9% of the intervals during which women were exposed to the risk of pregnancy did they want to become pregnant immediately. In 28% of the intervals, women wanted to stop childbearing altogether; this is the case when women had completed their families. As is natural, however, through the vast majority of their reproductive span (56% of all intervals) women wanted to space childbearing; they wanted another child but not immediately.[9] Thus, in 84% of the intervals where women were exposed to the risk of pregnancy, they wanted to either delay or limit childbearing.

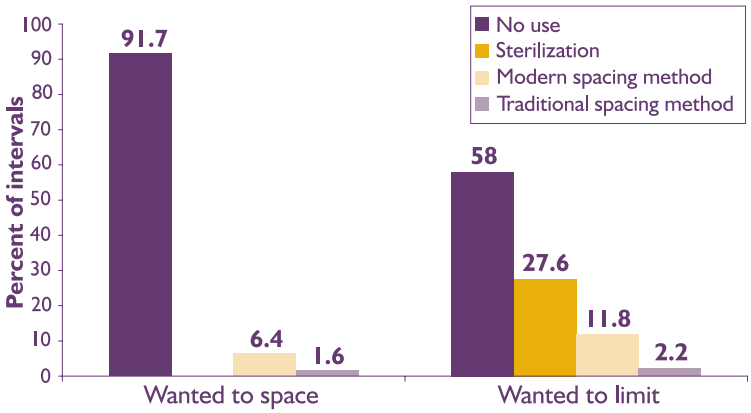
Figure 4.1
Women's desires on childbearing preceding any given pregnancy



Yet our data indicate that in only 17% of these intervals were women using any contraception. Even more interestingly, although women expressed a much greater need for spacing, contraceptive use is concentrated more heavily in intervals where women aimed to stop childbearing. Figure 4.2 shows that while contraceptive use is absent in 58% of the intervals where women wanted to limit their family size, it is absent in 92% of the intervals where women wanted to space their families. This pattern reflects the much greater availability and emphasis on permanent methods (specifically female sterilization) rather than temporary contraception in the Indian family planning program. As figure 4.2 shows, higher contraceptive use in intervals where family limitation was desired is largely accounted for by sterilization. Where women wanted to space their families, temporary modern methods were utilized in only 6.4% of the intervals, and traditional methods in an additional 1.6% of the intervals.

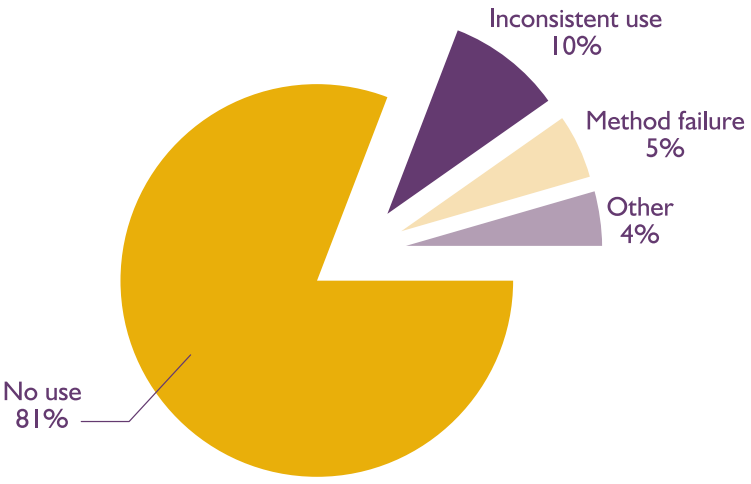
Demographers and women's health advocates have made the argument that in developing countries where women are shifting toward lower desired family size and fertility levels, the availability and access to contraception is a critical factor determining whether or not

Figure 4.2
Contraceptive use in intervals where women wanted to prevent or delay pregnancy



women end up resorting to abortion as the option for resolving unwanted pregnancies. The low levels of contraceptive use—and especially temporary method use—among women in our sample indicates that this may indeed be a critical factor in defining abortion behavior among the women in Madhya Pradesh. Figure 4.3 examines the pattern of contraceptive use among women who attempted abortions. Our findings indicate that women used contraception in only 19% of the intervals preceding pregnancies where they attempted an abortion. The most important reasons for non-use include: lack of knowledge and access[10] (42%), opposition from husband or family members (40%), and fear of side effects (19%). For the small minority who do use a method, however, contraception does not present a success story. As figure 4.3 shows, over three-fourths of the contraceptive use in the intervals preceding abortion was characterized by method failure (5%) or inconsistent use (10%). Women cited adverse health affects as the most common reason for inconsistent use or discontinuation of contraception. These women were either not provided the method suited to their needs, or they were not given adequate information or support to use the temporary method effectively.

Figure 4.3
Contraceptive use in intervals preceding attempted abortions



These findings confirm the argument that when Indian women are seeking abortion, for the most part, contraception—in particular temporary methods—has not been a real option for them. In terms of overall use of contraception, women who end up seeking abortions are not very different from other women; both groups are characterized by low contraceptive use (19% and 17% respectively). Women who used contraception, became pregnant and sought abortion, were by definition almost exclusively using temporary methods.[11] In this respect, this is a select group of women because they are relying on temporary methods in contrast to the great majority of contraceptive users who rely on sterilization.

Given India's poor history and experience with temporary methods of contraception, it is clear that this is not an easy or effective option for women to exercise even when they do undertake it against all odds. Our study supports documentation by other recent research that in addition to poor service access, the outreach, information, and follow-up support on temporary methods in India is poor: Between 30% to 50% of women discontinue contraception due to side effects (Gandotra and Das 1996; Talwar 1996; Mishra, Retherford et al. 1999). Program and policy personnel have been slow in addressing these concerns through fundamental shifts in service and provider orientation and outreach. Frequently, health concerns expressed by

women are dismissed as minor in nature, or resulting from misinformation and lack of knowledge. Our data along with the findings of these studies suggest, however, that although there is indeed plenty of misinformation and lack of knowledge, women's self-reported morbidity and health concerns need to be taken seriously. Often side effects and health issues that are not medically serious nevertheless have a major impact on women's quality of life, especially in circumstances where they are undernourished and overburdened already.

Dismissing rather than addressing women's fears and experiences also reinforces negative perceptions of temporary contraception among the general public. By breaking tradition and seeking temporary instead of permanent methods, women who adopt this option are serving as pioneers in many ways. To the extent that a preponderance of negative experiences and information from this group of pioneers circulates through women's networks, policy makers will continue to find it difficult to build momentum and normative support for temporary methods, even if service provision is increased substantially.

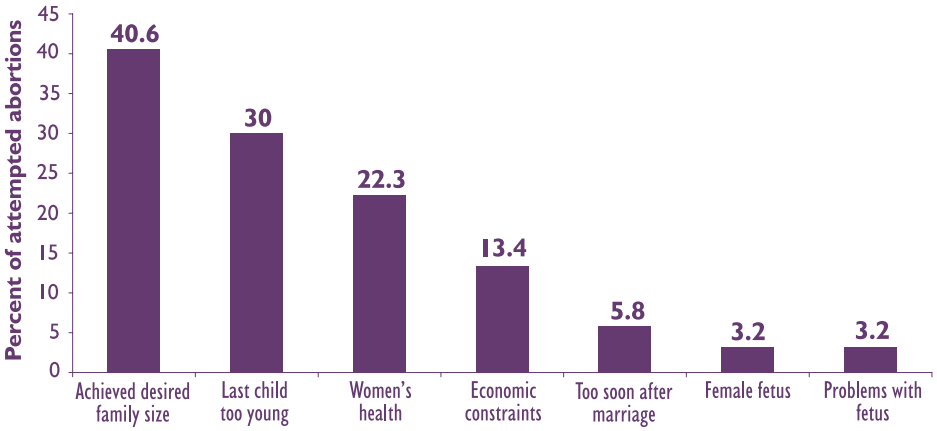
V The Abortion Experience from Women's Perspectives

As stated before, one of the unique features of the data we have collected is that we can present information on key aspects of the abortion experience as articulated by the women themselves. In this section, we discuss the why and how of the abortion experience in terms of reasons for seeking abortion, the methods and providers used by women, the financial fees paid, and the effort and mobility required to access services. We also discuss the importance of other family members in accessing effective services, the self-reported morbidity from abortion, and the extent to which follow-up family planning advice or counseling is given to women who have abortions. Finally, we discuss the extent to which our data indicate the practice of sex-selective abortions in Madhya Pradesh.

Reasons for Attempted Abortions

Figure 5.1 shows the reasons given by women as to why they attempted to terminate any given pregnancy. For the vast majority of pregnancies in which an abortion was attempted, women state that they either had enough children already (40%) or that they did not want another child while their last child was so young (30%). Thus, for these groups of women, the need for family limitation or spacing is the prime motivation in their efforts to resolve an unwanted pregnancy through abortion—a need that could be met through higher levels of family planning access and use. A significant proportion of abortion attempts (22.3%) were due to the risk for the mother's health, and to a lesser extent, due to problems with the fetus (3.2%). As reported by women themselves, sex selection was a reason in only 3.2% of the attempts. We discuss this issue more fully below.

Figure 5.1
Reasons for attempting abortion



Methods, Providers, Access, and Costs

Our findings indicate that the issue of access to adequate services is a major factor in determining the type of provider and method women use when they have an abortion. Urban women have ready access to a range of providers. As a result, for the vast majority of abortions in urban areas (77%), women relied on some type of a medical procedure (usually dilation and curettage). Moreover, as figure 5.2 shows, there is a clear preference among urban women for

private providers (52%) as opposed to government services (26%). It is important to note that based on women's self-reporting, it is not feasible to determine how truly "medical" these providers were, whether they were officially or otherwise qualified, or if they performed a safe procedure. In the Indian setting, the private sector is full of qualified physicians as well as self-proclaimed "doctors" who may or may not have the appropriate qualifications for the services they claim as their expertise. On the same note, government MTP centers may also be ill-equipped and served by poorly qualified personnel.

At the same time, however, it is clear from the findings in Figure 5.2 that urban women have a significant advantage in access to adequate abortion services when compared to rural women. While 77% of the pregnancies for urban women were terminated through some medical procedure, this was true for only 44% of the pregnancies for rural women. For medical procedures, the private sector plays an even more important role for rural women than it does for urban women, both due to preferences and the lack of adequate government facilities. What is most disturbing, however, is the fact that the majority of abortions for rural women (56%) are through dubious and potentially unsafe procedures, including a combination of folk methods, stress on the body, vaginally invasive procedures, and oral ingestion of pills (which in most cases are not safe abortifacients).

Poor access to abortion services among rural women is also apparent if we examine the distance and effort required for reaching a provider (Figure 5.3). For 78% of the abortions in rural areas, women had to go through considerable inconvenience and effort to reach a provider since the services were not in their community and required some type of transport for access. For urban women, this percentage is considerably smaller (41%), although not insignificant by any means. The access issue may be less relevant for urban women than this figure indicates since some women may be seeking providers outside their community for reasons of privacy.

Figure 5.4 suggests that effective access to safe abortion for women in Madhya Pradesh may also be restricted by the cost of services. Although the legal status of abortion in India means that services should be free at official MTP centers, our data indicate that only a

Figure 5.2
Methods used for abortion
self-reported by women

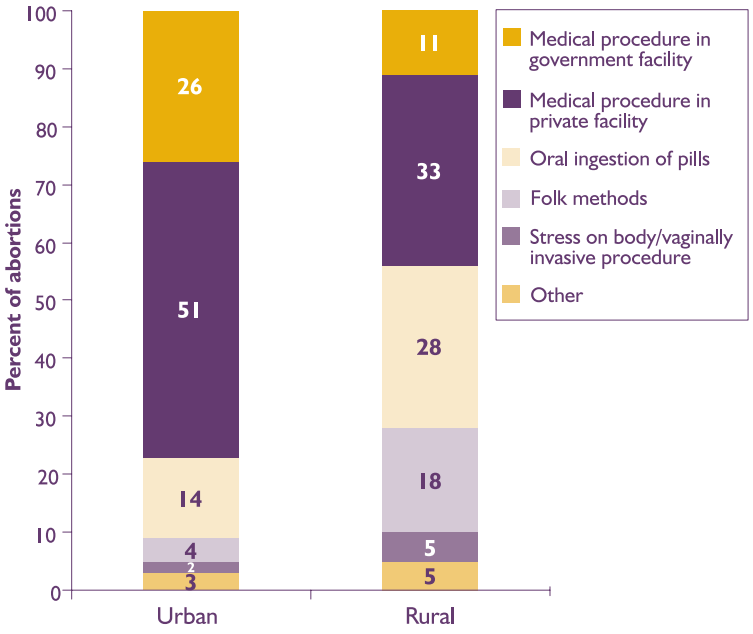


Figure 5.3
Convenience of access to abortion provider

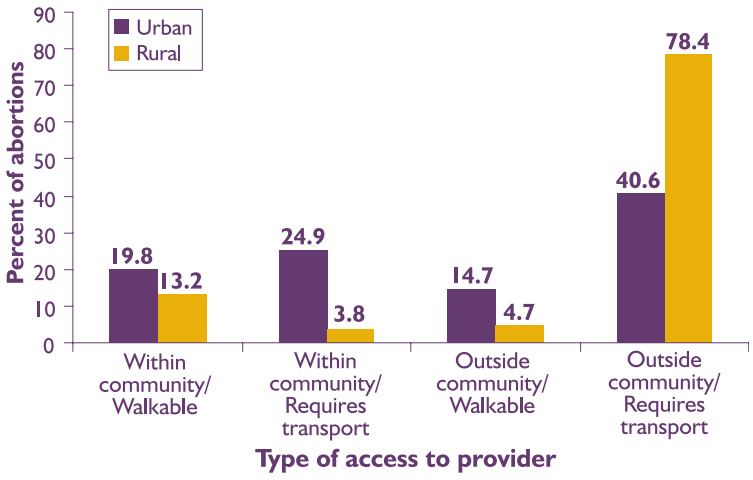


Figure 5.4
Provider fees for abortion (in rupees)

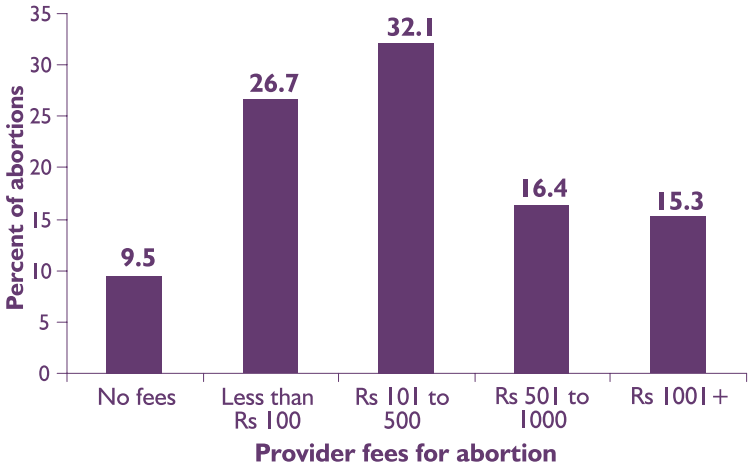
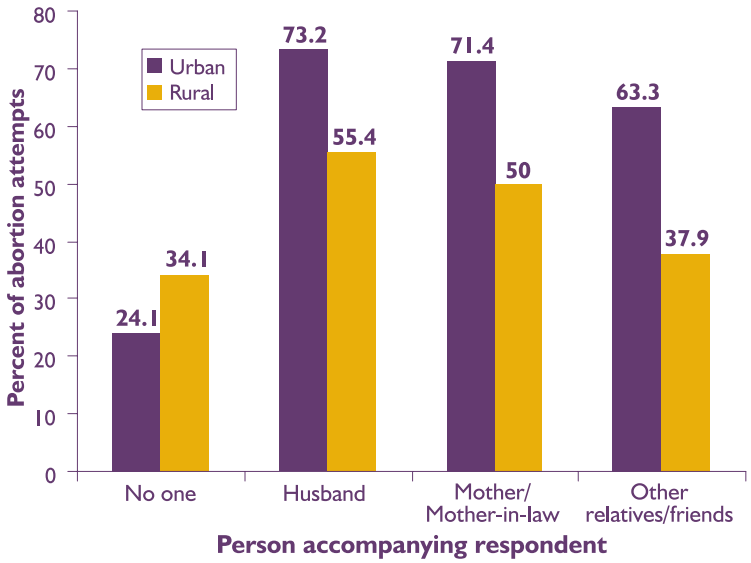


Figure 5.5
Success rate of attempted abortion by whether or not someone accompanied the respondent



small proportion of abortions are cost free (9.5%). Moreover, if we look at the distribution of provider fees paid, it becomes apparent that approximately one-third of the abortions cost between Rs.100-500, a fairly significant amount given the very limited resources of most families in MP, and the even more limited resources of most women.[12] Equally noteworthy is the fact that an additional one-third of the abortions actually cost in excess of Rs. 500, an amount that would be difficult to pay for all except the most privileged group of women.

Role of the Family

A wealth of evidence indicates that Indian women have limited power and control on decision-making regarding reproductive and childbearing issues (Yinger, Viswanathan et al. 1998; Jejeebhoy 2000). With regard to abortion, there is little existing documentation regarding the decision-making processes and how they affect the outcome of a given pregnancy (Jejeebhoy 1999). Among women seeking abortion, our data portray two simultaneously different profiles on the family's involvement. For a significant proportion of attempted abortions, women say that the decision was their own (44%), but for an equally significant proportion, they report it as a decision by both husband and wife (50%). Unilaterally or jointly, husbands had the major decision-making role in 20% of attempted abortions while the in-laws played a much smaller role, with decision-making input in approximately 5% of the abortion attempts. Similarly, data on consultation and discussion regarding the process of getting an abortion also show bifurcated results, with a little over half the attempts (53%) being undertaken by women without consultation with anyone, and the rest primarily with consultation with the husband (42%) and sometimes the mother-in-law (9%). Our data confirm the findings of other studies on the importance of other household decisionmakers in determining whether or not a woman has an abortion (Johnston 2002).

These data and our qualitative work indicate that many women are afraid to approach their families with the issue of abortion—especially if the family has been opposed to contraceptive use and family planning—while others realize that familial support is their best chance at getting the abortion. And indeed, our data show that women are much more likely to be successful in their attempts at abortion when the more powerful actors in the family, especially husbands and elder women, are

actively involved. As Figure 5.5 shows, this is especially true in urban areas: While only 24% of attempted abortions were successful when women were unaccompanied by anyone, over 70% were successful when they were accompanied by the husband, mother, or mother-in-law. Thus, an urban woman increases the likelihood of actually getting an abortion by almost threefold if she is fortunate or wise enough to have one of these family members present.

Husbands and elderly women in the family are key to success not only because they have the power of assertion in the family, but also because they are likely to have the knowledge, financial resources, and mobility to ensure that an adequate provider is sought. On their own, women are much more likely to be limited to nearby and ineffective providers or options. Furthermore, providers in MP frequently require women to have a husband or elderly family member present before undertaking the procedure. Although still substantial, in rural areas the difference in success rates based on whether or not a woman was accompanied is less dramatic. This is probably simply because *everyone* in rural areas—women, men, and elders—lacks access to abortion-related information and services.

Health and Family Planning

Better access, methods, and success rates among urban abortion seekers are also reflected in the self-reported morbidity from abortion attempts among women in Madhya Pradesh. As Figure 5.6 shows, rural women consistently report higher levels of health problems resulting from abortion attempts than do urban women. Of particular concern is the high proportion (35%) of abortion attempts for which rural women report severe complications; these include excessive bleeding, incomplete abortions, and prolapsed uterus. Given the earlier data on the proportion of abortion attempts among rural women that are likely to be under unsafe conditions, these results are not surprising, but disturbing, nevertheless.[13]

Figure 5.7 presents an even more disturbing picture of the extent to which the current system is failing women, both in terms of their health and ability to enact critical life choices. While women seeking abortions should be the prime candidates for appropriate family planning information, counseling, and services, almost two-thirds of the abortions (63%) were not followed up with any information on contraception. Moreover, in about 14% of the cases, women reported husbands as the prime source of follow-up contraceptive advice while government and private abortion providers were responsible for this advice

Figure 5.6

Self-reported morbidity from successful and unsuccessful abortion attempts

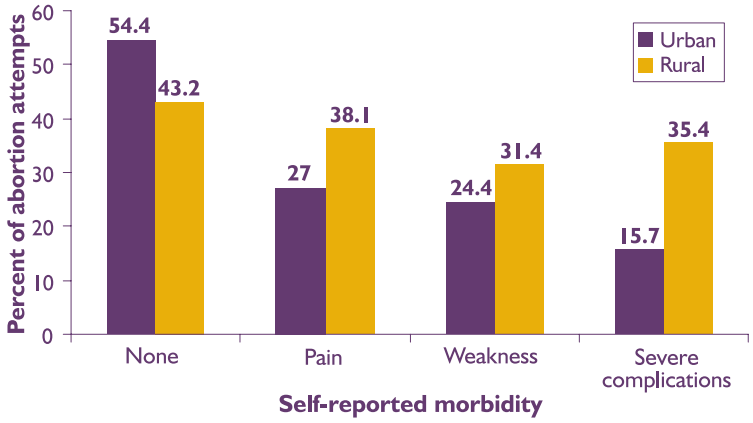
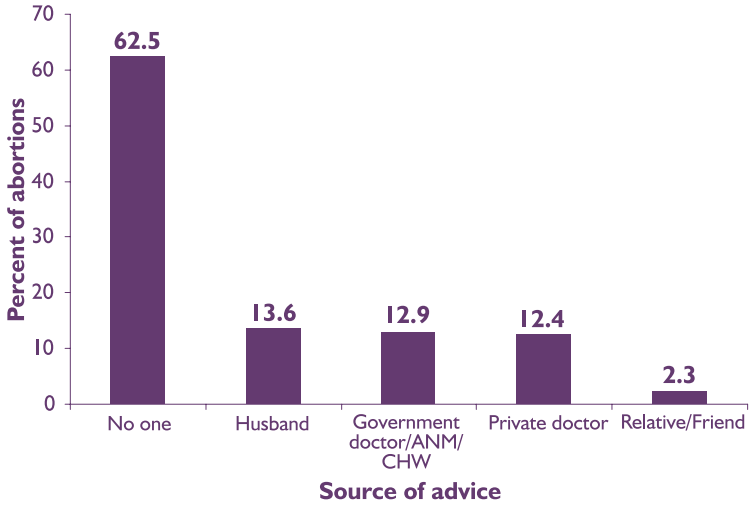


Figure 5.7

Post-abortion family planning advice



following only 25% of the abortions. Thus, the same system that sets women up for abortions does little to prevent their coming back for more.

Sex Selective Abortions

Sex selective abortions in India have attracted a lot of attention in recent years. As fertility preferences decline and ultrasound and amniocentesis technologies become readily available, parents are realizing their strong preference for sons by aborting female fetuses. The data from the 2001 Census have been particularly alarming in showing an increase in the overall and juvenile (0-6) sex ratios (proportion of males to females) in a number of Indian states. What is the picture with regard to sex selective abortions in Madhya Pradesh based on our data?

Since the campaigns against sex selective abortions have made it a sensitive issue on which women in a survey setting may not respond truthfully, data based on women's direct responses may not be the ideal tool for determining the level of sex selective abortions in a population. In our survey, we tried to minimize this response bias by addressing the issue through a series of indirect questions, embedding the question of sex determination in questions regarding overall pre-natal care. Our findings presented in Table 5.1 indicate that only a small proportion of pregnancies (3.2% in the urban areas and 1.7% in the rural areas) were aborted because the fetus was a girl. These results are also reflected in Figure 5.1 where female fetus was given as the reason for only 3.2% of the attempted abortions.

There is indeed a likelihood that these results underreport sex selective abortions in Madhya Pradesh. However, as we consider other relevant data on this state, there is a greater likelihood that these results are reflective of reality. The Census 2001 data do not mark Madhya Pradesh as one of the states where sex ratios have shown the rapid increases over the last decade experienced in states such as Punjab and Haryana.[14] Moreover, Madhya Pradesh does not parallel the economic development or the fertility declines experienced by these northern states. Demographers have argued that the sex selection issue becomes much more acute when family size preferences are very low, since parents are unwilling to accommodate any extra births. Madhya Pradesh still has considerably higher fertility levels and family size preferences

Table 5.1

Pregnancy outcomes by status on sex determination test

urban and rural

Status on test	Urban (percent pregnancies)		Rural (percent pregnancies)	
	Abortion	No abortion	Abortion	No abortion
Did not go for test	80.9	85.1	95.5	96.6
Test, no sex determination	12.1	11.5	2.4	2.1
Test, found boy	0.6	1.6	0.3	0.7
Test, found girl	3.2	0.9	1.7	0.4
Other	3.2	0.8	0	0.2
N (pregnancies)	157	1721	287	7039

when compared to states more noted for sex selective abortions. Also, given that 77% of the MP population is rural with poor access to even basic health services, the availability of sex determination technology is much more limited in this state.

Finally, it is important to note that although sex-selective abortions are worthy of policy attention because they reinforce discrimination against the girl child in such a dramatic manner, the vast majority of abortions are not due to sex selection, even in the states where the practice is most prevalent. For example, using data from NFHS-2, Arnold, Kishor, and Roy (2002) estimate approximately 100,000 sex-selective abortions, following ultrasound or amniocentesis tests, out of approximately 1.3 million total induced abortions to ever-married women in India each year. Although the overall numbers are underestimates, their analysis indicates that sex selective abortions comprise only about 7.7% of all induced abortions.

VI Conclusions and Recommendations

This study shows most vividly that the vast majority of Indian women do not have reproductive rights and choice despite the fact that abortion has been legal in India since 1972. Our findings demonstrate that in order to realize reproductive rights and choice for women in developing countries, it is essential to consider issues beyond the legalization of abortion. Results presented in this work show that in India, the lack of safe, effective, accessible temporary methods of contraception is as much a barrier to the realization of reproductive rights and choice for women as the ineffective and poor implementation of the abortion law. While most (although not all) women in the Western world may consider basic access to effective contraception a given,

Key Findings

Abortion

1. Abortion rates in MP, India are considerable, with almost one-fourth of currently married women 15-39 experiencing an abortion at least once by the time they reach their late thirties.
2. Demand for abortion is even higher, with four in ten currently married women 15-39 wanting an abortion at least once by the time they reach their late thirties. Failure rates for women attempting an abortion are substantial (35%).
3. Women's knowledge of their legal right to abortion is abysmal. Only 9% of women knew that abortion was legal and within what time period.
4. The vast majority of abortions were attempted because women wanted to limit their family size or space their childbearing (76%). Financial reasons and the mother's health were also important reasons. In MP, sex selection accounts for only 3% of abortion attempts.
5. Rural, poor, and marginalized women are especially disadvantaged with regard to access to adequate and safe abortion services. The majority of abortions in rural areas (56%) were through dubious and potentially dangerous means, and only a minority were through a medical procedure from a private or government provider. Rural women also report fairly high levels of severe complications (33%) following abortion attempts. Given that that vast majority of women in MP live in rural areas (77%) and are poor, these are numbers for serious concern.
6. Despite the provisions of the MTP Act, for most women, abortion is not cost free or readily accessible from government providers. A significant majority of abortions were sought from private rather than government providers, frequently at substantial cost and effort on the woman's part.
7. Family members play a significant role in women's decisions regarding abortion, and even more so in determining success if an abortion is attempted. Women accompanied by influential family members—husbands, mothers-in-law, mothers—were much more likely to access adequate services and get an abortion than women who made the effort on their own.

this is yet to be the case in many countries of the developing world, India being a case in point. Similarly, the passage of a law legalizing abortion is a necessary, but not a sufficient condition for ensuring access to safe and effective abortion services. It is equally important to ensure that women are apprised of their legal rights, service provision reaches a significant majority of women, and social, gender-based, and health related barriers to accessing services are addressed adequately.

Recommendations

The most significant policy message emerging from the findings of this study is clear: temporary methods of contraception must be made a viable option for Indian women. Given that women in India are expressing spacing as an overwhelming concern in their childbearing preferences, sterilization cannot continue to be the primary focus and emphasis of the Indian family planning program. Instead, the rhetoric for informed choice must be translated into a serious, committed, and energized effort at providing women safe and effective forms of temporary contraception.

To make temporary methods a viable option for Indian women, it is important to address not only the supply side factors of service provision, but also the demand side factors of women's perceptions, knowledge, health concerns, and family constraints. Our data show that women are not using temporary methods despite tremendous need in part because they don't know about them, or where to get them; in part because influential family members such as husbands, mothers-in-law, or mothers oppose their use; and in part because they themselves mistrust these methods. The mistrust arises from misinformation, but also from women's poor experiences with these

Contraception

1. The demand for contraception, even in a relatively poor, underdeveloped state of India such as Madhya Pradesh, is very high. Women wanted to delay or prevent pregnancy in 84% of the intervals where they had any possibility of becoming pregnant.
2. In contrast, actual contraceptive use in Madhya Pradesh is extremely low. Women were using contraception in only 17% of the intervals where they had wanted to delay or prevent pregnancy.
3. Despite the fact that women's overwhelming contraceptive need is for spacing births, sterilization accounts for most of contraceptive use in Madhya Pradesh. Women used temporary methods in only 8% of the intervals where they had wanted to space their childbearing.
4. The rate of contraceptive use was nearly the same for women who attempted abortions and those who did not.
5. Women who attempt abortions are pioneers in that they are making a concerted effort to use temporary methods of contraception in an environment where sterilization is the norm. However, of the women who tried temporary methods and then had an abortion, 75% discontinued either due to health concerns or experienced method failure.
6. Despite tremendous need, temporary methods of contraception have not been an option that women in Madhya Pradesh have been able to access or use effectively. The most important reasons for non-use are lack of information and access (42%), along with opposition from the family (40%).
7. The current system is failing women at more than one level. Over 75% of women's experiences with abortion were not followed up with advice on contraception from a medical provider.

methods. Except for limited NGO efforts, little has been done in the health system to address these fundamental problems. Respect for women's bodies and attention to their needs are the principles that are at the core of the concept of reproductive rights. It is critical that instead of dismissing women's health concerns, lack of proper information, and familial constraints to service access, the Indian family planning program begin addressing these issues systematically.

It is equally important to address demand side factors in structuring abortion services. Our data show that self-reported morbidity from abortion attempts is high, and that women's access to effective abortion services is highly dependent on the involvement of influential family members. Misinformation and lack of knowledge also pose serious barriers to accessing safe abortions. Most importantly, however, our data point to the need for the better integration of abortion and family planning services. This need is strikingly apparent in the very high proportion of abortions that are not followed up with family planning advice. Perhaps the most significant contribution of our work is in highlighting the extent to which contraceptive use (or non-use) and abortion are interconnected. In women's lives, these two issues do not exist independently of each other, and their separation in the health infrastructure does not serve women well.

Policy action is required to reshape the programmatic structure and implementation of abortion services in India. Not only must government providers be more plentiful, better trained, and better equipped (especially in rural areas), but the significant role of the private sector must also be acknowledged. Policy makers need to create a true partnership with private sector providers, finding the balance between the two extremes of over-regulation and absolute laissez-faire (both of which currently exist simultaneously).

On the legal front, several actions are required as well. Clearly, the legality of abortion for the last 30 years has had little relevance for many Indian women. A campaign to inform and educate women and their families regarding the legal right to abortion must be a first step in ensuring the enactment of this right. An education campaign informing providers of the precise provisions of the law is as necessary as an education campaign for the public. Additionally, the MTP Act itself requires revision. An amendment to the Act passed in the last few months, to simplify registration procedures for providers, suggests that pressure from committed stakeholders and constituencies can make a difference. However, future amendments to the Act must focus on making it more transparent and easily implemented.

Next Steps

The data from this study have been important in shedding light on the meaning of rights and choice in one—albeit fairly large—corner of the world. ICRW researchers have demonstrated that innovation in survey methodology can enable one study to capture an accurate measurement of abortion prevalence, its connection with contraception use, and a more comprehensive picture of women's reproductive lives. It is important that this approach and methodology be replicated in other developing countries (as well as in other parts of India), so that the reality of women's lives from their own perspectives can be documented in a number of other social and political contexts. Such documentation is essential for bringing meaning to the concepts of rights and choice internationally.

End Notes

[1] The unmet need for family planning is substantially greater than is obvious at first glance. The NFHS-2 calculates unmet need at 15.8% in India, using a limited definition of currently married, fecund women who do not want any additional children or who do not want another child for at least two years. In poorer, disadvantaged, high fertility settings such as the BIMARU (sickly) states, unmet need is higher. An ICRW study in Sitapur, Uttar Pradesh calculated unmet need at 31.7% when using this same definition, but at 54.8% when using an expanded definition where method dissatisfaction, non-protection by post-partum amenorhea, and incorrect traditional method use were also accounted for (Yinger 1998).

[2] The NFHS-2 uses a more sophisticated approach. A question about abortion is asked during the collection of birth histories by asking if an abortion occurred between any given two births. Our methodology uses a similar approach as part of the Day 1 questionnaire, although we do not directly focus on an abortion between two births, but rather on first determining if there are missing pregnancies between births that may have been resolved through abortion. NHFS-2's numbers from these data have yet to be published.

[3] The study design was approved by the Institutional Review Boards of each partner institution.

[4] Women without children are less likely to have pregnancy histories to record while women older than 39 may present considerable recall bias.

[5] More specifically, an interval is the period between marriage and the first pregnancy, between any two pregnancies, or the period following the last pregnancy. The latter is classified as an open interval while the former two are classified as closed intervals. The interval following a last pregnancy may also be considered closed if the woman or her husband is sterilized and the woman is not at risk of becoming pregnant.

[6] The 2001 census gives total female population in MP as 28,928,245. Based on the NFHS-2, the ratio of currently married women ages 15-39 to all women is 0.3193. Therefore, we calculate that there are approximately 9,235,697 married women aged 15-39 in Madhya Pradesh currently. We estimate that 2,124,210 of these women will have at least one abortion by the time they reach 39 based on our finding that 23% of our sample aged 35-39 have ever had an abortion.

[7] Abortion ratios from the NFHS-2 were calculated for the equivalent sample—married women 15-39 with at least one child—in MP as that used by ICRW.

[8] In this study, we define an attempted abortion from the woman's perspective rather than a technically medical perspective. A woman was considered to have attempted an abortion if she said she wanted to terminate a pregnancy and took some action with the intention of terminating it, whether or not that action is medically proven to result in an abortion.

[9] Our definition of not wanting a child immediately is not wanting another child for at least two years. This definition is most frequently used when describing unmet need for contraception.

[10] The responses classified as "lack of knowledge and access" include: did not know about contraceptives; did not know where to get them; contraceptives not available; and felt shy obtaining contraceptives.

[11] Of the 19% of intervals where contraception was used prior to an abortion attempt, 18% were characterized by (mostly modern) temporary method use, and 1% by failed sterilization.

[12] At the current exchange rate, one dollar is equivalent to approximately Rs. 48. The relative value of Rs 100-500 or over Rs. 500, however, has to be determined in the context of the local setting. The data on household circumstances show that the monthly household expenses of 77% of the families that we surveyed are less than Rs. 3000, and that over half the families have a difficult time meeting their monthly expenses.

[13] It is important to note that at least in one aspect our study underreports morbidity: The very nature of sample survey excludes women who have died from attempted abortions.

[14] For example, while the juvenile sex ratio in Punjab climbed from 114.3 in 1991 to 126.1 in 2001, and in Haryana from 113.8 to 122.0, the juvenile sex ratio in Madhya Pradesh experienced a much less steep increase from 104.4 to 108.1 during the decade.

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