LIVING WITH REPRODUCTIVE CONTINGENCIES: UNDERSTANDING ABORTION EXPERIENCES IN GUWAHATI

RWITTAMBHARA KASHYAP

G2020CODP033

A dissertation submitted in partial fulfillment of the requirements for the Degree of

Master of Arts in Social Work in Community Organisation and Development Practice

Centre for Community Organisation and Development Practice

Tata Institute of Social Sciences

Guwahati Off-Campus

2022

turnitin **Turnitin Originality Report**

Understanding abortion stigma in Guwahati
by Rwittambhara Kashyap

From MA CODP 2022 (MA)

Processed on 03-Jun-2022 07:47 IST
ID: 1849450358
Word Count: 12814

Similarity Index	Similarity by Source	
9%	Internet Sources:	6%
	Publications:	3%
	Student Papers:	6%

sources:

1. 1% match (Internet from 23-Aug-2020)
https://www.ippfsar.org/sites/ippfsar/files/2017-08/IPPF%20Political%20Mapping%20draft%20report_v.1_4.pdf

2. 1% match (Internet from 23-Jan-2022)
https://scholarworks.iu.edu/journals/index.php/jsriue/article/download/31847/36487/82117

3. 1% match (student papers from 23-Nov-2021)
Submitted to Helensvale State High School on 2021-11-23

4. 1% match (student papers from 26-Nov-2021)
Submitted to College of the Canyons on 2021-11-26

5. < 1% match (publications)
University of Tennessee, Knoxville

6. < 1% match (Internet from 01-Dec-2020)
https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2804%2924017-4

7. < 1% match (Internet from 10-Apr-2018)
https://feminisminindia.com/2016/04/11/abortion-rights-india/

8. < 1% match (student papers from 18-Apr-2022)
Submitted to Adtalem Global Education on 2022-04-18

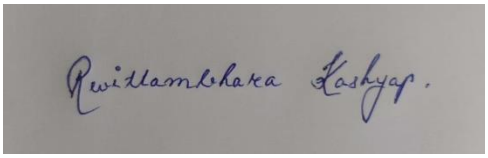
9. < 1% match (student papers from 13-Apr-2022)
Submitted to The College of the Bahamas on 2022-04-13

10. < 1% match (Internet from 28-Apr-2021)
https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx

11. < 1% match (Internet from 30-Jun-2018)
https://en.wikipedia.org/wiki/Abortion_in_India

DECLARATION

I, Rwittambhara Kashyap, hereby declare that this research report entitled “Living with Reproductive Contingencies: Understanding Abortion Experiences in Guwahati”, is the outcome of my own study undertaken under the guidance of Dr. Santhosh M.R. Ph.D., Assistant Professor & Dean, School of Social Work, Tata Institute of Social Sciences, Guwahati Campus, Assam. It has not previously formed the basis for the award of any degree, diploma, or certificate of this Institute or of any other institute or university. I have duly acknowledged all the sources used by me in the preparation of this dissertation.



6 June 2022

Rwittambhara Kashyap
G2020CODP033

CERTIFICATE

This is to certify that the dissertation entitled “Living with Reproductive Contingencies: Understanding Abortion Experiences in Guwahati”, is the record of the original work done by Rwittambhara Kashyap under my guidance and supervision. The results of the research presented in this research report have not previously formed the basis for the award of any degree, diploma, or certificate of this Institute or any other institute or university.

6 June, 2022

Santosh M.R. PhD
Assistant Professor and Dean
School Of Social Work

ACKNOWLEDGEMENT

I would like to express my gratitude to the Tata Institute of Social Sciences, Guwahati, for providing me with this opportunity to write a dissertation for my Master's program and for helping me realise the prevalent societal issues while simultaneously escalating my knowledge on the same.

This report would not have been possible without the abled guidance of my supervisor Dr Santhosh M.R, for which I am indebted and owe him a deep sense of gratitude. I would also like to extend my gratitude to our Deputy Director- Professor Kalpana Sarathy, Centre Chair- Dr Shivani Chauhan Barooah, and our centre professor- Dr. Joseph Riamei for their care and support throughout all semesters.

Again, without the willing cooperation of the research respondents, this study would have been incomplete. Therefore, I would like to thank them for their valuable time in providing me with significant information and for sharing their experiences.

I am forever grateful to my brother and my cousins for their constant companionship and support throughout my study. I am also indebted to my sister, Nimisha Goswami, for her consistent support and help to develop me professionally.

I would like to thank Rishiraj Sinha, Trishant Bora, Radhika Bagdi, Ronakjeet Sharma, Simi Chakrabarty, and Shatabdi Gohain for their constant love and support. Lastly, I am grateful to my batch-mates for their help and support whenever needed.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CEDAW: Committee on the Elimination of Discrimination Against Women

CESCR: Committee on Economic, Social and Cultural Rights

CRC: Committee on the Rights of the Child

HRC: Human Rights Committee

ICPD: International Conference on Population and Development

IPC: Indian Penal Code

MMR: Maternal Mortality Ratio

MTP: Medical Termination of Pregnancy

PoA: Programme of Action

RTI: Reproductive Tract Infection

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

UN: United Nations

ABSTRACT

Abortion is an idiosyncratic experience in the lifeworld of women. The struggle for abortion rights has been a contentious issue globally amid sundry political and socio-cultural challenges. The primary assumption of this study is that factors such as social location, power relations, and provider-seeker interfaces sculpt the reproductive lived experiences of women in Guwahati. It has further analysed and explored the abortion experiences of women with specific reference to abortion stigma, decision-making, and morality.

Unwanted pregnancies attest to a decisive milieu of women's inability to parlay and negotiate sexual autonomy or practice in India. Self- determination to have control over her own reproductive body is least recognised by a women's family, society, by the country's health providers, laws, and policy. Socio-cultural and familial contexts clubbed with her abortion experiences force every Indian woman to present the context of her unwanted pregnancy as a voice not only as a decision to discontinue her pregnancy but also as a way to express the daily struggles of her own self and her body.

Women's inability to access safe and stigma-free abortion services coupled with moral predicaments linked with their social relations severely constrain their reproductive autonomy. Therefore, this study voices the need for universal access to safe abortion and suggests that the provision of abortion should be free from moral and foetal personhood discourses. The law and its polity on abortion should recognise the historicity of gender discrimination in our Indian societies. Furthermore, this study reveals and illustrates the experienced abuse and torture that Indian women experience while seeking abortion in health institutions This study reiterates the need for a resilient and strong women-centric abortion policy and the provision of stigma-free and empathetic reproductive health care not just in Guwahati but across India.

CHAPTER 1

Introduction

Birth control and abortion are not neoteric phenomenon. It has been practised from time immemorial. Birth control and abortion, although strictly medical procedures have been at the centre of an intense socio-political and cultural debate, with emphasis provided mostly on the morality of such an act. As Petchesky quoted, the debate over abortion means that it is not exclusively a medical issue, but, "the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood and young women's sexuality are contested" (Petchesky, 1986).

Abortion, whether done overtly or covertly, has been resorted to by women for ages, but due to the influence of religion and other socio-cultural factors, their safe access to abortion has been limited by social and legal impediments (Jesani, 1995). Laws or social norms regarding abortion have been consistently shaped and reshaped to fit the time and social context in which they are enacted. Although discrepancies are bound to arise over time, cultures and social constructs, one consistent trend that could be observed is that such laws or norms governing abortion are often directed towards prohibiting or limiting its access to women, highlighting yet another way in which society structurally tries to alienate women from their rights, including their right to, chose what they want to do with their body.

Abortion is an idiosyncratic experience in the lifeworld of women. The struggle for abortion rights has been a contentious issue globally amid sundry political and socio-cultural challenges. Though abortion was lawfully restricted in almost all nations till the end of the nineteenth century, abortion is an indispensable yet common constituent of Sexual and Reproductive Health and Rights (SRHR) (Berer, 2017). Activists, feminists and women from the grassroots have been claiming their right to safe and legal abortion, which also implies the right of women over their individual bodies. The principal locus of the rights-based approach is that every woman should

have autonomy in decision-making with regard to their reproductive decisions. The former should be enabled by policies to operationalise women's decisions.

Abortion can be safe only when abortion services are available at women's request and is affordable and accessible (Berer, 2017). In spite of that, stigma and social norms around abortion influence women's decision-making and construct barriers to safe abortion care.

Stigma from abortion is profoundly a dynamic societal and contextual process. This stigma not just affects the women who seek an abortion or who have had an abortion but also other groups like abortion providers, family members, supporters, and partners of individuals availing or seeking to avail of abortion services. Kumar et. al (2009) cited in their work that abortion stigma also deeply affects abortion researchers and advocates. Stigma is one of the most influential and commanding tools in anti-abortion efforts across the globe. Today, legal battles in the field of abortion in many nations have been won, however, the moral battle is yet to be conquered. There are still moral qualms about abortion in all nations irrespective of their development status.

Although the list of the root of abortion stigma is non-exhaustive, one of the most identified reasons behind abortion stigma is based on the female ideals of motherhood and sexuality and its violation (Kumar et. al, 2009). These kinds of causes elucidate the hue of manifestation of abortion stigma for the affected population. Understanding abortion stigma and the diversity of women's experiences of abortion stigma has direct implications for improving the quality of abortion healthcare and accessibility to stigma-free services.

Today, the discourse on abortion is coupled with legal, ethical, and moral confers. Sunil (2018) cited in her work that abortion discourses are largely curved and delimited by the actors associated with the medico-legal-technological systems. Nevertheless, feminist researchers argue that abortion discourses should not be merely delimited to medico-legal-technological realms but should advance as "the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood and young women's sexuality care contested." (Petchesky, 1990).

In this milieu, the emphasis should be on the lived experiences of women and understanding them through their social location. Such approaches could aid in the development of effective policy-making and facilitate positive advocacy toward the promotion of abortion rights and empower women to make the right choices and decisions regarding their sexual and reproductive health.

In this context, this research commenced with the aim to learn about the diversity of women's abortion experiences with a special focus on experienced abortion stigma and how it affects the decision-making of abortion-seeking women. The researcher weaves a feminist perspective alongside the public health discourse on abortion. This study hopes to provide valuable insights into how abortion stigma carves decision-making, fear, autonomy, and exercise of sexual and reproductive rights of women in Guwahati seeking an abortion amidst the diverse and complex social fabrics and institutional structures. Acknowledging that, this paper attempts to meticulously understand the problematic environment or risk factors pertaining to abortion services available in the metropolitan city of Guwahati. This study is to look into, understand and capture the experiences of women who go through the process of abortion and the barriers they experience in curving their choices and decisions. It will focus solely on the experiences of these women to gain essential insights into the systematic exclusion of women from attaining bodily rights. This study attempts to refine present knowledge on the experience of abortion by women by permitting them to express different facets or aspects of their experiences that were most significant and consequential to them. This research argues the lop-sided bodily rights of women in the metropolitan city of Guwahati and identifies different factors that contribute to shaping the women's experiences towards their accessibility to safe abortion services.

1.1.Sexual and Reproductive Health and Rights (SRHR)

Sexual and Reproductive Health and Rights (SRHR) is linked to several human rights which include the right to health, right to life, right to be free from torture, right to privacy, right to education, and prohibition of discrimination (Officer of the United Nations High Commissioner for Human Rights, 2020). Several international bodies also undoubtedly denoted that women's right to health includes their sexual and

reproductive health (Officer of the United Nations High Commissioner for Human Rights, 2020). The SRHR is an inclusive label that includes abortion, pregnancies, family planning, Reproductive Tract Infection (RTI), Adolescent Sexual and Reproductive Health, etc. The definition of SRHR mirrors a growing unanimity on the interventions and services necessary to address the sexual and reproductive health (SRH) needs of all.

The consequent Programme of Action for the International Conference on Population and Development (ICPD) (1994) largely delineated reproductive health to include matters concerning the well-being of the reproductive system and its function and processes (United Nations, 2014). Briefly, it envisaged that every sexual contact or interaction should be free of cohesion, no pregnancy should be unintended and all childbirths and deliveries should be healthy (United Nations, 2014).

1.2.Women's rights and safe abortion

In numerous international treaties and other instruments, we can uncover immense international legal support for a women's right to safe and legal abortions. The right to life and health, freedom from discrimination, and autonomy in reproductive decision-making, support and guarantee the right to choose abortion (Centre for Reproductive Rights, n.d.).

In many human rights instruments, the right to life is protected. It has been proven by several research and acknowledged widely in the field of academia that in countries in which abortion is restricted, women tend to seek abortion illegally and under conditions that are medically unsafe or underqualified and threaten women's lives. Around twenty million women choose to go for unsafe abortion services every year which is responsible for nearly 70,000 women's death annually (Centre for Reproductive Rights, n.d.).

Any government around the globe that forces women to undergo or resort to unsafe abortion services threatens their right to life. Article 6.1 of the United Nations Rights Committee called upon states to inform that "any measure taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo

life-threatening clandestine abortions" (Office of the High Commissioner for Human Rights, 2000).

The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (World Health Organisation, 2003). The right to "the highest attainable standard of health" (World Health Organisation, 2003) is guaranteed by international law. Women's health can be devastatingly affected upon availing of unsafe abortion services or procedures. It may cost a women's life as well as may pass on long-term disabilities such as trauma, peritonitis, rupture of cervix, vagina or uterus, sepsis, pelvic inflammatory, etc. Women's right to health can only be safeguarded by providing safe abortion services.

Women have the absolute right to decide on whether or not to terminate their pregnancy. Any decision regarding her body can be taken by a woman and has the right to do so. The Office of the High Commissioner for Human Rights (2000) cited those provisions such as the right to physical integrity, the right to decide the number and spacing of children, and to do so freely and responsibly, ensuring freedom in the decision-making on private and bodily matters of women. One's reproductive capacity and decision on bodily matters lie in the purview of private decision-making. The government or any institution should not enact the role of decision-making for a pregnant woman because it is her choice and her right to decide on her pregnancy.

Penalizing women for exercising their basic human rights leads to compromised decisions in choosing abortion services, thus jeopardizing the life and health of the women.

1.3.Debates on Pro-Life vs Pro-Choice

Historically, the world has seen a changing discourse on abortions through abortion bans to the legalisation of abortions in select nations under specific conditions. This topic has generated substantial and passionate debates on moral, ethical, legal and political grounds. However, the debates include and engulf a much wider dogmatic

and ideological brawl where the meanings of sexuality, motherhood, family and state are contested. There still exists a divide between pro-choice and pro-life philosophers.

The first anti-abortion campaign has an interesting backstory. In Europe, laywomen healers were among the first to provide abortion services (Jesani and Iyer, 1995). However, in the mid-nineteenth century, there rouse a robust cogency in the domain of medicine that was predominantly a male-dominated sphere (Jesani and Iyer, 1995). They set on a contest to diminish non-professional health practitioners, mostly women and abortion providers, to top their contest. Resultant of this pioneered the initial and organised anti-abortion campaign.

Especially in the United States of America (USA), following the legalisation of abortion, the pro-life and pro-choice advocates became radicalised and even violent. A political movement was initiated by the pro-life activists after Roe v. Wade's judgement in the USA (Gale, 2018). In 1968, in response to the country liberalising abortion laws, pro-life activists formed the National Rights to Life Committee, the oldest pro-life organisation in the country (Gale, 2018). Founded in 1971, the Americans United for Life, contrived a legal defence in reaction to the Supreme Court's legalising of abortion laws (Gale, 2018). Pro-life activists and advocates argue that unborn children are "legally deemed individuals" (ibid). They even claim that unborn children even have the right to inherit property. In some nations, women or any individual who is responsible and liable for the death of an unborn child may be charged with manslaughter.

Abortions are ethically indefensible, according to pro-life advocates, and should therefore be prohibited. The pro-life argument might be moderate and non-absolutist, or it can be classical and radical (ethical absolutism). The pro-life argument is founded on the concept that the foetus' right to life should be safeguarded at all costs, because "the unborn are innocent, vulnerable, and helpless" (Lewis & Tamparo, 2007). As a result, the absolutist pro-life argument is based on the belief that human life begins at conception and that legalising abortions condones feticide or the deliberate death of a foetus. (Matwijkiw, 2020).

The pro-life viewpoint, or the case against abortion, is based on three principles: the Human Rights Principle, the Mens Rea Principle, and the Harm Principle (Matwijkiw, 2020). According to the Mens Rea Principle, "The agent's intentions should be given weight" (Matwijkiw, 2020). As a result, abortion violates this concept because the agent purposefully kills another, and the pregnancy is ended knowingly (Matwijkiw, 2020). Furthermore, abortion violates the Injury Principle, which states that "you should not cause substantial harm to other people as a rule." This is because pro-life proponents believe that it is impossible to dispute that abortion causes substantial harm when the foetus' life is taken away (Matwijkiw, 2020). Pro-life activists claim that it is an irrefutable fact that when you have an abortion, you are ending the life of another human being (again, assuming that human life begins at conception), and that it is also irreversible (Matwijkiw, 2020). The fourth principle to consider, the Human Rights Value (a fundamental ethical principle), is also violated by abortion. "Equal rights should be distributed on the basis of humanity," according to the Humans Rights Principle (Matwijkiw, 2020). The continuation or termination of that life signifies that life is at risk. Pro-life proponents believe that the life of the foetus should be preserved (Matwijkiw, 2020).

Abortions are ethically justifiable, according to the absolutist pro-choice perspective, and should thus be performed as long as the procedure is safe. This argument is based on the idea that the pregnant woman's rights are more important than anyone else's (i.e., the foetus); the decision to perform an abortion is the woman's right, and other factors, such as the circumstances or the viability of the foetus, are not to be considered (Lewis & Tamparo, 2007). Liberalism considers a pregnant woman's body to be her own, and she should be able to govern it (Matwijkiw, 2020). The basic pro-choice argument states that a woman should be allowed to make her own decisions and that these decisions are self-regarding because the foetus is simply a future person, not the Other as the pro-life argument claims (Matwijkiw, 2020).

1.4.Brief account of the politics of abortion

Regarding abortion policies or the legal grounds for abortion, these greatly vary from nation to nation. According to a United Nations report, in the year 2013, ninety-seven percent of governments allowed abortions on the grounds of saving women's life

(United Nations, 2014). But in about two-thirds of the countries, abortion was allowed only when the mental or physical health of a mother was imperilled (United Nations, 2014). Moreover, only in half, of the countries, abortion was permitted when the pregnancy resulted from incest or rape or in cases of foetal impairment (United Nations, 2014). About one-third of the countries allowed abortion on grounds of social or economic reasons or on appeal. Countries like the Holy See, El Salvador, Chile, the Dominican Republic, Malta and Nicaragua did not allow or permit abortions on any grounds (ibid).

The political environment and legal decisions in the field of abortion are still facing undercurrents of uneasiness in India. The Indian laws of abortion fall under the Medical Termination of Pregnancy (MTP) Act, enacted in the year 1971 (IPPF, 2015). This act was enacted by the Indian parliament with the sole intention to reduce the incidence of illegal /clandestine abortions and the consequent maternal mortality and morbidity (IPPF, 2015). The MTP Act 1971, legalized abortions up to 20 weeks of gestation, when offered by a registered medical practitioner at a registered medical facility based on certain conditions (IPPF, 2015). However, married women were allowed to terminate an unwanted pregnancy without providing any certain reasons within 12 weeks of gestation (IPPF, 2015).

Recently, the new Medical Termination of Pregnancy Act, 2021 was passed and came into force in the month of March 2021 (Unknown web source, n.d.). The new act aims to extend the period of allowed termination of pregnancy up to 20 to 24 weeks of gestation (Unknown web source, n.d.). To terminate a pregnancy until 20 weeks will need approval from one registered practitioner but to terminate between 20-24 weeks, there needs to be approval from two medical practitioners (Unknown web source, n.d.). While the proposed bill amendments show signs of progression, yet, the bill is still debatable. Many accuse the bill to be inadequate in providing women with the autonomy they deserve. In my personal opinion too, the bill is far from a rights-based approach and more of a needs-based approach. Rights-based abortion policies not only accentuate women's right to seek a safe abortion but her right to have access to safe abortion services and information about the accessibility of such services.

Despite all possible efforts and measures, the commotion of clandestine abortions is grabbing eyeballs and paving the way towards the contentious issue of unsafe abortions and the complications they give rise to. According to estimates and correlating data on maternal mortality ratio (MMR), unsafe abortion is killing one woman every two hours in India i.e. approximately, 4000 deaths a year (IPPF, 2015). In 2007, a Lancet paper reported that there were 6.4 million abortions and of which 3.6 million or 56% were carried out unsafe. Moreover, according to the Census 2011, abortion in registered institutions varies from 32 percent in Chhattisgarh to 73.9% in Assam (IPPF, 2015).

CHAPTER 2

Review Of Literature

This chapter indulges itself in a modest preliminary insight into the history of the politics of abortion. The trajectory has its initial focus on the abortion discourse at the global level and narrows its focus down to discussing the politics of abortion in India. This chapter will also indulge itself in the theoretical perspectives related to abortion and will present a review of literatures thematically to understand abortion from a feminist perspective.

2.1. History of Politics of Abortion

The former Union of Soviet Socialist Republics (USSR) was the first country in the modern age to decriminalise abortion in 1920. After almost a decade, Hitler passed the 'Law for the Prevention of Progeny with Hereditary Diseases,' which legalised and encouraged abortion to eliminate 'racially inferior' offspring. After WWII, this law was declared a "crime against humanity," which it was, because the justification for abortion was not the woman's life, but the child's race. In 1948, Japan became the second country to legalise abortion, followed by numerous countries in Eastern Europe in the 1950s. In 1967, Britain passed The Abortion Act of 1967, which made abortion lawful in the country. (Shrivastava et.al., 2018)

The United States, on the other hand, has a tumultuous connection with abortion rights. In the United States, the pro-choice movement grew more slowly. The early women's rights movement, which began in the 1850s, was strongly opposed to abortion. In reality, the prominent proponent of women's rights, Susan B. Anthony (1821-1906), denounced abortions. Three books released by doctors in the 1930s prompted the medical community to consider changing abortion regulations. Two psychiatrist conferences and a Planned Parenthood conference addressed the topic in the 1950s. Indian legislation still uses the term "planned parenthood" to refer to abortions. It somehow shows abortion in a less horrible light, which was also a pressing necessity considering how widely abortions have been stigmatised. The American Law Institute proposed expanding the scope of lawful abortion to include physical and mental reasons for the mother, foetal deformities, and cases of rape and incest in 1959 (Shrivastava et.al., 2018). Mississippi, California, and Colorado were the first states to legalise abortion in the 1960s (Shrivastava et.al., 2018). Only 16 of the 50 states

supported the abortion rights movement by the 1970s (Shrivastava et.al., 2018). After the Roe vs Wade ruling by the US Supreme Court in 1973, abortions were legalised nationwide. (Gold, 2003).

India already had the MTP Act of 1971 in place when the United States passed a law-making abortion legal nationwide. Abortion was originally made a crime, criminal for both the lady and the abortionist under the Indian Penal Code 1862, and the Code of Criminal Procedure 1898, which had their origins in the British Offences Against the Person Act 1861. Abortion laws were liberalised across Europe and the Americas in the 1960s and 1970s, and this trend continued in many parts of the world into the 1980s. In 1964 India's abortion laws were liberalised in response to high maternal mortality from unsafe abortions. The Shah Committee, which was formed by the Indian government, conducted a detailed assessment of the socio-cultural, legal, and medical elements of abortion and advocated legalisation in 1966 to prevent the waste of women's health and lives on humane and medical grounds. Despite the fact that some states saw the proposed legislation as a means of curbing population growth, the Shah Committee clearly refuted this charge. The phrase "Medical Termination of Pregnancy" (MTP) was coined to dissuade socio-religious groups opposed to abortion law liberalisation. With the exception of Jammu and Kashmir, the MTP Act, approved by the Parliament in 1971, legalised abortions across India (Hirve, 2005).

The Indian government promoted a liberalised (or seemingly liberalised) abortion system because India had a significant population problem, and family planning had to be an option if population growth rates were to be stabilised. In truth, the motto "Hum Do, Hamare Do" (Two of us, and our two) was associated with India's 1952 family planning initiative. Giving women the choice of whether or not to carry their pregnancies to term is consistent with the state's goal of regulating population growth rates. Smaller families are also a significant tool for escaping poverty (Agnihotri, 2016).

2.2. Abortion Discourse

In this section, we will briefly discuss the relevant discourses related to abortion in the global and Indian contexts. The purpose of reviewing literature in this context is to provide the readers with a brief background of the abortion context and to unveil the gaps.

2.2.1. Global context of abortion:

Unsafe abortion has been a pressing concern globally since it leads to maternal mortality and morbidity. De facto rights and choices have been bracketed with the legal access to safe abortion. A global trend had set in the 1950s, when Eastern and Central Europe liberalised abortion laws, to remove the ban on abortion on certain grounds (Finer and Fine, 2013). Sunil (2018) stated that there is a continuum of conditions based on which a country espouses or adopts the legal grounds for abortion. And two of the extremes are- outright prohibition and the allowing of abortion without restrictions as to reasons (Sunil, 2018). The major grounds on which countries allow abortion is: to save a woman's life, to preserve her physical health, her mental health, socio-economic reasons, rape and incest (Centre for Reproductive Rights, 2018).

Singh et. al. (2018) and their work suggest that around six percent of the world's 1.64 billion women live in countries where abortion is prohibited. Again, another thirty-seven percent of women of reproductive age live in countries where abortion is available without restriction as to reason, with maximum gestational limits (Singh et. al., 2018). Yet, twenty-one percent of women who are in their reproductive age live in countries where abortion is allowed to protect a woman's physical health (ibid). Four per cent of such women live in nations where abortion is allowed to protect their mental health and twenty-one per cent live in nations where it is permitted on social grounds (ibid). An estimated 55.9 million abortions occurred every year from 2010 to 2014 i.e., 49.3 million in developed regions (Asia (except for Japan), Africa), Latin America and the Caribbean, and Oceania (except for New Zealand and Australia and 6.6. million in the developed regions (North America, Europe and countries like Japan, Australia and New Zealand) (ibid). The Asian region recorded 35.5 million abortions from the year 2010 to 2014 (ibid). With considerable variations in the legal permissibility of abortions, almost all Asian nations' laws permit abortion to save a woman's life (ibid).

It is noteworthy that although abortion is legal on certain grounds in Asian countries, there exist considerable gaps between law, ideology, and practice. Many researchers

suggest that access to safe abortion remains limited in Asia due to social and economic barriers, negative attitudes of the health providers or the failure of health systems to provide quality comprehensive reproductive health services (Whittaker, 2014). In the past, various human rights laws such as the UN's Human Rights Committee (HRC), Committee on Economic, Social and Cultural Rights (CESCR), Committee on the Elimination of Discrimination against Women (CEDAW), and the Committee on the Rights of the Child (CRC) (Bringing Rights to Bear, 2002) have increased their application of rights framework for the abortion debates globally. As a landmark event for reproductive rights claims, the International Conference on Population and Development (ICPD), Programme of Action (PoA), Paragraph 7.2. include and mentions women's rights to make decisions concerning reproduction (Hessini, 2005).

Several governments have ratified commitments toward rights-based frameworks of reproductive health. However, a grey area pervades these commitments and the lack of political will for the implementation of abortion services. Khanna and Ravindran (2002) pointed out the ambiguity that ICPD takes on abortion. It views unsafe abortion as a public health concern and concurrently contends itself by merely demanding health services to address "complications arising from abortion" (Khanna and Ravindran, 2002).

> "women would be left to their own devices to terminate a pregnancy, and health services would step in then to save the woman from morbidity or mortality that could result" (Khanna and Ravindran, 2002)

Unfortunately, in India, the trend of research is merely led by the aforementioned public health outlook to understand the barriers to access to safe abortion services, the implications of unsafe abortion practices and the associated mortality and morbidity.

2.2.2. Politics of abortion in India:

There has been tremendous annotated and bibliographic literature published on abortion in India. However, most studies missed out on the women's perspectives and issues pertinent to the demand for abortion services. This observation was also raised by Stillman's work.

In this section, we will discuss the abortion discourse in the Indian context.

2.2.2.1. Liberalisation of Abortion in India

Previously in India, the law prohibited abortion unless it was medically essential. All of this changed when the (MTP) Medical Termination of Pregnancy Act was passed in 1967, which essentially liberalised abortion, making India one of the most liberal countries in terms of abortions in the world (Jesani, 1995). However, it is to be noted that the demand for liberalising abortion in India did not originate from a feminist women's rights movement, but rather originated from the utilitarian need of controlling the swift population growth in an otherwise poor country. Further, it was also recognized that irrespective of its legality, abortion was practised nonetheless, and since it lacked its legality previously, illegal and unsafe abortion procedures performed by people who are not professionals exposed women to great risk, often leading to death. So, by legalising abortion, it was assumed that women would get access to safer abortions from certified medical professionals. Thus, the demand for legalising abortion evolved strictly from a utilitarian perspective which aimed toward the subversion of criminal law.

In India, a country which lacked the momentum of a well organised feminist movement until the 1970s, the task of persuading or influencing the policymakers was not taken by women's rights activists but rather by demographers and doctors with deeply rooted professional and ideological interests (Jesani, 1995). The lobby pressurising for liberalisation of abortion laws involved a strong thrust from the people involved in family planning and population control on one side and medical professionals on the other. Family planners were keen to reduce the rate of population growth and the medical professionals were keen to address the insecure circumstances of abortion that could have adverse effects on the health of women.

Studies on abortion in India conducted in the 1950s and the 1960s were geared towards understanding the patterns of incidence and other trends that could provide a better insight into the relationship between abortions and socio-economic background, age, marriage duration, history of previous pregnancies, usage of contraception, etc. (Karkal, 1970). In the health policy of the government during the 1960s, a great deal of emphasis was placed on family planning. This prompted academicians to conduct in-depth research on the relationship between population control and abortion (Jesani, 1995).

In the mid-1960s, a special committee was appointed by the Government of India to look into the matter of abortions (Jesani, 1995). This committee was chaired by reputed medical professional Dr Shantilal Shah (Jesani, 1995). Following the recommendations of the report, which was submitted in 1966, the Medical Termination of Pregnancy Act was passed by the Parliament in 1971 (Jesani, 1995).

2.2.2.2. The Women's Movement and the Liberalisation of Abortion

Unlike other nations, abortion and its related issues still has not taken a central place in the rapidly evolving feminist movement in India. This can be partly attributed to the non-combative stand of the anti-abortion lobbies (Jesani, 1995). In the developed countries of the west, the pro-choice movement favouring the right to abortion is pitted against extremely powerful pro-life anti-abortion lobbies that are backed by religious organizations, the conservatives and the right-wing. The conflicts between the two stances have been crucial to the central position of the issue of abortion in feminist movements of the west. Antagonisms here play a fundamental role in mobilizing popular movements, something which is missing in the Indian context.

Now coming to liberal legislation. To fully understand liberalisation of abortion, we have to properly investigate the term 'liberty' to its depth. Liberty as a concept has three fundamental components. They are the absence of restraints, the presence of the element of choice, and the presence of the enabling conditions that empower the individual to exercise their choice. An individual can be free to make a choice, but he/she might not be socially or economically empowered to exercise their choice. Similarly, liberal legislations may look 'liberal', but they fulfil only one criterion that satisfies liberty, which is, the absence of restraints. Liberal legislation merely removes

the legal constraints on women that deterred them from undergoing abortions. However, the mere absence of legal constraints is not enough to provide women with safer access to abortion facilities. Here comes the element of choice and the presence of enabling conditions. Women must be socio-economically empowered so that they can exercise their choice. Enabling conditions that might empower women to exercise their choice of abortion might be in the form of free access to therapy, counselling, subsidised or free healthcare, etc. When all the three components of liberty are satisfied by governmental legislation supporting abortion, we can say that it is truly 'liberal.'

2.3. Abortion Stigma in a global context

Abortion stigma is demeaning to the individuals who are associated with abortion. However, stigma from abortion is profoundly a dynamic societal process and contextual. Globally, there are places where abortion may or may not include moral controversies. Also, Kumar et. al (2009) claimed in their works that there is a possibility that there can be places and situations in which abortion stigma may be minimal, non-existent, or even less stigmatised than in other places/situations. Johnson-Hanks (2002) in her works mentioned that in Cameroon, local beliefs and value systems around shame, honour, and motherhood make abortion less discreditable.

In Africa, Zambia has the most liberal abortion laws, however, due to stigma, the policy constraints, fees, and lack of professional and trained providers limit their access to safe services (Johnson-Hanks, 2002). Women and girls who avail of abortion or abort are labeled infective and viewed as having the potential to harm others (Webb, 2000). This label is also extended to the health providers, pharmacies, medical schools, hospitals, and even the family. Koster- Oyekan (1998) in her work reports that a high level of successful abortion resulted in health complications there as well.

Vietnam introduced induced abortion in the 1960s as part of their national project of socialism to modernise and develop the country (Gammeltoft, 2003). At around the same time, it recorded the world's highest abortion rates. However, women and girls along with their partners expressed experiences of stigma and even regretted availing abortion services.

They experienced guilt and a feeling equal to the commitment of an immoral and sinful act. However, these feelings were strongly governed by their ideas of religion and family. And these feelings were responsible for keeping their abortion experiences in secrecy (ibid).

In the Netherlands and other Scandinavian countries, fortunately, the legal battles in the field of abortion have been won. However, women who abort are expected to be apologetic or remorseful when exercising their rights (Lokeland, 2004).

The aforementioned cases validate that abortion stigma is a social phenomenon and that it is built, structured, and procreated locally. It is an undesirable attribute imputed to women who abort or seek to abort and marks them, externally or internally and as less feminine and defying the ideals of womanhood. A woman who seeks to terminate her pregnancy challenges assumptions about the indispensable nature of women. Though some variations to this notion, however, a woman choosing to abort counters the dominant vistas of women as the "perpetual life-givers" (Kumar et. al, 2009). Women seeking abortion are seen and labelled as ones defying reproductive physiology (Kumar et. al, 2009).

2.4. Locating Abortion Stigma in the Indian Context

Abortion laws in India are professed as liberal. However, to date, terminating a pregnancy is still a fraught and perilous experience for women due to the country's legal and social attitudes. The law leaves the final decision on abortion in the hands of the medical professionals, who themselves are not resilient to the notions of morality, guilt, and shame surrounding the procedure (Satish et.al., 2021). Several studies have established the fact that abortion is stigmatised in India. A survey conducted in 2018 in Assam and Madhya Pradesh, revealed that nearly sixty-two percent of the 500 respondents believed that abortion is a "sin" (IPAS, n.d.).

Abortion stigma warrants the silence and ignorance around abortion in India. And this stigma contaminates not just the community, but the thinking of medical professionals as well. Raman (2022) stated in her article that "Just because there is an abortion law in the country

does not mean all gynecologists are pre-choice" (Raman, 2022). In India, medical education does not include topics on socio-cultural aspects or gender rights.

Abortion stigma affects women's abortion-seeking behaviour. A study in 2007 in Madhya Pradesh on women seeking post-abortion care, stated that in ten government hospitals, the majority of women seeking post-abortion care had relied on induced abortion themselves or on unsafe providers due to fears of social stigma associated with abortion (Frost et. al., 2014). Moreover, since pregnancy before marriage is highly stigmatised in India, therefore, in a way abortion among unmarried women is more expected than among married women (Frost et. al., 2014).

Unmarried women experience delays in obtaining abortion services in India. One of the studies in Bihar and Jharkhand in 2007 among abortion seeking women aged 15-24 revealed that compared to married women, unmarried women experience delays in procuring the services (Frost et. al., 2014). These delays happen due to multiple reasons, first due to the delay in recognising pregnancy and second, due to delay in finding a facility to obtain abortion services. These delays lead to most women experiencing first unsuccessful attempts to terminate their pregnancies. Abortion attempts that happen to be unsuccessful manifest in women's fear of disclosure. Because of the stigma prevalent in Indian societies, many abortion-seeking women have little to no social support in place in their abortion-seeking journey.

2.5. Feminist Ethics of Care

The ethical and moral components of personhood frequently govern the abortion debate. Western ethical philosophies have tried to answer the question, "What is ethics?" These theories established a rationalist framework of moral principles aimed at providing a normative framework (objective set of standards) that is independent of subjectivist or individual and culture-specific values for all intents and purposes (Billimoria et al., 2007). The two most popular moral theories today are Kantian deontological ethics and utilitarianism. Both rely on general concepts that are applies to specific situations. Kant moved away from the naturalistic framework of Aristotle. As a result, he dismissed human preferences or inclinations in explaining the laws of morality, which differ from one person to the next. He sought out the basically rational nature that exists in all humans and labelled it "practical reasoning." The legitimacy of moral precepts, according to Kant, is in their universability and necessity – a moral principle that may be willed without inconsistency and

on which all rational actors can act. The 'categorical imperative' is a test of consistency. It implies that all moral issues may be resolved by applying a neutral, pure, and rational standard to all situations. This is the gist of the so-called "deontological" viewpoint. (Sunil, 2018)

Next is the rational choice theory, which provides the utilitarian perspective. Although emotion drives our wants for specific goals, this view contends that morality's role is to teach us how to pursue those goals in the most reasonable way possible. In other words, morally significant gains and losses in value to logically isolatable persons are morally relevant, and the goal of morality should be to maximise individual utility to guide our rational decisions. As a result, utilitarianism contends that emotional responses to moral dilemmas obstruct rationality. In this regard, Held (1990) contends that these prevailing ethical theories are irrelevant to women's experiences and should be ignored. In this context, feminists have pointed out that the phrase "the man of reason" encapsulates the history of ethics, resulting in a commitment to strong masculine ontology and individualist politics (Sherwin, 1991). As a result, existing moral theories must be transformed to adequately account for women's experiences.

Some of the most popular Western theories of mind-body relationships provide support for both conservative and liberal perspectives on abortion. The associations between reason, form, knowledge, and maleness that have persisted in various guises, and have pervaded what has been thought to be moral knowledge as well as what has been thought to be scientific knowledge, and what has been thought to be the practice of morality, as Virginia Held (1990) points out. Morality, according to prominent moral philosophers such as Rousseau, Kant, and Hegel, must be founded on rational foundations. All ethical theories have left the morality of experience in mothering (which is the basis of moral understanding) outside morality since women were thought to be devoid of full rationality and were expected to be more emotional beings (Held, 1990).

Women are concerned about how they should live and act in the context of abortion, and they must make a decision about the proper and incorrect ways to live and act. Moral dilemmas are often interpreted as conflicts between egoistic individual goals on the one hand and universal moral norms on the other by dominant moral systems. The concept of rationality in moral decision-making has to be reconsidered, with the potential to re-define ethical theories as a result. Recent feminist arguments in moral theory transformation have shifted the way

we think about abortion, extending beyond the qualities of personhood. The concept of rationality in moral decision-making has to be reconsidered, with the potential to re-define ethical theories as a result. Recent feminist arguments in moral theory have caused a shift in how the entire abortion debate is viewed, expanding beyond the qualities of personhood. Reason and emotion (where emotion is devalued), the public and private (where private is consigned to the natural), and the self are the three main areas being modified by feminists for more theoretical and practical engagements, as constructed in a male point of view (Sunil, 2018).

2.5.1 Reason vs. Emotion

According to psychologists like Gilligan, women's moral reasoning experiences are more embedded in a setting of specific others than a comparable group of men's reasoning (Gilligan, 1987). In her research on abortion, she discovered that rather than being viewed as a singular occurrence, decision was part of a larger story (especially the events of relationship). The background, story, and narrative of lives were not detached from choice. Rather than seeing self and other as distinct and antagonistsic, they must be regarded as interdependent. In the name of reason, these views have generated issues about the central lines of western traditional thought, which weaken relationships, caring, love, and reaction. Thus, rather than relying on abstract norms of reason to grasp morality, it is necessary to re-evaluate care by embracing emotion, caring, empathy, feeling with others, and being sensitive to one another. Unlike rationalistic systems, the ethics of care usually values the emotions and social qualities that allow morally concerned people to comprehend what would be ideal in real-life interpersonal situations.

2.5.2. Public vs. Private

Studies cite Okin's (1989) work as evidence that the conventional public-private dichotomy sees the public domain as a distinctly human arena (in which man transcends his animal nature), while the private sphere of the household is considered as a natural territory in which women merely propagate the species (Menon, 2004; Held, 1990; Beauvoir, 1956). Furthermore, following WWI and in the backdrop of industrialisation, the idea of a public-private division grew stronger. This was the turning point for women in the business, as they realised their potential to succeed in jobs that were previously thought to be dominated by men. As most liberal-

democratic states began to question the normative idea of man as the breadwinner of the household (due to necessity or choice), they encouraged women to work in paid jobs. These developments have impacted the state's understanding of men's and women's roles and obligations.

The state established a new policies and practices in order to promote labour economy's gains and the importance of keeping women's cheap labour. Nonetheless, these rules and behaviours primarily favoured men and limited women's role in the public realm to that of reproducers or supportive subsidiaries. The paternalistic and macho mechanisms that define the state's prevailing views drive it to see women as exclusively mothers, with little regard for reasonable dialogue (Ortner, 1974). There is also a great deal of inconsistency among women who are both 'working mothers' in the market and 'mothers' and caretakers at home. In both of these places, they are predominantly identified by their sexual orientation. As a result, it's critical to comprehend how patriarchy interacts with capitalism (Eisenstein, 1981).

Despite the fact that 'reproduction' is sometimes referred to as 'repetition' or 'natural,' the act of producing new social individuals and new kinds of people has the potential to be the most transforming human endeavour (Held, 1989). As a result, human interactions must be reconsidered in terms of private experiences, and the ways in which every human life is linked with personal and societal components must be reconsidered. In this regard, Held serves as an example. Persons do not pick the gender, racial, class, ethnic, religious, national, or cultural groupings they will be raised in, according to her. These kinds of link, however, may be crucial components of who individuals are and how their experiences might help them understand morality. As Menon (2004) points out, this has legal ramifications. The private is valued in legal discourse as a realm of individual freedom that has been denied to women, as well as a means of exposing injustice inside the private to legal examination. However, these legal debates fall short of resolving the public-private divide.

2.6. Women and the Situatedness of Her Body

This section simply highlights the rise of body talk by emphasising the female body as a major aspect of the conversation. In her book 'The Second Sex,' Beauvoir (1956) refers to the body as a predicament. Human transcendence-human freedom, according to Beauvoir, is

manifested in the contour of the body. As a result, the body's perception as a circumstance is intimately linked to subjectivity of individual women (Moi, 2005). "The body founds the experiences of myself and the world", meaning that the body is a circumstance that characterises how a woman makes sense of her situation and activities (Moi, 2005). It also recognises that a woman's body is inextricably linked to how she exercises her independence.

The body as a situation, according to Beauvoir, is the tangible body that is experienced as significant and is socially and historically positioned (Moi, 2005). Beauvoir avoids the topic of identity. For her, an individual's subjectivity is inextricably linked to the situation in which she finds herself. She does not imply how someone of a particular sex becomes a woman when she says, "one is not born, rather becomes a woman." Instead, the focus is on the values, standards, and demands that the female human being encounters in her interactions with others (or society) (Moi, 2005). The female body, according to Beauvoir is a socially inflected body. Women, she believes, behave, think, and perceive themselves in "man-made" ways (Hughes and Witz, 1997). Women, on the other hand, are "determined not by her hormones or inexplicable instincts, but by the manner in which her body and her relationship to the world are influenced by people than herself" (Hughes and Witz, 1997).

Beauvoir takes a two-pronged approach to the feminine body. There is a positive view of a built body that is malleable that emerges from oppressed women's experiences of their bodies in patriarchy. The other is a pessimistic view of residual, unconstructed, disturbed female body linked to visceral, menstruation, reproducing, lactating body, which appears to be an intractable component of a woman's condition. In some ways, this viewpoint is a theory of women's alienation. As a result, women's lived experiences are the manner in which each woman encounters, internalises, or rejects conventional gender norms. These lived experiences are the result of a continuous interaction between the subject and the environment, in which each term is constantly creating the other (Moi, 2005).

The postmodern concept of the materialisation of the sexed body offers fresh perspectives on 'bodily thinking.' Butler, for example, wants to establish a concept of the sexed body as materialisation that will be crucial to understanding gender (Butler, 1990). Butler argues in 'Bodies That Matter' that the body is both material and manufactured (Moi,2005). Sex is as culturally produced as gender in a discursive zone of heterosexuality, indicating that sex is as cultural, performative, unstable, and discursive as gender. Butler claims that biological truths are determined by 'regulatory discourse,' and that sex is the performative result of gender

(Moi,2005). As a result, Butler sees the body as material and manufactured, and as such, it is embedded in culture, history, and society. Butler, on the other hand, sees the 'materiality of the body' as a problem that exists outside of any specific scenario. As a result, the body is reduced to an abstract epistemological entitiy (Moi, 1995). Hughes and Witz (1997) emphasize the incorporation of a phenomenologically inflected notion of embodiment as lived, gender materiality in this setting, where sexuality/sexual differences play a fundamental part in the analysis of body.

2.7. The Reproductive Rights Discourse and Autonomy

Liberal feminist political thinking is built on the foundations of logic and reason. When reason is linked to the ability to comprehend reasonable moral principles, individual autonomy becomes the primary focus (Jagger, 1983). When reason is defined as the ability to select the best ways to reach a desired aim, however, the importance of self-fulfilment is emphasised (Jagger, 1983). According to liberal assertions, rights take precedence over goods, and those individual rights provide a framework within which we can pick our own independent products without jeopardising the rights of others (Sandel, 1984). It will only benefit particular individuals or groups, not the overall interests of any community. Petchesky (2000) defines rights as "a list of civil and political liberties that individuals and groups seek from those in positions of authority in order to express their equal claims to citizenship. They are a means to emancipation, not an end in itself, but not of genuine social and material life." She discusses how the term 'rights' connotes a preference for 'civil and political' rights over 'social and economic' rights.

"Control over one's body is an essential component of being a person with needs and rights," says the liberal tradition's most significant legacy (Petchesky, 1990). The 'individual' is depicted as isolated, atomized, exclusive in his possessions, and cut off from the greater social fabric in this work. The biggest criticism levelled against this framework is that it is static and disconnected from the social context. Thus, the principle of body control has a material foundation when we use it as a "material truth" asserting it as a right, as well as a moral and political foundation when it is characterised as a larger set of socially established human needs (Petchesky, 1990).

The second is the insistence on the concept of choice in all things – the right of a woman to choose. The liberal 'choice' has been criticised, because many women do not have the ability to choose because of patriarchal power relationships and discrimination (Tong, 2009).

Autonomy is also a process of self-reflection that occurs in stages. It can still be autonomous if the reason of the behaviour involves her in some way. As a result, all that autonomy necessitates is the self's active decisions of the choices and actions she does. Feminists such as Virginia Held and Nel Noddings criticise Kantian conceptions of autonomy, arguing that human agency is handled differently in actions performed for a 'reason,' and that it is strictly defined (Nodding, 1984; Held, 2005). Passion, desires, feelings, sentiments, volitions, and inclinations determined by the mental state or attitude are ignored by the Kantian tradition of autonomy's concept of 'reason.' Incorporating all emotions and behaviour in the use of 'reason' to define autonomy, the feminist ethics of care stance is a departure. The term autonomy is used here to describe decision-making that is influenced by the social, relational, interpersonal, or intersubjective elements and requirements of autonomy.

Conclusion

In India, there is plenty of literature reporting and examining the reasons for abortion. However, most literature is situated within the realm of the MTP Act and this law is relatively liberal to interpretation. Conversely, it restricts access to abortion services when the provider or society is the only decision-maker in providing services based on their opinion formed in the "good faith". There requires exploration in the context of unwanted pregnancies beyond the ambit of the law. Again, there is limited understanding of how gender and sexuality, abortion provider and seeker interfaces, construction of morality, and institutional barriers affect abortion decisions. And these reasons call for a profound understanding of women's perspectives on their abortion-seeking experiences. The abortion contest in the west has been dominated by the personhood criteria and the role of technology in pro or anti-abortion realms. There is not much information on the cultural context of comparable dimensions and their relevance to abortion discourse in India.

Furthermore, it is important to note that there have been only a handful of research on abortion in Assam. And the available researches are mostly quantitative in nature and lack serious consideration of the overlapping social determinants. Quantitative researches usually miss the complexities of abortion as an experience. While we can find a few previously done qualitative researches on abortion in India, yet, most of these studies only provide limited insights into the women's experiences. They have largely shed light on the isolated facets of

abortion and have exposed little about the meaning of abortion as an experienced to women. There is absolutely little to no literature to understand the nature of abortion as a human experience. Moreover, there is a need to examine how women relate to diverse contexts of unwanted pregnancies. It is crucial to understand how women contest, negotiate and resist the societal and institutional norms, values perspectives, and actions. To be precise, there is a teeming need for literatures on the abortion scenarios in India and in Assam. Very limited literatures are available to even proceed with this research.

CHAPTER 3

Research Methodology

This chapter will provide the research objectives and questions raised by this research. Moreover, it will provide an overview of the techniques, procedures, and methods used to facilitate and meet the research objectives of this study. It will also justify and explain the choices of the methodological approaches and sampling methods adopted for this study. The process of selection, identification, collection, and analysing of the data for this research will also be revealed in this chapter.

3.1. Statement of Problem

The commotion of clandestine abortions is grabbing eyeballs and paving the way toward the contentious issue of unsafe abortions and the complications they give rise to. According to estimates and correlating data on maternal mortality ratio (MMR), unsafe abortion is killing one woman every two hours in India i.e. approximately, 4000 deaths a year (International Planned Parenthood Federation, 2015). Moreover, according to the Census 2011, abortion in registered institutions varies from 32 percent in Chhattisgarh to 73.9% in Assam (International Planned Parenthood Federation, 2015).

Though abortion in Assam in registered institutions is relatively better than in other Indian states yet, the issue is still grave. Though induced abortion has been legally permitted in India on broad grounds, representative information on access to abortion services and abortion incidence remains scarce in the state of Assam. Keeping in mind the huge lacuna of research or studies on the same for the state, tracing unsafe abortion scenarios in the state is challenging. The lacuna of research in tandem with the contentious issue of unsafe abortions posits the problem and indicates the necessity for this research.

In this context, this research commenced with the aim to learn about the diversity of women's abortion experiences with a special focus on experienced abortion stigma and how it affects the decision-making of abortion-seeking women. The researcher weaves a feminist perspective alongside the public health discourse on abortion. This study hopes to provide valuable insights into how abortion stigma carves decision-making, fear, autonomy, and

exercise of sexual and reproductive rights of women in Guwahati seeking an abortion amidst the diverse and complex social fabrics and institutional structures. The result of this research will give us a foretaste of the quality of experience abortion seeker receives in Guwahati.

3.2. Rationale

The available literatures on Assam indicate the urgent need of addressing the research gaps that take into consideration social determinants when exploring abortion as a social issue along with statistical data. In India, there is plenty of literature reporting and examining the reasons for abortion. However, most literature is situated within the realm of the MTP Act and this law is relatively liberal to interpretation. There requires exploration in the context of unwanted pregnancies beyond the ambit of the law. Again, there is limited understanding of how gender and sexuality, abortion provider and seeker interfaces, construction of morality, and institutional barriers affect abortion decisions. And these reasons call for a profound understanding of women's perspectives on their abortion-seeking experiences. The abortion contest in the west has been dominated by the personhood criteria and the role of technology in pro or anti-abortion realms. There is not much information on the cultural context of comparable dimensions and their relevance to abortion discourse in India.

Acknowledging that, this paper attempts to meticulously understand the problematic environment or risk factors pertaining to abortion services available in the metropolitan city of Guwahati. This study is to look into, understand and capture the experiences of women who go through the process of abortion and the barriers they experience in curving their choices and decisions. It will focus solely on the experiences of these women to gain essential insights into the systematic exclusion of women from attaining bodily rights. This study attempts to refine present knowledge on the experience of abortion by women by permitting them to express different facets or aspects of their experiences that were most significant and consequential to them.

The implications of this research finding should be able to address that gap to an extent since a qualitative research approach will be adopted for this study. Though many qualitative researches on abortion have been done previously, yet, most of these studies only provide limited insights into the women's experiences. They have largely shed light on isolated facets of abortion and have exposed little about the meaning of abortion stigma as an experience by

women. There is a need to examine how women relate to diverse contexts of unwanted pregnancies. It is crucial to understand how women contest, negotiate and resist the societal and institutional norms, values perspectives, and actions. This study will present an integrative review and analysis of the abortion experience in Guwahati. Presumably, this will further aid the upcoming studies in this field and will provide evidence to inform better practice.

3.3. Significance of the study

In India, there is plenty of literature reporting and examining the reasons for abortion. However, most literature is situated within the realm of the MTP Act and this law is relatively liberal to interpretation. There requires exploration in the context of unwanted pregnancies beyond the ambit of the law. Also, there is limited understanding of how gender and sexuality, abortion provider and seeker interfaces, construction of morality, and institutional barriers affect abortion decisions. And these reasons call for a profound understanding of women's perspectives on their abortion-seeking experiences. The abortion contest in the west has been dominated by the personhood criteria and the role of technology in pro or anti-abortion realms. There is not much information on the cultural context of comparable dimensions and their relevance to abortion discourse in India.

This study attempts to meticulously understand the problematic environment or risk factors pertaining to abortion services available in the metropolitan city of Guwahati. This study is to look into, understand and capture the experiences of women who go through the process of abortion and the barriers they experience in curving their choices and decisions. It will focus solely on the experiences of these women to gain essential insights into the systematic exclusion of women from attaining bodily rights. This study attempts to refine present knowledge on the experience of abortion by women by permitting them to express different facets or aspects of their experiences that were most significant and consequential to them.

The implications of this research finding should be able to address that gap to an extent since a qualitative research approach will be adopted for this study. Though many qualitative researches on abortion have been done previously, yet, most of these studies only provide

limited insights into the women's experiences. They have largely shed light on isolated facets of abortion and have exposed little about the meaning of abortion stigma as an experience by women. There is a need to examine how women relate to diverse contexts of unwanted pregnancies. It is crucial to understand how women contest, negotiate and resist the societal and institutional norms, values perspectives, and actions. This study will present an integrative review and analysis of the abortion experience in Guwahati. Presumably, this will further aid the upcoming studies in this field and will provide evidence to inform better practice.

3.4. Research Objectives:

The primary objective of this study is to analyse the contexts of induced abortion experiences among the women who had an abortion in Guwahati with respect to their lived experiences along a reproductive health continuum. The sub-objectives are-

- To explore the influence of social norms and practices, morality, and traditions on women's sexuality and fertility
- To examine women's reproductive autonomy in the public and private spheres and its implications for women's sexual and reproductive entitlements.

3.5. Research Questions:

The research questions for this study are-

- What are the interpretations and narratives of abortion experiences by these women?
- How do the women's beliefs, familial norms and morality add to their psychological distress, fear, and trauma?
- How do different factors that exist in the community and medical institutions carve their decision-making during the abortion process?

3.6. Research Design:

The phenomenological research design will be adopted for this study because the focus of this study is to understand the meanings of women's experiences, beliefs and narratives on abortion. Phenomenology originated wrapped in the philosophical grounds that changed over centuries, but it was Edmund Husserl who made big contributions toward defining phenomenology. This approach aims to develop lucid, precise and articulate accounts and understand the specific experience or a moment of experience. Since phenomenology is concerned with the study of human consciousness and lived experiences, this method is apt for this study. To be more precise, **feminist phenomenology** will be used for this study. This is because, contrary to the narrow view of phenomenology, this study will include gendered experiences and sexual differences in this study.

3.6.1. Feminist Phenomenology:

The researcher adopted in particular feminist phenomenology because the current research involves issues related to gendered experiences While conventional phenomenology is sexless and genderless, feminist phenomenology uses feminist lenses to explore the phenomena It is a sub-field within the broad school of phenomenology. As already mentioned, this study is critical and even questions the patriarchal structure that exists in the family, medical and legal institutions in India.

3.7. Research Approach:

The qualitative research approach will be used for this study because it enables to reflect manifested complexities that are intrinsic in human experiences. This approach focuses on finding rich and lucid descriptions of the experiences that the researcher is studying. The researcher also gets an opportunity to observe and describe the context of an experience which they are studying. In some cases, the researchers also get chances to ask their research participants to elucidate and tell them in their own words regarding the entailed context of the phenomenon.

3.8. Tools for data collection:

The researcher will conduct unstructured and in-depth interviews with the research participants who went through the process of abortion. The interview of each participant will last not more than 45 minutes. A set of general interview guide might be used to give direction to the conversation. Moreover, the interviews will be tropical in nature.

3.9. Sampling for the study:

3.9.1. Sample Design:

The sampling technique used for this study is non-probability sampling. Also, for the study's convenience, the researcher will be using a combination of purposive and snowball non-probability sampling methods.

Firstly, purposive sampling method will be used because the sample is selected based on the researcher's judgment because of the need to fulfill the specific criteria that the participants have to meet for this research. This method is most effective when the sample size is small, which is exactly one of the characteristics of this study. Secondly, snowball sampling will be used for this study due to the lack of contacts of women who meet the specific criteria for this study.

3.9.2. Sample Size:

For this study, six respondents will be selected from different areas of Guwahati city. The age group of the participants are 16- 60. This arrangement is set so as to facilitate and direct the research to encapsulate the opinions and experiences of women from different age groups.

3.9.3. Criteria for sample selection:

One of the primary criteria for short listing the participants is that they went through the process of abortion at some point in their life. Also, the narratives, experiences and opinions of all respondents will be taken into consideration. These respondents should not be of age below 16 years for this study because, in the flow of discussion, the respondents might not be able to emotionally handle those past or recent experiences. This entire topic is stigma stricken within the Assamese society and for a participant below 16 years to participate in this study might permit her to go through the same trauma that she might have recently overcome or is still in the process of overcoming.

3.10. Site of Research:

For this study, the researcher has already selected the metropolitan city of Guwahati. Therefore, participants who reside in this city will be selected. Acknowledging that Guwahati is in fact one of the biggest cities in the entire Northeast, the researcher does understand that women residing in cities and women residing in the villages will have different encounters of experiences. However, studying the participants who reside in the city will shed some level of light on the entire abortion scenario in the states. It is a known fact that there is an uneven distribution of health institutions across the state of Assam. Guwahati metropolitan has the highest number of health institutions as compared to other places in the entire northeast. Therefore, this is another reason to select Guwahati as the site of research.

3.11. Sources of data collection:

This study will be primarily based on primary resources for data collection as it tries to refine the understanding of the experiences and voices of women who went through the process of abortion. These primary data will be collected from the aforementioned sites selected for this research via interviews.

Additionally, secondary resources will play a vital role in the background structuring of this study. Both research literature and concept literature will be referred which includes journals, articles, research works and other information from the internet.

3.12. Data Analysis:

The first step to data analysis is to carefully prepare transcripts of all four interviews by listening and re-listening to the recordings of the interviews. Coding of the data was a simultaneous process done alongside the transcription process. The data will then be thematically analyzed under broader themes.

3.13. Challenges faced:

Since snowball sampling was deployed, the researcher encountered respondents who were newly acquainted with the researcher and thus, there was hesitation to share information that is both personal and sensitive. Moreover, few of the research respondents did not fully recover from the trauma that they encountered during pre- and post-abortion periods.

3.14. Ethical Consideration

1. Participants in the study were well informed about what the research is about and only after their consent the study will be conducted.
2. Anonymity, confidentiality and privacy were respected when doing the research.
3. Participants' decision to withdraw from the research was also respected.

CHAPTER 4

4.1. Data Analysis

This chapter focuses on analysing the data obtained by the researcher for this study. An attempt has been made to reinterpret the experiences collected in the form of data in the words of the researcher while preserving the essence of the original data. This chapter we will try to explore every possible aspect of women's abortion experiences in Guwahati. The data collected has been analysed in an unbiased manner to acquire the research findings. Also, it has been thematically organised and analysed with the careful assistance of the interview transcripts and coding.

4.1.1. Brief profiling of the research participants

Background of the participants:

The decision and experience of abortion profoundly alter women's life and its impact is both physical as well as psychological. The interviewees were between the age group of 20- 60. They belong to diverse social groups and were all educated. Moreover, they are currently based in Guwahati and they availed abortion services in Guwahati.

Group-1 (Age group: 20- 40 years)						
Respondent Number	**Current age**	**Age when they underwent an abortion**	**Marital status when they underwent abortion**	**Native place**	**Religion**	**Educational Qualification**
Respondent Number- 1	23	17	Unmarried	Guwahati, Assam	Islam	B.A.
Respondent Number- 2	29	20	Unmarried	Tuensang district, Nagaland	Christian	B. Sc. In Computer Sciences
Respondent Number- 3	60	35	Married	Nagaon, Assam	Hindu	BA LLB, Bachelor of Commerce
Respondent Number- 4	32	25	Unmarried	Guwahati, Assam	Hindu	B.A. in Sociology, M.A in Sociology
Respondent Number- 5	25	18	Unmarried	Golaghat, Assam	Islam	B.A. in Political Sciences, M.A. in Political Sciences
Respondent Number- 6	26	23	Unmarried	Golaghat, Assam	Hindu	B.A. in Political Sciences, currently preparing for UPSC in Guwahati

4.1.2. Women's accessibility to abortion in Guwahati

Abortion in India should be legally available at the Primary Health Care (PHC) centres as well as at the tertiary levels. Unfortunately, as conveyed by the research participants as well as observed by the researcher, abortion services were available mostly in the government facilities at the tertiary levels. Except for Respondent 3, all three participants did not avail abortion at government hospitals. On inquiring for the same, Respondent 5 shared the following

> *" (...) at first I went to the Kahilipara PHC....It was close to my PG....they do not provide abortion there....they confirmed this....they did not have the facility there...they advised me to go elsewhere"*

The response of Respondent 5 gives us a glimpse of the available facility at the PHCs in Guwahati. The PHCs here do not have the facility nor enough abortion service providers thus, affecting the accessibility to abortion services. On another account, Respondent 2 shared that

> *"I was scared to avail it there.... I was scared to be put behind bars...Is not abortion illegal?.....They delay all processes...they ask for personal details and...since I alone, I cannot trust them...I cannot trust....I was unmarried then.... we cannot go there...leave alone seeking"*

Abortion is such an uncommon topic of discussion in Guwahati as well as across India, that many women are uneducated on the provisions and its legality. Here she clearly posts her thoughts as to why she did not avail of abortion from a government facility. She did not even dare to step into one of the institutions and inquire about its provisions. Her situation gives us a glimpse of the level of awareness among women on abortion-related legalities and facilities.

She also mentioned the fact that since she was unmarried, it was more difficult for her to have access to abortion. To add value to the same, we will analyse Respondent 1's experience.

> *"I went to a gynae (gynaecologist) in a government hospital…. and she outright rejected me….I felt helpless and cried a lot that day…It would have been more convenient for me to have an abortion if I were married…"*

In India, premarital sex is profoundly discouraged and so is pregnancy among unmarried women. And though the evidence is scant in India, pregnancy among unmarried women is awfully stigmatised, even among the providers. However, it is important for us to understand that these unintended pregnancies are mostly terminated. The above statement by Respondent 1 proves that the participants were scared to avail services provided by the government especially, due to the attitudes among the providers. When it comes to abortion, most obstetricians or gynaecologists, or health providers are reluctant to provide services.

The above experiences shared by the respondents point out that the law, as well as the government, fails to acknowledge women's agency. When safe abortion services are not readily available or easily accessible, either because of the restrictive law or awareness or stigma, women have to resort and turn to unskilled providers to abort, thereby, compromising their health and well-being.

4.1.3. Factors affecting decision making in the private in the private sphere

In this section, the factors influencing the abortion decisions of women emerging from the interactions with the family and related dimensions are presented.

4.1.3.1. Moral dilemmas and familial norms

Norms within the family, especially, in Indian families, and moral codes compel many women to seek abortions in secrecy and often in unhealthy settings without informing their families. Similar stances were presented by all the participants who got pregnant and were unmarried. The same story is run by all participants who

sought an abortion in such situations, thereby, endangering their lives when their pregnancy was unwanted. Women who get pregnant and are unmarried have awfully limited sexual autonomy. The fear of their family not consenting to an abortion, accompanied by societal frowns pointing at their sexual desires over violating prevalent moral codes force them to compromise their health and well-being without others' knowing. In her own word, Respondent 6 explains her story:

> *"After I got an abortion, I experienced pain in the abdomen….severe pain….I could not let anyone know about this or else they might take me to the doctor….I was afraid!....I fainted once due to the pain….I was thankful that I did not faint at home….my closest friend, who know about it, advised me to visit a doctor….I could never tell my family about this….they would kill me for sure….I live in a joint family….I come from a small town, everything spreads like wildfire there….And I will have to go back home at some point"*

Respondent 6 considers her abortion to be a private matter in her life. She has told very few people about her story. Her decision to share her story depends on her level of trust and how safe she feels around that person. Her social position and familial dynamics have affected the circumstances of her abortion. She was scared to death to reveal the truth to her family members, even if that meant putting her life in danger. She was scared that her family members and society will look at it lowly. She concealed her abortion in order to prevent negative emotions and reactions from her family members and society.

Respondent 3, who was married and went for abortion due to complications in her pregnancy mused that

> *" I was married….yes….however, it was still scary….only my mother, mother-in-law, my husband and my sister-in-law knows of this….people look at this lowly….even after so many years….I sometimes feel the negative emotions from my mother-in-law….I wish I had a support system then"*

Respondent 3 shared that she was not just concerned about her husband's reputation, but her family's reputation too. She availed of her abortion services from a

government setting, however, she still expressed that even then, she is frowned upon by her own family members. Respondent 3 had financial autonomy and catered to her own medical expenses; however, she is still experiencing frowned and disappointing looks from her family members even after 25 years.

4.1.3.2. Shame and blame for women's sexuality

In India, premarital sex is profoundly discouraged and so is pregnancy among unmarried women. And though the evidence is scant in India, pregnancy among unmarried women is awfully stigmatised. We will look into the context of Respondent 4:

"I was unmarried at the time of my abortion….it has to be a secret because if revealed, it will tarnish my reputation in the society….it will ruin my now marriage as well….I will be blamed and will be called irresponsible….indulging in dirty and promiscuous acts….I know what will be the consequences….it will eat my sanity…."

Respondent 4 had to opt for illegal abortion services which cost her not just a fortune but also her health. She confronts that the smell of the setting still makes her nauseous and traumatised. She had to seek illegal abortion services as she was aware that otherwise, she will be stereotyped as an irresponsible and promiscuous woman. In India, sex associated with motherhood is celebrated and advocated, but sex that satisfies sexual desires is blamed as non-feminine. Women are then reduced to and held responsible for their acts in the familial discourse of abortion.

"I was married….and got an abortion because of medical reasons….complications in my pregnancy….the shame is not overtly shown….but I can feel it….ofcourse I could not keep my abortion from my in-laws….I was already in the trauma of losing a child yet the shame and blame….I tried my level best to not have complications….was it even my fault?!"

Respondent 4, share her experience with the shame and blame she had to go through pre- and post-abortion. Stigma can manifest itself in many ways and this is one of

them. Feelings of guilt, shame, and fear associated with seeking an abortion impact the ability of women to make autonomous and independent choices. In respondent 4's case, the stigma around abortion is closely interwoven with other social expectations and stereotypes around gender roles in relation to motherhood and family responsibility.

4.1.3.3. Religious interpretations around abortion

In India and elsewhere, religion remains an enshrined topic of discussion. It is one of the foremost and chief social agents in molding attitudes on issues especially, on the beginning and end of life. It has aided in shaping and defining gendered roles and expectations. Respondent 1 who follows Islam, muses

"I belong to a very conservative Muslim family….once my sister got beaten by my uncle because of clicking a picture when wearing shorts and posting it on social media….forget getting an abortion….I had an aunt who had to terminate her pregnancy one due to medical reasons….that is what I know of but I am not sure because no one talks about it….she still partly got blamed….my mother said that Allah will never spare someone who will undergo an abortion for petty reasons. However, since her husband consented to it….in my family, a male member's opinion is important…. I am not sure if I am god fearing....however, I still have conflicts on the same till date…. sin.....I do not know"

Respondent 2 who follows Christianity shared that:

"in my village, abortion is common….though frowned….they are done in secrecy ofcourse….it is not accepted but is common….we know of many women from our village who went for abortion….However, while growing up, I always heard that abortion is a sin….If a chaste woman like Mother Mary can give birth to Jesus, other women are also supposed to bring happiness to the family….Somewhere I blame myself too"

Respondent 3, who is a Hindu by religion and was married when she underwent an abortion provides a rather conflicting view. She states:

"I did no wrong….I only got an abortion because of my medical situation….I was referred by a doctor….I got abortions twice….a child is God's gift. Do you know how many times I visited the Kamakhya temple? God will never forgive a woman for giving up on her child….It hurts not to get a child when you and your entire family yearns for it….it is not easy to give up on a child….it is a sin to my eyes"

All the aforementioned views of the respondents coincide with each other and they point to the same thing over and over again. All the respondents stated that in their surroundings, everyone believed that a child is a gift of God and that it is a sin to terminate a pregnancy. Respondent 2 even drew reference to Mother Mary and chastity. Though the experience shared by Respondent 3 might look conflicting in some way, it is not. In fact, all these views help define each other and prove the same. These testimonies provide an understanding of how religion defines women's sexuality and curbs women's reproductive rights. Chastity is a quality that is enshrined in all religious books across all religions globally. It extends to the argument of the interplay of the power relations gender and religion share. While repeatedly being referred to, all respondents made it clear how religion instils within them a sense of fear that drove them to adhere to these negative notions and thereby, curbing their reproductive autonomy. The association of abortion with negative practices in the religious realms affects their decision-making and experience of abortion.

4.1.4. Factors affecting decision making in the public sphere: Women and abortion provider interface

In the public space, our respondents interfaced with the likes of doctors (gynaecologist), nurses and pharmacists during their abortion journey. While the interactions and the interface between the abortion provider and abortion seekers were hinted in the previous section, this

section will analyse in detail the aspects and how these interfaces challenge or influence the possibility for women's agency to seek an abortion.

4.1.4.1. Denying and delaying abortion provision

Recognition of pregnancy at an early stage reduces the need for surgical abortion procedures. It has implications in terms of the cost as well as the post-abortion complications experienced by women (Winkler et. al., 1995). As analysed, we found that delaying abortion procedures indicates the denial of abortion. The narrative of Respondent 3 relates to this and shares her experience:

"When I and my husband got to know that I had complications….yes, we got to know at GMCH (Guwahati Medical College and Hospital)….government it was….I started my treatment there….they made referrals after referrals….I got so many medications….vitamins….so many tablets….the need was for an immediate abortion, but with the referrals, it was not happening….my husband then suggested that we go to Dispur Hospital….costs were high even during those days….thankfully we were both working and had savings….we struggled with our finances"

The research participants conveyed that the attitudes of the medical professionals towards abortion complicated their decisions. The abortion provider interfaces have profound impacts on the decision-making abilities of these women. Here, for Researcher 3, even though she needed an immediate abortion due to delay she opted to get the service from a private medical setting which cost her a fortune. However, not everyone has the financial or social environment to receive an abortion from a private hospital. It has not been the option for the other respondents. Respondent 1 shared her experience of her being denied abortion

"I went to a gynae (gynaecologist) in a government hospital. She asked me about my issues and I started to tell her about everything…. and she outright rejected …. I felt helpless and cried a lot that day…It would have been more convenient for me to have an abortion if I were married…. After this, I reconsidered my decision to get an abortion but I also knew I had no other option….I did not go anywhere near these

medical settings, not even close to our nearby pharmacy for a week. I did not want to face another embarrassing and traumatising situation….I told my partner about it….our common friend shared about this place where I could get my abortion….it was still expensive….Rs 30,000 we arranged…. my partner went with me….I had no courage otherwise….but the process still haunts me till today…."

Delayed recognition of pregnancy and delay in decision making delay the availing of abortion. On top of that, the providers denying adds more to the problem. Here, Respondent 1 shared her daunting experience with abortion. It is also evident from her interview that along with the provider's interfaces, knowledge from other known persons and their experience with providers also influences the decision making. Instead of providing the services at the earliest or making referrals to settings where they can avail safe abortion services, most medical professionals or abortion providers scold these women who seek an abortion. It was very evident from all the participants and their experiences that abortion providers misdirect, delay, and discourage women who seek abortion in Guwahati. This led to many women, especially, unmarried women who have no agency to avail of illegal abortion services where their health and well-being are compromised.

4.1.4.2. Shame and Blame: Stigma experiences in the medical setting

From the previous chapters and sections, it is very evident that the reasons for abortion are very intimately bound. Nonetheless, the narrative below of Respondent 4 will explain how abortion providers evoke the shame and blame of sexuality against women while they seek an abortion.

"I had just returned from Delhi….I was two months pregnant….When I went to the hospital, one of the nurses asked me about my husband….they first asked me if no one came with me, and to which I said no….when I went to the doctor, the senior doctor asked me the same question….I told the senior doctor about my situation….to my surprise she scolded me….I don't know what got her irritated, was it my questions or my presence….she made me feel like I was promiscuous….she scolded me in front of the two nurses….that was the last thing I wanted to experience…."

Shame and blame are not just associated with society or family members talking ill of abortion-seeking women. Abortion providers too abuse them. She was labelled as a sexually and morally loose character by the senior doctor. Moreover, the researcher observed that another way of instilling shame and blame and dissuading women to seek abortion is by bringing up the story of the "healthy foetus" by medical professionals. Respondent 4 shares her experience as,

"(….) after my first visit to a medical setting seeking an abortion, where I got treated like an insect, I went to another one….the doctor seemed good to me at first….after consulting, she asked me to come the next day, which I did. It was my second visit to her….she told me that the baby looks good and healthy….she insisted that I do not abort….it was taxing for me to sit there and listen to her as she showed me the scan….She emphasised repeatedly that my baby is healthy and big and that two months delay is a big deal and the baby is big….She tried to persuade me to not go for an abortion and even said that the foetus was a life inside me….I decided to change my gynaecologist…."

Most of these women faced this kind of blame from the health professionals, some in subtle while others in a more unconcealed manner. Abortion providers give this impression to the abortion seekers that is morally and legally correct to go ahead with abortion only when there are complications or abnormalities with the foetus. When these professionals spit out that the foetus is growing healthy, it affects the women's decision-making. These kinds of tactics used by the providers authorise the providers to have an upper hand in the decision-making of the abortion seekers. It affronts, disrespects, and affects the autonomy of the abortion seekers and ebbs their lived experiences. Here, from the interviews, it adds to clear that medical professionals have the command to instil shame and blame among abortion-seeking women which has a direct impact on their decision-making autonomy. Foetus personification by doctors and other related providers to convince women to continue with a pregnancy debases women's decision to abort. Even though many abortion seeking women do not seem to be propagandised when explained the status of the foetus by the doctor,

personification of foetus killing and associating it to the realms of moral sins puts the women who seek abortion in a state of dilemma and trauma.

4.2. Major findings:

In the data analysis section, the researcher thematically organised and analysed the collected data which attempts to reveal the experience of the women who had undergone abortion in Guwahati. In this section, the researcher will list the major findings from the data analysis. The major findings will be organised in the same thematic order as the data analysis section.

4.2.1. Women's accessibility to abortion in Guwahati

Analysing the collected data, the researcher found three powerful determinants that influence women's accessibility to abortion in Guwahati. However, these findings cannot be generalised. The three determinants are discussed below.

One, although abortion in India should be legally available in all government health centres, i.e., from Primary Health Care (PHC) centres to the tertiary levels, unfortunately, abortion services were typically available in the government facilities at the tertiary levels in Guwahati. The PHCs here do not have the facility nor enough abortion service providers thus, affecting the accessibility to abortion services.

Secondly, accessibility also depends on the level of awareness regarding the abortion provisions and its legality among the women who seek an abortion. Many do not dare to avail these services at the hands of safe providers due to their unawareness of abortion-related legalities and facilities, thus, compromising the health and well-being of abortion seekers. Secrecy on abortion has been so well maintained by society, the government, and health professionals that many do not have access to information on abortion and family planning in Guwahati.

Thirdly, premarital sex is profoundly discouraged and so is pregnancy among unmarried women in Guwahati like elsewhere in India. And though the evidence is scant in India, pregnancy among unmarried women is awfully stigmatised, even among the providers. All the unmarried research participants here were scared to avail services provided by the

government especially, due to the attitudes among the providers. When it comes to abortion, most obstetricians or gynaecologists, or health providers are reluctant to provide services here.

These findings point out that the law as well as the government failed to acknowledge women's agency. Safe abortion services are not readily available or easily accessible, either because of the restrictive law or awareness or stigma in Guwahati. The consequences has been that women are forced to resort and turn to unskilled providers to abort, thereby, compromising their health and well-being.

4.2.2. Factors affecting decision making in the private in the private sphere

In this section, the factors influencing the abortion decisions of women emerging from the interactions with the family and related dimensions are presented.

4.2.2.1. Moral dilemmas and familial norms

Like elsewhere in India, norms within the family and moral codes compel women to seek abortions in secrecy and often in unhealthy settings without informing their families in Guwahati. Similar stances were presented by all the participants who got pregnant and were unmarried. The same story is run by all participants who sought an abortion in such situations, thereby, endangering their lives when their pregnancy was unwanted. Women who get pregnant and are unmarried have awfully limited sexual autonomy as compared to married women. The fear of their family not consenting to abortion, accompanied by societal frowns pointing at their sexual desires over violating prevalent moral codes force them to compromise their health and well-being without others' knowing. The respondents concealed their abortion in order to prevent negative emotions and reactions from their family members and society.

4.2.2.2. Shame and blame for women's sexuality

In India, premarital sex is profoundly discouraged and so is pregnancy among unmarried women. And though the evidence is scant in India, pregnancy among unmarried women is awfully stigmatised.

Many of the respondents had to opt for illegal abortion services which cost them not just a fortune but also their health. They sought illegal abortion services as otherwise, they will be labelled as irresponsible and promiscuous, defying the enshrined feminine traits. Sex associated with motherhood is celebrated and advocated, but sex that satisfies sexual desires is blamed upon and labelled as non-feminine. Women are reduced to and held responsible for their acts in the familial discourse of abortion.

Stigma can manifest itself in many ways. Feelings of guilt, shame, and fear associated with seeking an abortion impact the ability of women to make autonomous and independent choices. The stigma around abortion is closely interwoven with other social expectations and stereotypes around gender roles in relation to motherhood and family responsibility.

4.2.2.3. Religious interpretations around abortion

Religion still remains one of the chief social agents in moulding attitudes on issues especially, on the beginning and end of life. It has aided in shaping and defining gendered roles and expectations. Religion defines women's sexuality and curbs women's reproductive rights.

The finding extends to the argument of the interplay of the power relations gender and religion share. All respondents made it clear how religion instills within them a sense of fear that drove them to adhere to these negative notions and thereby, curbing their reproductive autonomy. The association of abortion with negative practices in the religious realms affects their decision-making and experience of abortion.

4.2.3. Factors affecting decision making in the public sphere: Women and abortion provider interface

In the public space, our respondents interfaced with the likes of doctors (gynaecologist), nurses and pharmacists during their abortion journey. This section will discuss the findings on how these interfaces challenge or influence the possibility for women's agency to seek an abortion.

4.2.3.1. Denying and delaying abortion provision

Delayed recognition of pregnancy and delay in decision making delay the availing of abortion. On top of that, the providers denying adds more to the problem. Recognition of pregnancy at an early stage reduces the need for surgical abortion procedures. It has implications in terms of the cost as well as the post-abortion complications experienced by women (Winkler et. al., 1995). Attitudes of the medical professionals towards abortion complicated their decisions. The provider's interfaces, knowledge from other known persons, and their experience with providers also influence the decision making. Unmarried women who seek abortion in Guwahati shares daunting experiences. Medical professionals or abortion providers scold these women who seek an abortion. Abortion providers misdirect, delay and discourage women who seek abortion in Guwahati. This led to many women, especially, unmarried women who have no agency to avail of illegal abortion services where their health and well-being are compromised.

4.2.3.2. Shame and Blame: Stigma experiences in the medical setting

Shame and blame are not just associated with the society or family members talking ill of abortion-seeking women. Abortion providers too abuse abortion-seeking women. They are labelled as sexually and morally loose characters by medical professionals. Abortion providers instil shame and blame and dissuade women who seek abortion by bringing up the story of the "healthy foetus" too.

Abortion providers give an impression to the abortion seekers that it is only morally and legally correct to go ahead with an abortion if there are complications or abnormalities with the foetus. When these professionals spit out that the foetus is growing healthy, it affects the women's decision-making. These kinds of tactics used

by the providers authorise the providers to have an upper hand in the decision-making of the abortion seekers. It affronts, disrespects, and affects the autonomy of the abortion seekers and ebbs their lived experiences. Sunil (2018) cited in her work that there is strong evidence that medical practitioners have the muscle to shape and mould how a woman is supposed to act and feel when pregnant. Foetus personification by doctors and other related providers to convince women to continue with a pregnancy, debases women's decision to abort. The personification of foetus killing and associating it with the realms of moral sins put the women who seek abortion in a state of dilemma and trauma. This murky tactic used by providers portrays women who seek abortion in a negative light and even vicious.

CHAPTER 5

Discussions

The intention of this study is to explore and deconstruct the abortion experiences of women in Guwahati. While the previous chapter engulfed itself in the analysis of data and the consequent findings, this chapter will thrive to explain and understand the meanings of the findings. If possible, it will also attempt in discovering alternative explanations for these findings.

As evident from the findings, one of the major findings of this study is that despite a few discrete differences, all women who underwent abortion had almost the same set of experiences. All women experienced stigma at different levels. Stigma can manifest itself in many ways. Feelings of guilt, shame, and fear associated with seeking an abortion make abortion look discreditable and each of these feelings is an upshot of the abortion stigma present in their environment. The stigma around abortion is closely interwoven with other social expectations and stereotypes around gender roles in relation to motherhood and family responsibility. For all the participants, the abortion experience was a journey of nightmare, guilt, anxiety, and physical ills.

This brings us to the present-day controversy on this issue i.e., abortion poses an emotional risk to many women. These women are bound to experience some level of turbulence, with the pressure to conform to social norms. Desai (1964), found in her study that between married and unmarried women, the latter experience higher levels of emotional risk. An American study by Barbara (1973) examined the verbal and non-verbal reactions to abortion. And the study revealed that 69% of the respondents experienced distress (Barbara, 1973). And this distressed category consisted of mostly girls who were aged twenty-one years or below and the second group comprised of women aged thirty-five years or even older (Barbara, 1973). It is noteworthy that the present study presents Collaboratory results. It was found that for the women who underwent abortion when they were unmarried, the distressed reaction of their family, especially, their parents have been an additional burden along with their latent anxiety.

Social reasons have a direct relation to traumatic experiences. Unmarried women's experiences with abortion are more traumatic than married women's. Several factors offer reasons why women engage in the practice of abortion and these reasons vary among women depending upon their ages and the circumstances encircling the pregnancy. Though it cannot be generalised and this can vary from one individual to another.

The underlying results from this research reveal several things. One is that people who had an abortion, do not speak much about their experiences and they do not because they do not have an accepting or safe environment to talk about their abortions.

According to Lewit (1972), motivation is one of the prime determinants for the future course of women who experiences an abortion. She states that it is very rare for one to enumerate psychiatric sequelae if the abortion-seeking woman is strongly motivated (Lewit,1972). Desai (1974) cited the works of a team of Harvard Psychiatrists who studies hundreds of post-abortion cases and indicated that "a vast majority of women do not experience mental anguish, on the contrary, they feel great relief" when the abortion is over and their mental health remains or becomes better" (Desai, 1974). However, unlike their study, which happened in most developed nations, the situation in India provides a different scene. Kumar et. al (2009) claimed in their works that there is a possibility that there can be places and situations in which abortion stigma may be minimal, non-existent, or even less stigmatised than in other places/situations. Johnson-Hanks (2002) in her works mentioned that in Cameroon, local beliefs and value systems around shame, honour, and motherhood make abortion less discreditable.

Stigma from abortion is profoundly a dynamic societal process and contextual. Women seeking abortion are seen and labelled as ones defying reproductive physiology in India. In this connexion, it would be worthy to clarify our conviction that religion can provoke a deep sense of anxiety in women who seek an abortion. The setting in which abortion occurs also heavily influences the emotional as well as the physical well-being of abortion-seeking women (Desai, 1974). If abortion occurs in a well-appointed clinic or hospital, where personnel provide stigma-free abortion services to women and provide counselling, then the likelihood of them experiencing psychiatric sequelae is greatly diminished. However, if the providers are negative, hostile, and indifferent toward these women, then there is likely to have an adverse effect on the women's mental health.

Abortion stigma is demeaning to the individuals who are associated with abortion. However, stigma from abortion is profoundly a dynamic societal process and contextual. Stigma and risks associated with abortion influence and affect women differently. It happens to be more severe and life-threatening to women who experience more vectors of oppression. However, the level of emotional risk can be empirically reduced by the use of precautionary measures so as to prevent unwanted or unintended pregnancy which ultimately leads to abortion.

The findings of this study reveal no definite trend of abortion seekers or their experiences. One cannot generalise from this study due to the small sample, however, it has opened avenues in which future research on a wider scale would provide a better indication of the situation in the society.

Limitations of this study:

1. As aforementioned, this study demands the use of qualitative research methodology because of the subject matter that this study intends to explore. However, one of the characteristic features of the qualitative research approach is the small sample size. This study too is no exception and includes only six research participants based on which the entire research findings have been produced. Due to its rather small sample size, findings cannot be generalised to the entirety of the women population who underwent an abortion in Guwahati.

2. Literature is scarce in this field, especially, in the context of North East. Abortion has been a vulnerable topic to take on research. There has been a virtual absence of qualitative and social studies on abortion. Most studies do not consider the lenses of reproductive rights and the use of feminist phenomenology in the context of abortion. Therefore, this lacuna aids in the lack of support for the study's claim.

CHAPTER 6

Conclusion

The original idea of this research was to explore and understand the abortion experiences of women in Guwahati, Assam. A feminist perspective, rooted in the public health discourse on abortion paved the way to proceed with this research in understanding the barriers women encounter while accessing induced abortion. And as this journey reaches its conclusion, this study unveils that the discourses on decision-making, reproductive rights, and autonomy cannot be merely pigeon-holed into crude frameworks. Instead, these aspects necessitate being studied and understood as complex constructs that are interwoven in the struggles of abortion seekers. The findings and insights discussed in this research are subjective and largely relevant to the women participants who hail from Guwahati, Assam. It was very evident from all the interviews that, irrespective of research participants' reproductive history, they experienced and perceive abortion stigma. This study also highlights that woman who sought an abortion and has undergone abortion are still living with reproductive contingencies.

The debate on the role of liberal abortion law in a nation like India should take into consideration the provision of general health care services. Universally accessible and rational healthcare is crucial at all times for all. Conversely, foregoing studies and even this study indicate abortion services are beyond the reach of many women. Even Jesani (1995) accuses the government and other approved medical settings that provide abortion services as insensitive to the women who seek an abortion.

It is crucial to understand that liberalisation has failed to reduce the incidence of illegal abortions and improve the health of women. This study too proves that the government has failed to recognise that for the MPT Act to be effective, along with providing safe, free, and humane abortions, other social inputs such as empowering women through Sexual and Reproductive Rights are crucial. An abortion can be truly and possibly safe when a wide range of social services such as pre-natal child care, child care, reliable contraception, sex education, protection from abuse, and other related services are available.

Foregoing studies have only focused on the mere issue abortion poses at the political and legal levels. However, it is beyond that, and this study's findings consistently expose that. It is an issue of social, moral, and cultural conflict and the findings of this study confirm and uphold that. Furthermore, research on abortion is marked by a complete absence of social content. Researches do not consider the reproductive aspects of abortion and solely focuses on the legal and political aspects of abortion. Researches focusing and indulging on psycho-social aspects of abortion, issues faced by women seeking an abortion, difficulties faced during the decision making, and their experiences during abortion are scant.

The Indian government has treated abortion as a medical phenomenon only and fails to recognise that abortion alone will not relieve women of all the mental health issues like anxiety, guilt, fear, and ambivalence. Women who underwent an abortion or seek abortion require the guidance and help of experts in the decision-making and other relevant series of the process an abortion demands from a woman. The current law still has made no statutory provision for an expert counsellor to take care of the mental health of abortion seekers.

Recommendations for further research

This study was an attempt to fill in the gaps in the previous research and literature. Yet, a lot has to be done in the field of women and abortion in Guwahati and elsewhere in India. At this juncture, the researcher would like to express her personal opinions, by way of recommendations for further research.

- More research is required in greater depths revealing the status of abortion in contemporary times.
- Researches on the psycho-social aspects of abortion would specifically be beneficial for social workers, especially to the counselling bureau.
- There is no research and study on the awareness or knowledge of the community on the provisions for legal abortion and the range of services available.

APPENDIX

1. Guiding Themes and Interview Guide

i. Personal Profile

Current Age:

Sex:

Marital status:

Religion

Caste

Educational Qualification

Native Place:

Current Residence:

ii. Guiding Themes:

In order to evoke the research participant to share their experiences, rapport building was a precocious process. The research participant was informed about the research, its objectives and the interview proceedings. They were made comfortable and aware that they can choose to not answer or end the interview at any point.

The interview was more of a conversation, occasionally accompanied by open-ended questions if necessary to keep the flow of the conversation. The conversation gradually led to exploring their meaning on unintended pregnancy and abortion typically while trying to understand their opinions and beliefs regarding these events. Keeping in mind the comfort zone of the co- researcher/ research participant, the researcher subsequently moved on to kindle a comprehensive account of their abortion experiences in their city i.e., Guwahati. There were a few specific topics based on which the conversations were directed by the researcher to squeeze out the

required information for the study. The major theme of the interview is to understand and capture the experiences of women who go through the process of abortion and the barriers they experience in curving their choices and decisions This major theme was further narrowed down into other sub-themes as-

- Childbirth History
- Abortion decision-making process
- Accessibility to safe abortion services
- Abortion episode
- Role of the family in decision making
- Role of the partner during decision making

iii. Interview Schedule:

1. Would you like to talk about your native place?
2. What made you to come to Guwahati?
3. Suppose a pregnancy is unwanted, it can be terminated. Have you heard of it? Do you know if it is legal?
4. Around here, is it easy or difficult for a woman to terminate a pregnancy?
5. Generally, in this place, where would a woman go if she wants to terminate a pregnancy?
6. What was your marital status when you underwent an abortion?
7. How and when did you know that you were pregnant?
8. What was your initial reaction or emotion at that point?
9. Who was the immediate person you went to share this news?
10. When did you have an abortion?
11. What does it mean to you to have an abortion?
12. What has it been like to you to have experienced an abortion?
13. What were the primary considerations that convinced you to go for abortion?
14. Were you comfortable to share about your decision for abortion with your partner or family?
15. Did your partner/family share your medical costs/ expenditure?

16. Would you like to explain your experience with the health professionals in Guwahati?
17. Could you kindly talk us through your entire abortion experience in the medical setting?

2. Glossary

Induced Abortion: The termination of a pregnancy by a procedure or action provided by a provider to end a pregnancy.

Reproductive Health: Reproductive health implies that an individual is able to have responsible, satisfying and safe sex. They are able to and have the capacity to reproduce and the freedom to decide if, when and how often to do so.

Reproductive Healthcare: "The constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems." (Programme of Action of the International Conference on Population and Development, 1994).

Reproductive Rights: Reproductive Rights rests on the recognition of the right of all individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. (Programme of Action of the International Conference on Population and Development, 1994).

Self- Induced abortion: It indicates the procedure or an action taken by the women to end a pregnancy and expel the products of contraception by herself.

Sexual Health: WHO has defined sexual health as " A state of physical, emotional, mental and social well-being on relation to sexuality; it si not merely the absence of disease, dysfunction or infirmity" (WHO, 2006).

Sexual and Reproductive Health and Rights (SRHR): The SRHR is an inclusive label that includes abortion, pregnancies, family planning, Reproductive Tract Infection (RTI), Adolescent Sexual and Reproductive Health, etc.

Spontaneous Abortion: A miscarriage; the natural, involuntary termination of a pregnancy. Medically, spontaneous abortion takes place before the 13^{th} week of pregnancy.

Surgical Abortion: Use of transcervical procedures for terminating a pregnancy. Some of the surgical methods include Electronic Vacuum Aspiration, Dilation and Curettage (D&C).

REFERENCES

Beauvoir, S. d. (1956). *The Second Sex*. (Translated and ed, by H.M. Parshley, Reprint Edition), London: Jonathan Cape.

Beneia,L.,& Sen, G.(1981). Accumulation, Reproduction and "Women's Role in Economic Development".Boserup Revisited. *Signs*, 7(2), 279-298.

Berer, M. (2017). Abortion law and policy around the world: In search of decriminalization. Health and Human Rights.

Centre for Reproductive Rights. (n.d.). Safe and Legal abortion is a Women's Human Right.

Center for Reproductive Rights (CRR). (2018). *Ensuring reproductive rights: Reform to address women's and girls' need for abortion after 20 weeks in India*. New York: Center for Reproductive Rights.

Cooksey, A. & Robinson, C. (n.d.). *The Ethical Dilemma of Abortion*. Journal of Student Research at Indiana University East.

Desai, N. (1964). From accommodation to articulation: Women's movement in India.

Gammeltoft, T. (2003). The Ritualisation of Abortion in Contemporary Vietnam. The Australian Journal of Anthropology. 14(2).

Galati, A. J. (2015). Onward to 2030: Sexual and Reproductive Health and Rights in the context of the Sustainable Development Goals. *Guttmacher Policy Review*.

Gilligan, Carol. (1987). ―In a different voice‖ in D.L.Eck and D. Jain (Eds.), *Speaking of Faith-global perspectives on women, religion and social change*, (p.236-245). Philadelphia: New Society Publishers

Gold, R. (2003). Lessons from Before Roe: Will Past be Prologue?

Government of Assam. (2020). *Comprehensive Abortion Care*.
Guttmacher Institute. (2018). *Abortion and Post-Abortion Care in Assam, 2015*.

Held, V. (1989). Birth and death. *Ethics*, 99(2), 362-388.
Held, V. (1990). Feminist transformation of moral theory. *Philosophy and Phenomenological Research*, 1(suppl), 321-344.

Held, V. (2005). *The Ethics of Care: Personal, Political, and Global*. New York: Oxford University Press.

Hirve, S. (2003). Abortion Policy in India: Lacunae and Future Challenges. Abortion Assessment Project, India. CEHAT. Health Watch: Mumbai.

International Planned Parenthood Federation. (2015). *Political environment and CSO relevant to SRHR in South Asia*.

Iyer. A & Jesani. A. (1995). Abortion- Who is Responsible or our rights.

Jesani, A. Iyer, A. (1995). Abortion- Who is responsible for our rights.

Jaggar, A. (1983) (2004). 'Feminist politics and Epistemology; the standpoint of women', in S. Harding (Ed): *The Feminist standpoint Theory Reader: Intellectual and political controversies*, Routledge: New York, pp. 55-66.

Johnson-Hanks, J. (2002). On the Modernity of Traditional Contraception: Time and Social Context of Fertility. Population Council.

Johnson- Hanks, J. (2002). The Modernity of Traditional Contraception. Population and Development review. 28(2).

Kapur, K. (2020). How Fares India in Healthcare? A Sub-national Analysis. Observer Research Foundation.

Kumar, A. Hessini, L. Mitchell, E. (2009). Conceptualising Abortion Stigma. Culture, health & sexuality.

Koster-Oyekan, W. (1998). Why resort to illegal abortion in Zambia? Findings of a community-based study in Western Province.

Lewit, S. (1972). Joint program for the study of abortion (JPSA): Early medical complications of legal abortion. Studies in Family Planning 3.

Lewis, M. A. & Tamparo, C.D. (2007). Chapter 14: Abortion. In Medical law, ethics & bioethics for the health professionals. F.A. Davis Company

Lokeland, M. (2004). Abortion: The Legal Right Has Been Won, But Not the Moral Right. Reproductive health matters.

Menon, N. (2004). *Recovering subversion: Feminist politics beyond the law*. NewDelhi: Permanent Black.

Matwijkiw, A. (2020, October). Issue & dilemma: Is abortion immoral? [Lecture notes]

Noddings, N. 1984. Caring: A Feminine Approach to Ethics and Moral Education. Berkeley: University of California Press.

Office of the High Commissioner for Human Rights. (2000). CCPR General Comment No. 28: Article 3 (The equality of Rights Between Men and Women).

Officer of the United Nations High Commissioner for Human Rights. (2020). Abortion
United Nations, Department of Economic and Social Affairs, Population Division. (2014). *Abortion Policies and Reproductive Health around the World*.

Petchesky, R.P. (1984). Abortion and women choice: the state sexuality and reproductive freedom. Boston: North Eastern University Press.

Petchesky, R.P. (1995). The body as property: A feminist re-vision. In F.D. Ginsburg and R. Rapp (Eds.*) Conceiving the new world order: The global politics of reproduction* (pp. 387-406). London: University of California Press.

Petchesky, R.P. (2000). Rights and need: Rethinking the connections in debates over reproductive and sexual rights, Health and Human rights. 4(2).

Programme of Action of the International Conference on Population and Development, Cairo (1994). New York: United Nations

Ravindran, T. S., and Khanna, R. (2012). Many a slip between the cup and the lip: Universal access to safe abortion services in India. Kaancheepuram, India: CommonHealth.

Sandel, M. J. (1984). Liberalism and its critics. New York: New York University Press.

Shrivastava, S. Shrivastava, P & Ramasamy, J (2018). Can legalization of abortions be the right approach to minimize the incidence of unsafe abortions worldwide?. Journal of Dr. NTR University of Health Sciences. 7 (1): 81.

Singh, S., et al., (2018). The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*, 6(1), e111-e120.

Sunil, B. (2018). Gender, Body and the Self: A Study on the induced abortion experiences of women in Kumbakonam, Tamil Nadu

Tong, R. (2009*). Feminist thoughts: A more comprehensive introduction*. USA: Westview Press.

United Nations Development Programme.(n.d.). *Sustainable Development Goals*.

Webb, D. (2000). Attitudes to 'kabonya mafumo': The terminators of pregnancy in the urban Zambia. Health Policy and Planning 1

Winkler, J. Oliveras, E. and McIntosh, N. (1995). *Post abortion care: A refence manual for improving quality of care.* New York: JHPIEGO Corporation.

World Health Organisation. (2003). Safe Abortion: Technical and Policy Guidance for Health Systems 12.

WHO. (2006). *Defining sexual health: report of a technical consultation on sexual health*, p.5,
28–31 January 2002, Geneva

World Health Organization. (2018). *Millennium Development Goals (MDGs)*.