HIDDEN IN PLAIN SIGHT

Experiences of abortion in unmarried women and the impact on well-being

Sana Parakh

A dissertation submitted in partial fulfilment of the requirements for the Degree of Master of Arts in Social Work in Mental Health

Centre for Health and Mental Health

School of Social Work

Tata Institute of Social Sciences, Mumbai

2020

To,
Batch of 2020.

Who are striving to complete their work and get a job amidst a pandemic.

Life is under no obligation to give us what we hope for. It is, indeed, a difficult time for all of us, and especially for student of TISS, because we are worried about both; the pandemic and the fascism.
However, don't lose hope. Do not get dejected for the time we lost.

These are dark times, but if it were not for the darkness, we could have never seen the stars. You all are the stars, the real MVP.

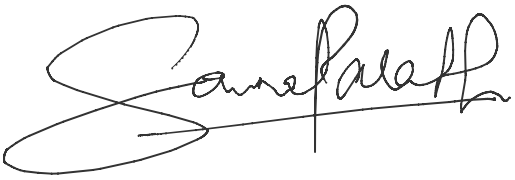
Give yourselves a pat on the back and keep fighting and working towards what is right.

Batch of 2020, signed off and already in the real world.

DECLARATION

I, **Sana Parakh** hereby declare that this dissertation entitled **Hidden in plain sight: Experiences of abortion in unmarried women and the impact on well-being** is the outcome of my own study undertaken under the guidance of **Dr. Asha Achuthan**, Asst. Professor, Advanced Centre for Women's Studies, School of Development Studies, Tata Institute of Social Sciences, Mumbai. 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.

April 16, 2020



SANA PARAKH

M2018MH017

Centre for Health and Mental Health
School of Social Work
Tata Institute of Social Sciences, Mumbai

CERTIFICATE

This is to certify that the dissertation entitled **Hidden in plain sight: Experiences of abortion in unmarried women and the impact on well-being** is the record of the original work done by **Sana Parakh** under my guidance and supervision. The results of the research presented in this dissertation/thesis have not previously formed the basis for the award of any degree, diploma, or certificate of this Institute or any other institute or university.

April 16, 2020

DR. ASHA ACHUTHAN

Assistant Professor,

Advanced Centre for Women Studies
School of Development Studies
Tata Institute of Social Sciences, Mumbai

ACKNOWLEDGEMENT

"How lucky I am to have something that makes saying goodbyes, so hard." (Winnie, the Pooh)

Writing acknowledgement is an extremely stirring task, especially in times such as these. In writing a few words, I relived the past two years of my life; where campus had become a synonym for home, and the people, mi familia.

I do not think that a line in my acknowledgements can be enough to thank my family for all they have done. My **Maa and my Baba**, despite their reservations, sent me to this college in the first place. My **Mumma and Papa**, thank you for the faith you had in me, for all the worrying you did and parcels you sent that reminded me of home. Thank you for everything, because not everything can be listed here. Thank you to my little one, **Vama**, who never failed to believe in me even when I did not. They always understood when I was working and made calls accordingly, while I could call at midnight if I were feeling anxious.

I would like to extend my gratitude to my guide, **Dr. Asha Achuthan** who made me want to do better. In one of our meetings, I remember, she said to me, "Sana, you have a very good data. Make sure you do justice to it" I probably did not meet her expectations, but it made me work harder. And my citation game definitely became much stronger. Thank you, professor.

Most importantly, I am grateful to the **women who are a part of my research** whom I got the chance know. They were brave and selfless to give me such rich accounts of the most intimate details of their lives. This research would never would have been possible, if not for you all. I am indebted to you.

I would like to also thank my **fam in Indore** for making working in Quarantine, as breezy as it could have been. And to all my '**sibling like cousins'** who had faith in me and pegged me on with encouragement and insults.

Thank you also to my '**sunshine' girls: Amisha, Mahika and Poorvi** who have never felt far despite the distance and the schedule. Thank you for cheering me on, girls! **Diva**, with you I have been nothing but my honest self lately, and you play a huge role here. **Somit**, you have been my rock, all my life. Thank you for all your poorly timed and insensitive sense of humour that kept me same and away from sadness!

Before coming to my family at TISS, I would like to selectively send my love to those who helped me academically. Thank you Shrutika and Utkarsh, for reading my thesis and finding faults, necessary or not. Kunal and Tushar, thank you for being my emergency paraphrasing machines and **Kuhu**, for helping me find that perfect theoretical framework. Your contributions are noted.

To, **Core**. I do not want to do an umbrella thank you because each one of you mean so much, in such different ways. **Shrutika**, thank you for always one-upping my sadness and making me forget about my thing by bringing in your own. And thank you for matching my over-enthusiastic energies and getting me to do my work by literally sitting on my head. **Shubham**, you are my rock. Thank you for being an inspiration and being there, no matter what. and thank you for resolving every inch of doubt and worry I had around my thesis **Rakhe**, I am still unsure about your spelling, haha, but had it not been your positivity and spontaneity, I would not have been able to survive this. Thank you for the lovely music and high spirits! **Sneha**, thank you for making me feel so good about myself by starting the baby trend. And thank you meeting me at the back gate for our little breaks. ek tu hi sahara, bro. **Shashi**, thank you for always being there and hyping us up. I cannot find a more resilient person in my life than you are. **Utkarsh,** you are my soul sister. Thank you for being exactly like a perfect twin brother. You have always been a call away, irrespective of the purpose of my call.

To my essentials in TISS, without whom I would not have remembered college so fondly. **Aakanksha** (my bad joke and hug machine) **Kevin** (my promise guy who gave me the prestigious task to check memes and always a reason to smile) **Sanjyot** (my respite in the lockdown times and before and always being ready with sugar, spice and everything nice along with chemical X), **Raees** (for being ever so considerate) and **Tushar** (if the word true friend had a face and if Chacha Chaudhary was real and younger).

To **Prateek, Gautham, Zarana, Hitesh, Avinash, Saagerika** and **Gunjan**, for some prominent moments of happiness in my memory. I don't remember a time when seeing your faces did not make my day.

My **MH batch of 2020**, thank you for being the safest classroom possible, despite differences. I could not have asked for a smarter, more encouraging and laid-back class. It was an honour to be the class representative to y'all when I was clearly not equipped to be one.

Lastly, I am indebted to **Kunal**, perhaps the sole definition of constant for me; and my guiding north star. I could have done none of it without you. Thank you for seeing this through with me.

You never really leave the place you love. I would like to thank what **TISS** has meant to me, and the space I had in this college to grow tremendously as a person. For all the nooks and corners where we could sit and study, to ever open library, to always buzzing roads and to spaces that made us work hard to reach the end.

To end with, I owe this dissertation to myself and my journey. And for that, I am grateful to **myself and my laptop** for not giving up.

ABSTRACT

The research explores the narratives of urban, middle class women who are not married and have undergone legal abortions. In-depth interviews were taken with 12 women and a few stakeholders to understand the same. The study explores the personal as well as socio-economic factors that directly or indirectly affect the women. This includes the relationship with the partner and the family, internalisation and implications of the social stigma around abortion and premarital sex, the exclusionary nature of the MTP Act and the role of health practitioners. The research also identifies emerging themes from these narratives and tries to understand the overlap between the dynamics in the lives of the women. It seeks to identify the coping mechanisms used by the women, look into the life events and recognise the impact of the given factors on the well-being of the women.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION 9

CHAPTER TWO: REVIEW OF LITERATURE 15

ABORTIONS ARE AS OLD AS PREGNANCY: A QUICK HISTORICAL RECAP 16

ABORTIONS THROUGH A FEMINIST LENS 19

PRO-LIFE AND PRO-CHOICE DEBATES: USA AND INDIA 22

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971 23

ORDER, ORDER: THE LEGAL ASPECTS OF ABORTION IN INDIA 26

PSST, ABORTION: A REFELCTION ON THE ROLE OF THE SOCIETY ON WOMEN AND THEIR DECISION MAKING 28

IMPACT ON DECISION MAKING 30

DOCTOR WHO: PUBLIC HEALTH PERSPECTIVE 34

TCH TCH, BECHARI: PATHOLOGISING ABORTIONS 38

IMPACT ON INIDVIDUALS 40

LET'S TALK ABOUT SEX, BABY: CAMPAIGNS, AWARENESS AND SEX EDUCATION 42

CHAPTER THREE: METHODOLOGY 47

QUALITATIVE RESEARCH 48

NARRATIVE APPROACH 49

OBJECTIVES 50

RESEARCH QUESTIONS 50

METHODS AND TOOLS 51

SAMPLING 52

PROCESS OF DATA COLLECTION 52

DATA ANALYSIS PLAN 54

ETHICAL CONSIDERATIONS 54

CONCEPTUAL FRAMEWORK 57

THEORETICAL FRAMEWORK 57

PARTICIPANT PROFILE 61

OPERATIONAL DEFINITIONS 62

RESEARCH ANALYSIS 63

CHAPTER FOUR: THE INPUTS 64

HUM SAATH SAATH HAI: THE ROLE OF FAMILY 65

MANNING UP: THE ROLE OF THE PARTNER 73

DRIFTING AWAY FROM KAMASUTRA: THE SORRY STATE OF SEX EDUCATION 81

MONKEY SEE, MONKEY DO: MESSAGING AND REPRESENTATION 85

HOLDING BACK OR LETTING GO: WHAT GOES INTO THE DECISION TO ABORT 90

CHAPTER FIVE: THE IMPACT 92

KABHIE KHUSHI KABHIE GHAM: EMOTIONS; WHERE DO THEY COME FROM AND WHERE DO THEY GO? 93

DAWA AUR DUA: THE POWER OF THE PROFESSIONALS 102

EKLA CHOLO RE: TOWARDS WELL BEING AND SELF-CARE 111

SAFARNAMA: THE JOURNEY OF CHANGE 114

CONCLUSION 119

TENTATIVE RECOMMENDATIONS FROM THE STUDY 119

LIMITATIONS 121

REFERENCES 122

APPENDIX: INTERVIEW PROBES 127

CHAPTER ONE: INTRODUCTION

In India, a uterus is more heavily regulated than a bottle of acid.

Abortion in India has always been talked about by citing the example of the MTP act. In India, the second most populous country in the world, abortion has been legal on a broad range of grounds since 1971.The MTP act has always been considered ahead of its time, which technically is true. The MTP Act and the case of India is unique in the politics of abortion across the globe because the law came without resistance, and was widely accepted across ideologies, that is, there was no over the top condemnation or celebration of the act.

In comparison to what is currently happening in the most developed countries of the world including the United States of America, the 50-year-old act still seems progressive. Perhaps because USA currently is the worst possible comparison to make. In a world where the POTUS, for the first time in the history of the nation, attends a pro-life rally in 2020.

However, it is time to change because India is a country like no other. There are several things at play, including the stigma which pushes almost two third women undergoing abortion into the clinics of illegal practitioners and quacks. (TOI, 2017) The MTP act has not undergone a single amendment in 50 years, up until 2019, and that makes India a regressive country, contrary to its progressive image when it comes to abortion laws.

The essence of abortion laws, ideally, should be quite simple; her body, her choice. But with rampant female foeticide and the inability of women to assert their agency, some laws might be necessary. However, this excuse is getting old. With the coming of technology, gender of a baby can now be detected at 12-13 weeks as well. Instead of taking a detour and confining the right of every woman to decide what is best for her, the problem should be tackled for what it is. To give an analogy, it is like treating the symptoms of COVID-19 but not targeting the virus and cause of spread itself. That spells a pandemic; or in the case of abortions, a disaster. The relationship between the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 and the MTP act is a significant one in the abortion debates in India,

and thus unavoidable. The PCPNDT act if often used as an excuse to crack down on abortion as a whole. Now there are two consequences of this overlap. First, the practitioners deny women abortions, even if they are not sex selective because in case the foetus is female, the crackdown on doctors is harsh and the punishments, severe. This has restricted the access of women to essential abortion services. Second, more often than not, the choice to undergo an abortion, precisely a sex selective one, is not the choice of the woman. However, she is the one put under the knife and risks to lose her life in case of illegal and unsafe abortions. This overlap also puts women under risk of getting pushed into illegal and unsafe abortions.

There are several problems with the MTP act. However, those cannot be talked about without acknowledging the fact that the act itself is drafted under the biases that the society holds, against the autonomy of women and premarital sex. The idea that a woman can have sex as and when her heart desires, with the person of her choice is bizarre for us as a country to comprehend. Abortion is taking it one step further when she is making a bold choice of being practical and choosing for herself instead of facing the consequences of 'committing the sin of sex' before getting married.

There are four major issues that are at the core of the MTP Act. The recent amendments in the MTP act do not really make an impact on these issues (except one) and are not substantial strides in the direction of autonomy for women.

- MARITAL RAPE IS NOT RAPE

  According to Maneka Gandhi, marital rape is inapplicable to Indian Society. (Sen, 2016) The understanding and sanctity of marriage changes from on country to another, and so does the definition of marital rape. And this is the reason we use to justify a case of marital rape by calling marriage 'sacred'. There is no provision for women to access abortion for marital rape per se, more so above the 20-week limit.

- CONFLICT WITH POCSO AND PCPNDT

  A case of a ten-year-old girl, who was denied abortion on the grounds of risk to life, is a good example to show that the MTP Act has got the nuances wrong. (Parul, 2017) Section

3, explanation 1 of the MTP Act considers pregnancy out of rape causes mental anguish. The allowed termination period for mental anguish is 20 weeks, in the same section. Section five draws an exception, that says an abortion can take place if the termination of such pregnancy is immediately necessary to save the life of the pregnant woman. The decision if the woman can undergo abortion totally depends on judicial interpretation, which brings me to my next point.

- FOR THE WOMEN, BY THE COURTS

As Dr. Willie Parker said "In every case except abortion, society bestows upon individuals this trust, even if those individuals have demonstrated that they cannot be trusted to make good decisions. The presumption undergirding abortion decision making is that the women who have had sex and are accidentally or unintentionally pregnant can't be trusted to comprehend the consequential weight of their actions. The law requires them, like little bad girls, to 'prove' to authorities that they have thought carefully about what they are about to do." (Parker, 2017)
A Delhi court has said that 'premarital sex is immoral and against the tenets of every religion' while holding that every act of sexual intercourse between two adults on the promise of marriage does not become rape. It is in these courts the women are supposed to seek permissions for their own bodies and be subjected to biased judgements.

- NO ACKNOWLEDGEMENT OF UNMARRIED WOMEN

A woman cannot just walk in and get abortion, without being asked about her marital status and mostly feeling attacked if the answer is no. In the MTP Act, there is no mention of unmarried women's access to abortion. They have to satisfy the conditions under section three. Thus, abortion is just a legal procedure and not a right given to the women for their own bodies. The supreme power to decide if the woman can have an abortion, from a medical perspective which is often laced with morals, lies with the practitioners and the courts.

However, in the amendment of the bill in January 2020, one of the major changes made was replacing the term “married women” with “all women” and the word “husband” with “partner” in the contraceptive failure clause, in an attempt to clarify that abortion is legal for all women, not only those who are married.

The unmarried women above 18 years of age and in need of termination of pregnancy ARE NOT discussed or talked about or acknowledged in the MTP Act, 1971 at all. The ‘Legal Status’ of abortion of unmarried women above 18 years of age is unclear and ambiguous. They are neither allowed nor denied abortions. Community-based studies have not been able to obtain reliable information about unintended pregnancy and abortion among unmarried youth, but in a recent study of unmarried college students (Shveta Kalyanwala et.al, 2010), 9% of sexually experienced females reported an unintended pregnancy and 17% of sexually experienced males reported that they had ever impregnated a partner; all of these pregnancies were reported to have been terminated.

The research primarily focuses on the last point of the problems with MTP. It tries to analyse how women have managed to navigate their spaces without legal or social security and how it has impacted their well-being. Perhaps, the most interesting turn in the topic of the paper is that mental health is an equally controversial topic in the country. There is not only denial, but serious lack of understanding of the concept of mental health in a wholesome manner. The paper seeks to understand various impacts of abortion on mental health of women, positive or negative, how women dealt with societal pressure and what could have gone better for them throughout the process.

There were certain reasons for which this topic was chosen for the thesis. Abortion is a topic that has been at the heart of discussion and debate for a long time. It is also one of the topics where both sides of the ideology have produced immense research, rallies and discourse. There have always been a tussle and each point has been countered, with grace, by the people of the opposite views. It is a he said-she said situation in a world where he and she are taken to be equals. It is an extremely engaging issue where the researchers don’t seem to run out of new and ever evolving perspectives and fresh takes on the issue.

Academically, there were two primary reasons for choosing this research topic.

First, the existing literature on the mental health implications of abortion focuses on abortions in general and are not need specific to different groups. The studies are mostly quantitative which are more focused on statistics than the experiences themselves. The researches are also often, not always, very polarised and biased to one kind of feeling that the women must be feeling. The literature talks mostly about 'mental disorders' and thus majority of researches found no causal relationship between the two. However, there is a need to explore the topic from the lens of mental health and well-being rather than 'disorders'. There is also a need to understand that all impacts are not negative. Thus, each experience should be analysed individually and no general conclusions should be drawn. However, it is important to note than every experience has multiple aspects, especially something as complex as abortions. It is important that a balanced view of the things is presented to give a clearer picture of the reality of abortions and the emotions of the females.

Second, the focus of the researches around abortion are the vividly vulnerable groups like women located in rural areas, teenagers or victims of rape/incest. There is not enough literature around the urban, working and seemingly 'independent' and 'modern' women in urban areas. The researcher also felt a need for a qualitative research, to document the experiences of women as a whole, and as they tell it. This very reason is where the research gets it title from; hidden in plain sight. The women are not recognizable because neither are they presumed to be vulnerable instinctively, nor is there a space or discourse where women can speak about the same.

The research has explored the role of family, partner and the society. It also viewed and analysed the messaging and perception about sex and contraception through sex education and the society. The impact of all of these systems were seen on the decision to abort. Further, the research explored the impact of going through abortion, on the over all well-being of the women, the impact on their relationships and the changes in their ideas and relationships.

The research does not emphasise that abortion, by the virtue of expelling a foetus, is a stressful experience in itself and causes distress. That differs from one individual to another.

Abortion here is seen not as process but as an experience, in which the stressors are located in the social and healthcare systems. It is the impact of interactions of these systems that the study aims to analyse and understand.

CHAPTER TWO: REVIEW OF LITERATURE

“Abortion stigma is widely acknowledged in many countries, but poorly theorised. Although media accounts often evoke abortion stigma as a universal social fact, we suggest that the social production of abortion stigma is profoundly local. Abortion stigma is neither natural nor ‘essential’ and relies upon power disparities and inequalities for its formation.” (Anuradha Kumar, 2009)

No single health-related issue today engenders more controversy, debate, and even violence, than abortion. Recent policy changes, developments in medical technologies, and maternal deaths from illegal abortions are some of the indicators of the centrality of abortion as an issue in women's reproductive lives. Hillary Kunins in 1991 talked about the vast amount of literature that has been generated in and around the subject of abortion, mostly since 1973. These researches range from quantitative demographics studies and morbidity and mortality rates to examining the emotional and physical sequelae of abortion. Still others have carried out social science studies on the reason’s women choose to abort and on contraceptive attitudes and practices regarding contraception. Due to the abundance of studies, Willard Cates, a prominent researcher in the provided field, has stated, "we have come to know more about [abortion] than any other surgical operation" (Hillary Kunins, 1991).

“Abortion stigma is difficult to isolate because it is produced and reproduced across different levels, including individual, community, organizational and legal, and is played out through private and public discourse, including the media. Women who need abortions face stigma and may even perpetuate it, as do providers of abortion services. Entire communities have developed ways of separating, stereotyping and discriminating against women who need abortions. Legal frameworks create categories of “acceptable” and “unacceptable” abortions and reward privilege to those women who obtain early abortions. And abortions have been separated from comprehensive reproductive health-care services and from insurance programs, as well as totally dissociated from family planning.” (Hessini, 2011)

ABORTIONS ARE AS OLD AS PREGNANCY: A QUICK HISTORICAL RECAP

According to the oldest found records around abortions by Hippocrates, abortions are prevalent since 450 B.C. In 4th century AD, abortion was allowed only till the first three months of pregnancy (We are still allowing abortions only until the first trimester, liberally) From middle ages until the 1900s, there was a shift in the outlook towards abortions and they were made illegal for the longest period of time in many countries. For instance, England in 1869 came up with a legislation called "Offences Against the Persons Act", that outlawed abortions for any reason. ((Saurabh, 2018)

In the modern era, the former Union of Soviet Socialist Republics (USSR) was the first country to legalize abortions in 1920. After around a decade, in 1933, Hitler passed a law to legalise and encourage abortion to terminate 'racially invaluable' children and the act was called 'Law for the Prevention of Progeny with Hereditary Diseases'. After the WWII, this law was found to be a 'crime against humanity', which it indeed was as the basis of abortion was not even the threat to the life of the woman but the race of the child. Japan became the next country to make abortions legal in 1948 followed by several Easter European countries in the 1950s. Interestingly, Britain reversed its stand in 1967 through The Abortion Act of 1967 which legalized the practice in the United Kingdom. (Saurabh, 2018)

USA, however has a fluctuating and a turbulent relationship with abortion rights. has a fractured history of abortion rights. The pro-choice movement started more slowly in the United States. The early women's rights movement, which started in the 1850s, did not support abortions at all. In fact, Susan B. Anthony (1820-1906), the leading proponent of women's rights, condemned abortions. In the 1930s three books written by doctors started the medical community to begin discussing a change in the abortion laws. The 1950s saw two psychiatric conferences and a Planned Parenthood conference dealing with the issue. Planned parenthood is a synonym for abortions that Indian law uses till date. It somehow portrays a less evil image of abortions and that was also the need of the hour, given how much abortions

have been demonised amongst the people. Then, in 1959 the American Law Institute suggested broadening the definition of legal abortion to include maternal physical and mental reasons, fetal defects, and cases of rape and incest. In the 1960s, Mississippi, California and Colorado became the first states to allow abortions. However, by the 1970s, only 16 of the 50 states supported the abortion rights movement. Later due to the US Supreme Court's decision in *Roe V Wade*, in 1973, allowed abortions nationally. (Gold, 2003)

As USA passed a law to legalise abortions nationally, India already had the MTP Act of 1971 in place.

"The Indian Penal Code 1862 and the Code of Criminal Procedure 1898, with their origins in the British Offences against the Person Act 1861, made abortion a crime punishable for both the woman and the abortionist except to save the life of the woman. The 1960s and 70s saw liberalisation of abortion laws across Europe and the Americas which continued in many other parts of the world through the 1980s. The liberalisation of abortion law in India began in 1964 in the context of high maternal mortality due to unsafe abortion. The Shah Committee, appointed by the Government of India, carried out a comprehensive review of socio-cultural, legal and medical aspects of abortion, and in 1966 recommended legalising abortion to prevent wastage of women's health and lives on both compassionate and medical grounds.[4] Although some States looked upon the proposed legislation as a strategy for reducing population growth,[5] the Shah Committee specifically denied that this was its purpose. The term "Medical Termination of Pregnancy" (MTP) was used to reduce opposition from socio-religious groups averse to liberalisation of abortion law. The MTP Act, passed by Parliament in 1971, legalised abortion in all of India except the states of Jammu and Kashmir." (Hirve, 2005)

An obvious reason for the Indian state promoting a liberalized (or seemingly liberalized) regime of abortions is that India had a very serious population problem, and family planning had to be an option if the population growth rates were to stabilize. In fact, the slogan 'Hum Do, Hamare Do' (Two of us, and our two) was a slogan associated with India's family planning program launched in 1952. Giving women the option to choose whether to carry pregnancies to term is compatible with the State's objectives of stabilizing the population

growth rates. Further, smaller families are an important tool to rise out of poverty. (Agnihotri S. , 2016)

Historically, the world saw a shift to legal abortions, to ban on abortions and then legalisation of abortions in some countries under specific provisions. However, the rift between the pro-choice and pro-life thinkers was always present.

"The early abortionists in Europe were lay women healers who practised 'medicine' among the peasantry. When the male dominated profession of medicine emerged as a formidable force in the mid-nineteenth century, its practitioners went about the task of weakening competition from all non-professional practitioners, a majority of whom were women and providers of abortion services. Doctors thus spearheaded the first organised attack on abortion." (Amar Jesani, Abortion-Who is responsible for our rights, 1995)

After legalisation of abortion, USA faced a huge divide in the pro-life and pro-choice supporters which turned radical, and even violent.

"The Roe v. Wade decision provided pro-life activists [in USA] with a clear objective for building a political movement. Activists founded the National Right to Life Committee, the country's oldest pro-life organization, in 1968 in response to states liberalizing their abortion laws. Americans United for Life, founded in 1971, created a legal defence in response to the Supreme Court's ruling. Approximately twenty thousand activists marched together in Washington, DC, to protest the one-year anniversary of the Supreme Court's decision in the March for Life, the first in what has become an annual tradition for pro-life activists. Critics of the court's decision assert that unborn children are legally considered persons in other situations. Unborn children have the right to inherit property, for instance. Likewise, if an unborn child is wrongfully killed, the person at fault can be charged with manslaughter in some states. Critics argue that these inconsistencies reveal the decision's lack of legal foundation." (Abortion." Opposing Viewpoints Online Collection, 2018)

"The pro-life movement has given rise to a network of fervent activists, including those who hold public demonstrations outside of health care facilities that provide abortions. Protesters at abortion clinics often brandish signs with images of foetuses intended to disturb witnesses and shout condemnations and threats of violence toward doctors and patients entering these

buildings. In response to these incidents, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act in 1994, which made blocking the entrances of places providing abortion counselling or services a federal offense punishable by fines and imprisonment." (Abortion." Opposing Viewpoints Online Collection, 2018)

Some anti-abortion activist groups adopted extremist tactics to promote their cause. Members of the militant pro-life organization Operation Rescue have been involved in incidents of domestic terrorism, including the bombing of abortion clinics and the aggressive harassment of health care workers who provide abortions. (Abortion." Opposing Viewpoints Online Collection, 2018)

India however, has been very different in terms of political debates around abortions. There has been very less backlash from both potential pro-choice and potential pro-life rallies. The reasons they held were different, but almost everyone seemed to be in agreement, fully or selectively, with the MTP Act, 1971.

"The absence of a backlash against women's right to choose may also have to do with the fact that not too many women are really free to make a 'choice'. Despite the law in India providing access to abortions, structural constraints of education and poverty, coupled with the lack of decision-making power given to women in families ensure that the choice on whether to terminate a pregnancy, is not really left to the woman. But perhaps a woman's right to choose has not evoked a backlash because, for a large number of Indian women, the termination of a pregnancy is not a 'free' choice." (Agnihotri S. , 2016)

ABORTIONS THROUGH A FEMINIST LENS

Abortion as a reproductive health choice has been a very long-standing narrative that says one simple thing; abortion should be a choice of the women and not the state. The state should not have the final authority over the fate of a woman's body, against her own wishes. In countries like India, where the laws are seemingly liberal than a lot of other countries, this debate is

essential to understand how the law is not all flowers and butterflies but also has a flip-side to it where it is made clear that these laws have nothing to do with the autonomy of the women.

As scholars have argued, the right to abortion indicates not just the right to choose an abortion if one needs it, but rather a step towards realising a woman's control over her own body, in sync with whatever imaginations or perceptions she might choose to have of herself at the time (Cornell 1995). Further, this argument then implies that the lack of the right to abortion indicates a deeper problem within the society where women are not deemed capable to make decision regarding their own bodies, and these decisions are rather placed in the hands of others, thus "separating the womb from the women herself" (Smith 2002).

"These two ideas reflect the long-standing tension in feminist theory between an emphasis on equality and an emphasis on women's autonomy. The first is derived from the biological connection between women's bodies, sexuality, and reproduction. It is an extension of the general principle of "bodily integrity," or "bodily self-determination," to the notion that women must be able to control their own bodies and procreative capacities that is, the reproductive and sexual uses to which their bodies are put. The second is a "historical and moral argument" based on the social position of women and the socially determined needs which that position generates. It states that, insofar as women, under the existing division of labour between the sexes, are the ones most affected by pregnancy, since they are still the ones responsible for the care and rearing of children, it is women who must decide about contraception, abortion, and childbearing. The first emphasizes the dimensions of reproduction, the second on the social dimension" (Petchesky, 1980).

Apart from abortions as an important topic for feminist thinkers, there is one question that Nivedita Menon has beautifully chalked out how sex selective abortions creates a very crisis that stems at the very base of feminism. "…feminists generally support the unconditional rights of women to safe and legal abortions. We see this as necessary because pregnancy and child-rearing are for all practical purposes, the sole responsibility of women. We should therefore, have the right to choose when and under what circumstances we will bring a child

into the world, for we should be able to control what happens to our bodies and to our lives. The right to safe and legal abortion is an essential right of self-determination." (Menon, 2012)

"Many matters regarding abortion are complex, but some matters confront feminists with particular complexities in thinking about autonomy and ''rights'' in relation to abortion. Two such sensitive issues are sex-selective abortion and abortion in relation to foetal abnormality. Taken to its ultimate conclusion, the (liberal) logic of according a woman the right to decide the outcome of her pregnancy means extending this right to a woman who wants to terminate her pregnancy because of the sex of the foetus or because of a foetal abnormality (no matter how minor or how low the probability of its occurrence). This is clearly a controversial stance, not only from a feminist perspective but also from an intersectional perspective that connects multiple forms of oppression (disability and gender, for example). Feminist approaches that enable nuanced arguments are much needed in such cases." (Jeanne Marecek, 2017)

"But in general, in India there has been no consistent and organised opinion against abortion. Far from having to struggle for the right to abortion, feminists have found themselves raising questions about the widespread sanction for abortion rather than contraceptives, especially condoms, as a method of controlling population. This means that the physical cost of population control is borne almost entirely by women." (Menon, 2012)

Abortion is not the only topic that is talked about in hushed voices in India. Along with immense social and legal pressures, abortions at times, might make the women undergo negative emotions. How much of these emotions are learnt and internalised behaviours is something that is yet to be known. However, the pressure from the different systems tend to take a toll on the mental well-being of the woman, for which women again cannot seek out professional help without facing the stigma of doing so.
"Few remnants of this stigma, coupled with a lack of understanding of mental capacity, have survived in the form of discriminatory laws. This is true of laws dealing with reproduction as well. The intersection between mental health, disability and reproductive justice has not merited much attention in India" (Parthasarathy, 2019).

Were aborted lives counted as are other human lives, induced abortion would be acknowledged as the largest single preventable cause of loss of human life (McCurdy, 2016). Opponents of abortion generally refer to themselves as pro-life, while advocates for reproductive rights typically identify as pro-choice. Differences of opinion persist within both movements. Some pro-life activists may condone abortions in cases of rape or incest, while others take an uncompromising stance, believing that all abortion is murder. Within the pro-choice movement, some activists contend that no restrictions should be placed on abortions, while many who identify as pro-choice support laws that require a waiting period before the procedure can be performed or laws requiring minors to obtain permission from their parents. (Abortion." Opposing Viewpoints Online Collection, 2018)

Proponents on both sides of the abortion debate have often been responsible for politicizing the findings about the psychological effects of abortion. As Rogers and colleagues note, "both advocates and opponents of abortion can prove their points by judiciously referencing only articles supporting their political agenda." In fact, as researchers have argued, a lot of the studies on the psychological implications of abortion suffer from serious methodological errors, including ineffective sample sizes, inadequate control group, and using unreliable or invalid data collection instruments (Kunis 1991).

Opponents of abortion often argue that the unborn child are the weakest of the weak, and hence in a democracy, it’s absolutely imperative that the right to life of the unborn is legally protected (McCarrol 1997). However, the advocates of the right to abortion have argued that these claims rely both “on a logic of misogyny at the heart of the rights theory”, as well as attaching heavier moral weight to certain right bearers based on their own political agenda, operating through a “misperception og who or what a rights bearer is.” (Smith 2002).

In recent decades, there has been an emergence of a new, modified discourse, namely the care theory, owing to a growing dissatisfaction with the earlier rights-based approach. This relationship owes it emergence to a changed understanding about the relationship between a mother and a child. Scholars such as Kymlicka have argued that care theory is not enshrined

in the principles of ‘rights and fairness’, but rather of ‘responsibilities and relationships. Kymlicka further argues that the need for this new theory was felt because the earlier discourse disregarded the well-being of the woman in favour of the well-being of others, and women were often forced to remain pregnant simply owing to this perceived responsibility towards the society as a whole, more so in contexts where abortions are perceived as a threat to the common social order (Smyth 1998)

“The pro-life/pro-choice binary, as discussed above has not gained currency in India. This is surprising since the pro-life position, though prima-facie advanced as a philosophical belief, very often has religious moorings. Religion plays an extremely important role in Indian public life, and India is a home to Hinduism, Christianity, Sikhism, Jainism, Buddhism, Islam, Zoroastrianism, and Judaism. Since most world religions, are opposed to abortions, to a varying degree, one would think that the right to choice and the pro-life positions would be hot-button issues in India.” (Agnihotri S. , 2016)

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

In India, abortions were prohibited (unless medically indicated) till the Medical Termination of Pregnancy (MTP) Act was passed. Abortions were made selectively legal after the passing of the Medical Termination of Pregnancy (MTP) Act of 1971. According to (Menon, 2012) “[the law] came about not because of feminist concerns, or concern for women, but purely as a method of population control.” The Medical Termination of Pregnancy Act of 1971 has several provisions under which women can access safe and legal abortions. The act was brought in place to tackle the issue of severely high maternal mortality rate in the country; unsafe abortions being the third-largest reason.

During the discussions leading to legalization of abortions in India in 1971, the pro-life arguments were raised quiet vehemently; however, these did not find much ground. The middle class in India was convinced by the logic of reducing fertility and population growth through abortions, which would further contribute to the economic growth of the country. In addition, the fact that medical abortion services would reduce maternal mortality rates was

also sold as an argument for legalising abortions. In addition, “abortion is often considered a private family matter in India rather than being a societal issue, and is context specific.” (Patel 2018)

In her paper, Abortion Rights: Impact of Current Abortion Laws on Unmarried Females (15-30 Years) In New Delhi, (Khasa, 2017) has talked about the impact of the current abortion laws in unmarried females. She talks about the loopholes that make it difficult for unmarried women to access legal and safe abortions. She substantiates her paper with statistics including the rate of pregnancies and abortions in unmarried women to establish that this issue is not talked about enough. She moves on to talk about how the provisions in the MTP Act are driving women towards illegal abortions when the goal behind the act was to counter the high maternal mortality rate. (Khasa, 2017)

At present, the MTP Act does not guarantee a woman the right of choice and control over her body and deprives her of right to life under Article-21 of the Constitution. This argument is well explained in a paper by (Arijit Ghosh, 2017). He cited the precedence from the Puttaswamy judgement (Justice K S Puttaswamy v Union of India 2012a: para 72, 2012b: para 46, 2012c: para 38) that recognised the constitutional right of women to make reproductive choices, as a part of personal liberty under Article 21 of the Indian Constitution. “The bench also reiterated the position adopted by a three-judge bench in Suchita Srivastava v Chandigarh Administration (2009), which held that reproductive rights include a woman’s entitlement to carry a pregnancy to its full term, to give birth, and to subsequently raise children; and that these rights form part of a woman’s right to privacy, dignity, and bodily integrity.” (Arijit Ghosh, 2017)

The article 21 of the Indian constitution states “No person shall be deprived of his life or personal liberty except according to procedure established by law” As Arijit Ghosh has argued, the right of the state to place limitations on individual fundamental rights has to be enshrined within the framework of constitutional jurisprudence. As Ghosh argues, “Since privacy claims can be grounded in any of our fundamental rights, the bench affirmed that any limitation on privacy will be tested according to the fundamental rights which it infringes and the established jurisprudence on those rights. The bench separately highlighted Article 21, which guarantees the fundamental right to life and personal liberty, and entails a “just,

reasonable, and fair" test (Maneka Gandhi v Union of India 1978), that is, any law restricting Article 21 must be "just, reasonable, and fair" to remain constitutionally valid." (Arijit Ghosh, 2017)

A study of the MTP Act points out that the pregnant woman cannot simply state that it is an unwanted pregnancy. A woman must align her reasons with those stated as the permissible under the MTP act to get access to legal abortions. It will then be certified by the practitioner that either the pregnancy involves a risk to the life of the woman or would cause grave injury to her physical or mental health, or alternatively, that there is a substantial risk that a seriously handicapped child would be born. (Menon, 2012)

"The Act does not define 'health', 'substantial risk', 'seriously handicapped' and so on. It is left to the medical practitioner to decide how these terms are to be interpreted, although two explanatory notes indicate that pregnancy in the case of rape (excluding marital rape) and contraceptive failure (in the case of married woman) may be treated as causing injury to mental health. In fact, even the words 'abortion', 'miscarriage' and 'termination of pregnancy' have not been defined, which leaves the medical opinion on these matters sacrosanct." (Menon, 2012)

"The currently liberal-seeming provisions of the MTP Act could become restrictive without, a single word of the text being altered" (Jesani and Iyer 1993).

"Clearly, the pregnant woman seeking abortion cannot avoid giving an explanation. To say that pregnancy was wanted at the time of conception but is unwanted now disqualifies her. She is required to furnish explanations that fit into the broad liberal though restrictive conditions listed in the Act. This situation keeps the Act open to differing interpretations" (Amar Jesani, Abortion-Who is responsible for our rights, 1995)

In the amendment of the bill in January 2020, one of the major changes made was replacing the term "married women" with "all women" and the word "husband" with "partner" in the contraceptive failure clause, in an attempt to clarify that abortion is legal for all women, not only those who are married. The amendment talks about abortion at the 'request' of the woman until 12 weeks of gestation period. The idea clearly indicates a lack of concept of choice in the 1971 Act. The word 'request' shows a lingering sense of denial of giving women

the right to their own body and its decisions. Although these ideas are more relevant in case of women seeking to have a child, it has a huge impact on the women who have had unintended pregnancies and have ample reasons to not keep the child, sooner or later along the gestation period.

ORDER, ORDER: THE LEGAL ASPECTS OF ABORTION IN INDIA

The tenets of the MTP Act 2017, that enforce the condition of 'risk to life' for women to access abortions are broadly understood to include possible attempts to suicide. (Arambepola & Rajapaksa, 2014) (Jeanne Marecek, 2017)
In western and high-income countries, feminist advocates emphasise on 'choice' and 'rights' as the basis for legalisation and access to abortions. "Drawn from liberal political theory, these principles recognize and support women's autonomy in making decisions about their bodies, and they send a clear message that the state should desist from regulating women's reproductive lives." (Ferree, 2003 as cited in Jeanne Marecek, 2017)

"Legal proscriptions of abortion do not prevent women who need abortions from obtaining them. Indeed, rates of abortions appear to be slightly higher (37 abortions per 1000 women between 2010 and 2014) in countries in which abortion is prohibited or highly restricted than in countries where it is available on request (34 per 1000 women) (Sedgh, Ashford, & Hussain, 2016). This striking finding underscores the fundamental importance of abortion in women's reproductive lives across the globe" (Jeanne Marecek, 2017).

Eklund and Purewal (2017) observed that the policies set in place to tackle sex selective abortions did not succeed in eliminating it. This is possibly because "healthcare policies may be dissonant with legal statutes." (Jeanne Marecek, 2017). Eklund and Purewal (2017) also talk about the cultural and economic pressures of son preference in India and China. These pressures are so dominant in the societies that they have produced noticeable imbalances in the sex ratios of both the countries. (Jeanne Marecek, 2017)

Women [in six states of India] were mostly aware that sex selective abortions are illegal and were more well-versed with the new PNDT Act as compared to the MTP Act, 1971.They reported that women visit different kind of facilities for getting sex selective abortions. (Dr. Mala Ramanathan, 2004)
"The bio-politics of both population control and sex-selective abortion have limited women's agency, but neither country has adequately addressed contexts in which son preference inflects decision-making around abortion." (Jeanne Marecek, 2017)

Melissa stillman has talked about the MTP act and the abortion policy in sync with the healthcare systems of the country. She points out how the current abortion policy in India talks only about allopathic physicians and exclude any other abortion providers. "Despite the legality of abortion provision in the public sector, actual provision at lower level public facilities (such as primary health centres) was scarce prior to 2000. In 2000, the National Population Policy officially recommended expanding the provision of abortion up to eight weeks' gestation to all public facilities, including primary health centers.21 A decade later, community health centres [in India] continue to be the main providers of abortions up to eight weeks' gestation, and provision at the lower level remains a challenge because most primary health centres are not staffed with certified abortion providers"
(Melissa Stillman, 2014)

Amar Jesani made a nuanced observation around the fact that women are not allowed to access abortion as a right. The MTP is a mere liberalisation of the conditions under which women can have an abortion, which is approved by the practitioners. "Medical liberalisation, therefore, necessitates medicalisation of the liberalised conditions given in the Act. This is done by expanding the earlier medical indication of saving a pregnant woman to include medical and psychological morbidity or the potential of such morbidity if the woman is forced to carry an unwanted pregnancy to full term. Thus, from the medical angle, the termination of a pregnancy becomes a "therapeutic" intervention rather than a right." (Amar Jesani, Abortion-Who is responsible for our rights, 1995)

Mere liberalisation has not led to desirable consequences, and evidence shows that legislation has not significantly increased the rate of legal abortions. Legaisation did not significantly

reduce the incidence of illegal abortions, nor improve health outcomes for women. The fact that this was tied to the population programme breeds skepticism among Indian academics too. Historical and contemporary evidence suggest that it is not possible for the state to control all aspects of women's bodies through employment of technology, legal sanctions or repression. (Jacobson J, 1990: 5) (Amar Jesani, 1995)

The fact that behind the seemingly liberal availability of abortion service lies legislation that could be easily invoked to restrict access is perhaps also not fully appreciated. For the law does not endorse women's legal right to abortion but ends up being a regulatory mechanism of doctors and abortion centres. (Amar Jesani, 1995)

PSST, ABORTION: A REFELCTION ON THE ROLE OF THE SOCIETY ON WOMEN AND THEIR DECISION MAKING

Women in India rarely decide for themselves, more so matters pertaining to abortions. In the household and qualitative studies by Dr. Mala Ramanathan, the women reported that they barely have a choice in deciding in the matters of their own bodies. Usually, it is their spouse, or worse, a relative, who decides for them. “While physical access seems to be reasonably good [in India], social access remains restricted since providers, especially in formal and certified facilities, do not provide services to women if they come alone and/or if the spouse or some close relative does not give consent.” (Dr. Mala Ramanathan, 2004)

- THE SOCIETY AND THE STIGMA

Certain religions raise moral objections to terminating a pregnancy by induced abortion. Devout women who face an unwanted pregnancy may experience considerable difficulty in weighing their courses of action. (Jeanne Marecek, 2017) The sources of these moral objections stretch beyond the family systems in healthcare institutions as well. These extrinsic sources of objection cause more issues in women’s access to abortion than the intrinsic ones. The best example around this would be the Savita Halappanavar case where an Indian Hindu woman was denied abortion in Ireleand because the country was Catholic. Despite severe

physical agony and what doctors called ‘an inevitable miscarriage’ the doctors denied their requests of induced abortion because the foetus still had heartbeat.

Cultural factors other than religious beliefs also influence abortion policies, practices, and individual decisions. Amar Jesani and Petchesky, both talk about abortions having multiple systems, standing to question what passes it as a right. They both agree that it not merely a political or legal issue, but a social, cultural and moral one.

Women have practised forms of birth control and abortion throughout history. This is not merely a techno-medical issue of women's health, but the crux of broader ideological debates which challenges the construction of family, state, motherhood and sexuality (Petchesky R.P,1986: vii). Historically, women have overtly or covertly resorted to abortion, but their access to these services has been restrained through social and legal restrictions. Many of these can be traced back to morality and religion. The norms and ethics governing child abortion are shaped by the times and social context. Despite the diversity in construct, intent and orientation of such norms, the common thread is that they are invariably designed to fulfil the societal expectations and do not recognize the women's right to determine their sexuality, fertility and reproduction. (Amar Jesani, 1995)

Moreover, abortion is not merely an issue of political and legal conflict but of social, cultural and moral conflict as well. Good social services expand the scope of what is meant by "women's reproductive freedom" and are, therefore, of utmost relevance and urgency. However, this could result only in a partial or total shift in child rearing responsibilities from women to men and ease the burdensome aspect of motherhood (through improved benefits and services). Petchesky argues that "it may also operate to perpetuate the existing sexual division of labour and women's social subordination" and suggests that the realisation of "women's reproductive freedom" will have to be part of the radical transformation in the social relations of reproduction and production (Petchesky 1986: 16-17)

- ABORTIONS AND MEN?

The paper by Sapna Kedia et. Al is one of the most comprehensive works about male engagement in the process of abortion in India. It talks about various areas of male engagement in abortions; from sex education to sensitization. “In addition to the potential benefit for individual women, male involvement may at a broader level improve women’s access to safe abortion and quality care. Men can facilitate abortion access by gathering information, locating services, providing transportation, covering or sharing the cost of abortion, post-abortion care and by providing emotional support.” The paper also emphasises the various roles that men play in the lives of the women and how their outlook and engagement will contribute to how abortions are perceived in the society. This statement, apart from telling us why men should be involved, also shows how our perceptions on women as a society are so low, that it takes men to be involved and declare that a woman’s issue should be normalised for the women to have access to healthcare with dignity. A woman’s opinion on her own body and right is worth nothing.
“In case of an unintended pregnancy before marriage the role played by men, becomes more crucial because social stigma associated with premarital sex, particularly in a context like India, heightens a woman’s vulnerability, isolation and alienation. Men’s supportive involvement in the case of an unintended pregnancy before marriage can expand access to abortion services and improve them so that they are more youth-friendly and non-judgmental. Since men play a key role in determining social norms and exercise greater decision-making power in a relationship, this study posits that such a privileged position can be positively leveraged to challenge and reduce the stigma associated with premarital abortion.” (Sapna Kedia, 2018)

IMPACT ON DECISION MAKING

Reasons for having an abortion were also different [in Bihar and Jharkhand]. The main reason among those who were unmarried was that they were unmarried (92%), the pregnancy had resulted from a forced encounter (11%), or that they wished to continue their education (13%).

The main factors that influenced the choice and location of the abortion facility or provider, in terms of travel time from their home. Fear of disclosure was frequently reported by the unmarried young women in the in-depth interviews. Less than one-third of the unmarried and fewer than half of the married had confided in a family member or friend. (Shireen J Jejeebhoy, 2010)

Jeejabhoy draws some comparisons between married and unmarried women to highlight the vulnerability in point. Unmarried women are more likely to delay the termination of pregnancy as compared to married women, even when other socio-demographic factors are controlled. They also have higher chances of obstacles in their access to abortion which includes delay in recognition of pregnancy, lack of partner support, no autonomy, fear of disclosure and negative past experiences. Moreover, the narratives of the unmarried young women showed how poorly informed they were about the signs and symptoms of pregnancy. “Indeed, while being unmarried posed a significant obstacle to early abortion, the combination of being unmarried and experiencing any of these obstacles made unmarried young women three to four times more likely than married ones to undergo a second trimester abortion” (Shireen J Jejeebhoy, 2010) Women often delay abortions because of financial problems or because they have no say in the matter. “This decision may be dependent on spouse, family and, in cases like Niketa Mehta’s, on the courts. Even today, despite the advancements in medical technology, the law fails to provide women access to abortion services, and more fundamentally, the choice of doing so.” (Patel, 2018)

There is a dearth of post abortion care and contraception in our healthcare systems. This becomes increasingly important for women who do not have the luxury of after care by well-wishers. Unmarried women, who fight stigma at every step of abortion, often go without any after care because of the secrecy of the whole process. (Patel, 2018)

The discourse and stigma around premarital sexuality centres around notions of 'chastity' and 'honour'. The stark difference between men who talk about, and often flaunt, their sexual encounters among their peers who see perceive premarital sex as a rite of passage; and unwed pregnant women who hide their sexuality even from their friends for fear of judgement is a

reflection of how society views sexuality. The biggest fear for both men and women is their family. However, here too, women are more vulnerable since the range of violent actions they could be subjected to is far wider. From deschooling, getting married early/forcibly, to physical harm and murder- such acts are inexorably linked to the notions of honour and chastity. (Sapna Kedia, 2018)

The incidence of premarital sex and abortion have grown across class, even though the stigma still exists among the youth, their parents and even doctors. Only a minority of middle to upper-class young men and women with the privilege of education, income, independence and mobility have asserted and claimed their sexuality. This minority does not view premarital sex as a precursor or condition for marriage, and shares this perspective with youth from lower-income group. Hence, the notions are less traditional with respect to attitudes toward premarital relations. (Sapna Kedia, 2018)

Petchesky writes brilliantly. Each point is layered with gradation. Petchesky talks about how the situations that women find themselves in, when it comes to reproductive health, is not only because of their engagements, but rather what is understood of those engagements. Feminists are focussing more on the social and material conditions under which the ‘choices’ are made by the women, which is more crucial than the right to choose itself. He gives the example of sex selective abortions where women might choose to abort a female foetus, but that comes out of the devaluation of females in the society and not the willing decision of the woman. “It is important, however, to keep in mind that a woman's reproductive situation is never the result of biology alone, but of biology mediated by social and cultural organization. In regard to a theory of reproductive freedom, these examples suggest that the critical issue for feminists is not so much the content of women’s choices, or even the "right to choose," as it is the social and material conditions under which choices are made. The "right to choose “means very little when women are powerless. In cultures where "illegitimacy" is stigmatized or where female infants are devalued, women may resort to abortion or infanticide with impunity; but that option clearly grows out of female subordination.” (Petchesky, 1980)

He then talks about a change in discourse around reproduction where the entire responsibility is not decided based solely on gender. He, as a feminist, aspires for a community where men hold equal responsibility for nurturance and child care. “A materialist (and, I would argue, feminist) looks forward to an eventual transcendence of the existing legalisations of reproduction, so that gender is not ultimately determinant responsibility. This implies that, should existing social arrangements change-should society be transformed so that men, or society bear an equal responsibility for nurturance and child care basis of the needs would have changed and control over reproduction might not belong primarily to women” (Petchesky, 1980)

The idea of premarital sex is still a taboo in India. This, of course, makes abortions a bigger concern among the majority of the people. A girl’s virginity is not only associated with her purity, but also with the honour and name of the family. The same is rarely true for their male counterparts. This makes abortion a very difficult, and yet almost mandatory, the decision for the woman in almost any setting in India.

In a study, 24% of 500 unmarried adolescent abortion seekers reported that their parents had taken punitive measures, including beating or starving them for prolonged periods. (Melissa Stillman, 2014)

A pattern of delay in seeking an abortion has also been seen and can be partially attributed to the fear and helplessness the women go through. They experience delays in recognising the pregnancy, accumulating resources and setting up support structures.

The situation is flawed in India where there is no acknowledgement, let alone acceptance, of women engaging in sex and abortion before marriage. Despite this social restriction, there is evidence that shows that a significant number of young men and women have engaged in sex before marriage.

“In a recent survey of youth aged 15–24 in six states, 15% of men and 4% of women reported having had premarital sex. A review of a number of less representative studies found rates of 15–30% among young men and 1–10% among young women.3 Evidence also suggests that sexually active unmarried youth rarely or inconsistently use contraceptives, which exposes

many young women to the risks of unintended pregnancy and abortion." (Melissa Stillman, 2014)

In instances like these, the pregnancies are almost always terminated which may or may not have been what the woman would have wanted, personally.

In a study mapping patterns of abortion in married and unmarried women, 59% of unmarried adolescents, compared to 26% of their married counterparts, underwent second-trimester abortions. A study, why do women have abortions, 1989 shows that the mean gestation at termination was nine weeks for married women and 14 weeks for unmarried women. (Aida Torres, 1988)

DOCTOR WHO: PUBLIC HEALTH PERSPECTIVE

"Medicine is a social science, and politics is nothing more than medicine on a large scale." (Rudolf Verchow, Father of public health)

In recent decades, the widespread availability of reproductive technologies, such as ultrasonography, has allowed couples to learn the gender of the foetus during pregnancy, and some to choose to selectively abort female foetuses. Because this technology can only reliably determine gender during the second trimester of pregnancy, sex-selective abortions can only occur among the10–15% of abortions that are performed after the first trimester. And, since not all later-term abortions are done for this reason, only a small proportion of all abortions in India are likely performed for the purpose of sex selection. (Melissa Stillman, 2014)

- THE 'TREATEMENT'

Medical abortions do not require surgery, unlike surgical abortions, and are considered safe and effective until the ninth week of pregnancy. The patient is prescribed mifepristone, which blocks the natural production of an essential pregnancy hormone, progesterone. This causes the uterus to contract and expel the embryo. In 2015 Arkansas and Arizona passed legislation

requiring doctors to inform patients that medical abortions could be interrupted or “reversed” after taking the mifepristone pill by taking a dose of progesterone, the chemical that mifepristone stops the body from naturally producing. (Abortion. Opposing Viewpoints Online Collection, 2018) This information is not known to the people seeking abortion and neither is it communicated before to the clients.

Misoprostol and mifepristone are included in the latest revision (in 2011) of the National List of Essential Medicines of India, which means it should be available at the tertiary health facilities According to data on drug price regulator National Pharmaceutical Pricing Authority’s website, the ceiling on mifepristone 200 mg is ₹ 304.38, while that on misoprostol 200 mcg is ₹ 15.80.

Not many people are aware of the fact that these drugs can be brought on prescription or the practitioner can choose to dispense it themselves. More often than not, the practitioners choose to give out the medicines on their own. The article points out that people are also unaware of the cost of the drugs and since there is no regulation over how much can be charged. This coupled with the social stigma around abortion puts women in a very tough spot and the practitioners use the situation to their advantage to make enormous amounts of money.

“In India, there is no legal bar on consultation fees doctors can charge. But patients can complain to a state’s medical council regarding any issues encountered with doctors. No similar overcharging is seen in any other situation where an expert is required and the task is simply to administer generic drugs coupled with tests.” (Soumya Gupta, 2017)

ABORTION FACILITIES AND SERVICES

The study of 380 abortion facilities across six states (Kerala, Madhya Pradesh, Orissa, Rajasthan, Haryana and Mizoram) tells us that on an average there are 4 formal (medically qualified, though not necessarily certified for abortions) abortion facilities per 100,000 population in India. (Dr. Mala Ramanathan, 2004). Two-thirds of the providers in the non-

certified facilities had the requisite training or qualification as per MTP Act to conduct abortions; thus, a majority of uncertified facilities were perhaps providing safe abortions. (Dr. Mala Ramanathan, 2004)

Public investment in abortion services is grossly inadequate. Only 25% of abortion facilities in the formal sector are public facilities, 87% of the abortion market is controlled by the private sector. (Dr. Mala Ramanathan, 2004) This is a major disadvantage for the women who come from economically weaker or vulnerable sections of the society. Not only socio-economic vulnerable groups, but even the women who seek abortion outside of marriages are a vulnerable. Thus, a better quality and number of public abortion centres are needed. (Amar Jesani, 1995), writes in his research that PHC level services of abortion are unheard of by women, where Uttar Pradesh and Tamil Nadu fared slightly better. A few more findings in the paper give us a picture of the dismal situation of our public health system. the findings revealed that ANMs and Lady Health Visitors, who are not authorised to do MTPs, used government and PHC facilities for conducting abortions, with the knowledge of the doctors, thus making illegal abortions more rampant Even when women went to government and PHC doctors they were made to pay fees for services rendered. Above all, the study found that a majority of abortions are still conducted using indigenous methods. Further, it found that amongst literate and unauthorised providers, the proportion of males was significantly high. (Amar Jesani, Abortion-Who is responsible for our rights, 1995)

There was an overwhelming perception [in India] that private facilities were better. There were several reasons for women and their families to choose private facilities over public. Private facilities are faster and more efficient. They also have better doctors and equipment and the women are allowed their time and space after the procedures unlike government hospitals where they are asked to leave as soon as possible. Private facilities also ensure confidentiality. Even though they are expensive, women said that government hospitals are also not cost-free in terms of money, time and emotional labour. (Melissa Stillman, 2014) Similar findings have come out in the qualitative component of the Abortion Assessment Process: India study, 2002.

PRACTITIONER’S ROLE AND BIAS

Stillman finds that among government facilities in Bihar and Maharashtra which did not offer medical abortion, the reasons included a general lack of interest, concerns that surgical backup is not available, preference for surgical abortion because of income-generating potential, lack of knowledge about medical abortion and scepticism about women's ability to comply with the regimen. The decisions about abortion provision, hence, are influenced by subjectivity rather than motivated by access to medical facilities. (Melissa Stillman, 2014)

Although consent of husband or guardian is not officially required for women to access abortion services, Stillman finds that both public and private providers in West Bengal and Jharkhand are more likely to offer counselling, referral and abortion services to married women than to unmarried women. Only 31% of all participating providers agreed that all women, whether married or not, should receive information on contraception IF they request it. (Melissa Stillman, 2014)

Stillman reports preferential attitudes of health providers offering contraceptive and abortion services towards adolescents based on their marital status. Providers were generally more willing to offer referrals than actual services to unmarried adolescents, which is indicative of the stigma around sexuality against unmarried young women. A higher proportion of public than private providers reportedly offered abortion services to young unmarried adolescents; still only 50% did so (Melissa Stillman, 2014).

In a study conducted in Rural Maharashtra around perceptions of women around reproductive healthcare services, the paper showed how unmarried women find it more difficult to navigate these spaces and what is it, that they value the most in a healthcare provider or a facility. “Given the social circumstances under which an unmarried, widowed, or deserted woman seeks an abortion, it is not surprising that respondents to our survey gave secrecy precedence over all other considerations when asked which indicators were important for women seeking extramarital abortion care. Confidentiality on the part of the doctor received the highest cumulative score and was the first-ranked score among the indicators of quality. Also receiving high cumulative scores were a discreet and distant location for the abortion service, not having to obtain a husband's permission, a short waiting period, empathy and concern form the doctor, only one visit being necessary, the presence of a woman doctor, and the availability of drugs.” (Manisha Gupte, 1999)

The study also reported that women who were single, were reprimanded for their choices from the healthcare providers. If they claimed to be married, they were asked for a signature from their husband. If they admit that the pregnancy was conceived outside marriage, they have to claim that it was rape or cite physical or mental distress to align their reasons with those permissible under the MTP act. "For a single woman to acknowledge her sexuality openly and, if pregnant, obtain an abortion is to incur social censure. Single women who are sexually active therefore are made to feel as though they are engaging in an illegal activity, as well as ashamed and immoral. Their situation is made worse by their limited access to good reproductive health care." (Manisha Gupte, 1999)
"Most women consider empathy, concern, and counselling from the doctor to be very important, especially in abortion care." (Manisha Gupte, 1999)

Feminism in India talked to a gynaecologist who is now working in the development field, Dr. Suchitra Dalvia, to know what it is like on the other side of the table. She talks about her experiences of patriarchy and how they were never taught about consent, rape or that women knew what is best for them. She also listed instances of sexual harassment in her conversation. To sum it up, she says "…your gynaecologist may be judgemental and patronising and even uncooperative and that is not okay. But remember that they are as much a product of the system as any one of us. Remember that modern medicine emerged from a strong patriarchal uprising which resulted in the witch hunts. It was never a women-centred system." (Dalvia, 2019)

TCH TCH, BECHARI: PATHOLOGISING ABORTIONS

Women who have underwent abortions are often associated with grief and regret for they are supposed to feel pain at the loss of their child. This, is true for a lot of cases. However, this feeling cannot be generalised. Given the social and cultural context where women barely have a genuine say in their choices, who is to say that they have complete control over what to feel?

A lot of narratives around abortions highlight the distress that women go through because of the procedure. However, they forget to highlight the sense of relief as well, for personal or

social reasons. They also fail to point out that the distress is not always caused by the process itself but also the same, secrecy and judgement. If not entirely inducing, this at least contributes to the mental stress.

In a lecture by M. Shuping (Shuping, 2014) on women's mental health and abortion, she listed several common negative emotions, according to Clinician's guide to medical and surgical abortions, which are most common in women, post-abortion. The list includes depression, fear, grief and even PTSD. However, there is no mention of any positive or neutral emotions.

In a SABC video, the clinician talks about how the women who seem to be doing fine and 'not showing' the symptoms of some form of digression from the usual might stem from denial, 'building up walls' and numbing themselves. The outbursts might be in the form of entirely unrelated issues and the peers most likely will fail to notice.

A 2011 study published in the British Journal of Psychiatry reported that there were drastic changes in mental health in women who had an abortion. The study examined medical information from 877,000 women, of which 164,000 had an abortion; the women who had an abortion were 81 per cent more likely to experience mental health struggles.

The study found that 10 per cent of these issues could be linked to the woman's abortion.

This study falls on the extreme end of the spectrum where the causal relationship between abortion and impact on mental health, or abortion as a trigger, can be identified.

A number of researches have shown that abortion may have a long-term impact on the mental health of women because of the feelings of guilt, shame, feeling of loss and low self-esteem. (Ney, Fung, Wickett, & Beaman-Dodd, 1994; Speckhard & Rue, 1992). These concerns have been more clearly articulated by Reardon and colleagues, over three researches, who claim that abortion may increase risks of a wide range of mental disorders, including substance abuse, anxiety, hostility, low self-esteem, depression and bipolar disorder (Cougle, Reardon, & Coleman, 2003; Reardon &Cougle, 2002; Reardon et al., 2003).

A paper by Susan Cohen on abortion and mental health talks about how the pro-life thinkers have resorted to numerous methods when the traditional ones lost their hold. They now talk

about abortions being risky, having a tremendous effect on the fertility and the cause of breast cancer among women. They also talk about the tremendous impact of abortion on the physical and psychological wellbeing of a person and have resorted to researches that are not reliable or have huge methodological loopholes.

There are ample of researches about abortion and mental health, with different lenses throughout the whole spectrum of abortion; as a cause or trigger for disorders to establishing absolutely no mental health consequences of abortion. Since the researches lie on such a vast spectrum, we can infer that there is no standard response to what a woman might go through after an abortion. The range of feelings we talk about here and not on differences in intensity on the negative side, it can also be positive and have a pragmatic impact on the lives of the women who underwent abortion.

IMPACT ON INIDVIDUALS

Abortion stigma translates into internalized stigma, fear of disclosure and shame, difficulty finding information and services, and fear of the health system. Stigma creates barriers to open and frank discussion about abortion and to women using services. It leads to the notion that abortions are rare, when they are not. The cost of ignoring stigma and not finding strategies to address it is potentially huge. (Hessini, 2011)

The physical and psychological sequelae of abortion have been the subject of many studies. Although research on the physical consequences of abortion conclusively demonstrates a very low rate of morbidity and essentially no long-term physical sequelae, the results of studies of the psychological sequelae are somewhat less firm. In one of the most comprehensive reviews of the physical consequences of abortion, Hogue and colleagues examined over 150 studies regarding the association between induced abortion and subsequent reproductive outcomes. They concluded that the weight of evidence shows no association between induced abortion and subsequent infertility, mid-trimester spontaneous abortion, shortened gestation, or ectopic pregnancy. (Hillary Kunins, 1991)

The question of abortion in India is inherently linked to the availability and use of contraceptives, and the cultural, familial and gender dynamics around its social acceptance. The Abortion Assessment Project, a qualitative study carried out during 2002, found out that majority of unintended pregnancies leading to abortions occurred when contraceptive wasn't used and only a minority were due to contraceptive failure. This non-use of contraceptives reflects a lack of availability and stable supply, especially of temporary methods of contraception. In addition, it is also perpetuated by gender dynamics that severely restrict women getting information about and access to contraceptive use. As certain studies have shown, abuse and violence in relationships is also related to abortions, sometimes having direct effect on contraceptive use. (Melissa Stillman, 2014)

There is considerable stigma attached to having nonmarital pregnancy or birth, especially during adolescence. In a 2008 study conducted among 549 unmarried adolescents obtaining abortions in Bihar and Jharkhand, nearly all (92%) chose to terminate their pregnancy because they were unmarried or did not want to raise a child alone. A large minority of respondents reported that the pregnancy resulted from non-consensual sex (18%), most often perpetrated by a family member (9%) or neighbour (6%). Similar findings were reported from in-depth interviews conducted in Maharashtra in 1996-1998. (Melissa Stillman, 2014)

The costs of an abortion are financial, emotional and physical. Khasa reports that all the women in the study report common feelings of relief and guilt. Relief stemmed from the fact that they had finally accomplished the mammoth task. Guilt usually followed relief, although the duration and severity depends on variable personal circumstances. Women commonly reported feeling guilty about not being a good mother due to abortion, and none except one could survive the relationships they were in during the time of pregnancy. (Khasa, 2017)

Those who resolved their abortion experiences were usually in long-term monogamous relationships and felt supported by their male partners. Abortion was followed by higher rates of use of contraception. The clinical studies of abortion majorly focus on anxiety and depression. (Freeman, 1976)

A majority of women chose abortion from "necessity" and report experiencing impersonal pressure influencing their decisions. They saw abortion as a forced response to a problem, and

had no history of ascribing value to their own actions or experiences. However, post-abortion data suggests that for many women, the abortion experiences resulted in different awareness about themselves. (Freeman, 1976)

Gerrard reports that abortion patients show higher levels of guilt than nonpregnant, sexually active university co-ed students. The implications are tied to the definition of sex guilt. If Mosher scale measures the transient affective state of guilt, the elevated sex guilt scores of the abortion group suggests that they are unmarried and they just discovered they are pregnant. However, if the scale measures a more general personality disposition, the implication is that sexually active women with high sex guilt are predisposed to unwanted pregnancy (Gerard, 1977).

LET'S TALK ABOUT SEX, BABY: CAMPAIGNS, AWARENESS AND SEX EDUCATION

Data on provisioning and quality of contraceptive counselling and services for abortion clients in India is limited. Although various studies indicate a high percentage of women (49-96%) want contraceptive methods after an abortion, evidence suggests that the counselling and provisioning of these services is scant. Post abortion family planning and counselling is rarely integrated into abortion and post-abortion services, unless a special effort has been made to train providers in counselling and emphasis has been placed on its importance. Data from the 2005–2006 NFHS-3 indicate that among 5, 135 women who had had an abortion in the previous 60 months, 70% did not adopt any contraceptive method within two months after the abortion. (Melissa Stillman, 2014)

Mishra & Dilip, 2006, as quoted in the paper by Sukirty Khasa, said 'The numbers of adolescent girls and young women getting pregnant, experiencing birth and abortions is very high and young people are more interested in sex due to several biological reasons- hormones. They experiment and experience and this is an open secret.'

According to Anita Anand, 2oo3, ‘Reproductive health, especially reproductive health of adolescents is poorly understood in India. Even fewer studies discuss female sexual health than males. This makes young couples, especially females very vulnerable and prone to situations of pregnancies and abortions. Unmarried Adolescents, constitutes a large number of abortion seekers.’

Although data on premarital sex is usually severely underreported in the country, Youth in India: Situation and Needs Study, a large-scale survey of young men and women aged 15–24 conducted in six states in2006–2007, found out that 4% of the women interviewed reported having sex prior to marriage, with gifures ranging from 1-2% in Bihar, Tamil Nadu and Rajasthan and 6-7% in states like Jharkhand and AP. 21% of the women who indulged in premarital sex reported having more than one concurrent partner, and only 3% reported condom use. Less than 50% of the women reported knowing that they could get pregnant owing to the first sexual intercourse or knew how to use a reversible method of contraception. Moreover, regarding the question of having knowledge about the minimum legal age of marriage for women, only 60% answered yes.

Lack of awareness about laws affects the choices made by women. A 2011 study in Rajasthan reports that, in rural areas where many women mistakenly believe that husband's consent is required for abortion, the less likely women were to terminate a pregnancy. Knowledge of legal providers varies

too, and many believe any health worker is a safe and legal abortion provider regardless of specialized abortion training and certification. A significant proportion also believe that abortion in any form is completely illegal, regardless of the provider. (Melissa Stillman, 2014)

“Indian Institute of Population Studies (IIPS), an NGO dealing with demographic studies, conducted a survey in 7 south Indian and an equal number of north Indian states to find out about the level of awareness amongst youngster aged 18-24 years regarding abortion procedures and laws in India. They found that states in southern India were more aware when

it came to knowledge about medicinal means to carry out induced miscarriage, with about 1/3rd of men and half of the women surveyed were aware vis-à-vis the national average of roughly 25 per cent men and 30 per cent women. It was also found that over 75 per cent of men and women surveyed knew that sex determination and resultant abortion is outlawed. This seems to suggest that the Indian government's attempt to counter sex determination tests and resultant induced miscarriages have succeeded to a certain degree. Roughly 2/3rd of men surveyed and 3/4th of women surveyed knew about the 20-week norm to abort a child legally in India. However, less than 40 per cent of men and about 45 per cent of women surveyed knew about unmarried women being legally allowed to opt for induced miscarriage. Only 1/4th of men and women surveyed knew about married women being legally allowed to opt for induced miscarriage. It was also found that married youths and those in urban areas were more aware of abortion rights and methods than their unmarried and rural counterparts. Similarly, youth in South India and Maharashtra were more aware of their sexual rights, abortion rights and methods as well as Sexually Transmitted Diseases (STDs) and ways and means to prevent them." (Usha Ram, 2010)

There is a need to recognise unmarried young women as a highly vulnerable group and measures are required to facilitate easier access to abortion for unmarried young women. All young women in adolescence should be provided with sound reproductive and sexual health education, so they are equipped to deal with unintended pregnancies and sexual health problems. This should include the signs and symptoms of pregnancy, importance of early recognition of pregnancy and awareness of legal right to abortion. Young men should also be sensitised about gender roles, ensuring safer sex and importance of supporting their partner in case of unintended pregnancy. Providers must also be trained and sensitized with regard to the legal rights of unmarried young women to terminate an unintended pregnancy and the right to confidentiality. (Shireen J Jejeebhoy, 2010)

"Youth-centred services are needed that are sensitive to the realities of pre-marital sex, including sexual abuse by adults and sexual coercion by peers, unintended pregnancy and the need for abortion among the young, both married and unmarried. Providers must be trained to understand the law with regard to the rights of unmarried young women to secure a safe abortion and the right to obtain abortion confidentially. Efforts must also be made to ensure

that providers do not stigmatise the unmarried, that they maintain their confidentiality and that they provide sensitive counselling as required and non-judgemental services. Indeed, our findings highlight the need to recognise unmarried young women as a highly vulnerable group and ensure the realisation of their right to obtain safe abortion ser vices in a timelier manner." (Shireen J Jejeebhoy, 2010)

At the abortion stage, access to non-judgmental medical advice and psycho-social help/counselling is not available for young people. Thus, anxiety and guilt-ridden youth, due to the stigma associated with premarital sex, get caught in a ripple of complications – little/no sex education implies little/no knowledge about pregnancy related issues. Lack of open communication and support systems cause abortion seekers to rely upon their peers' ill-informed/incomplete/dated information, which leads to health risks and then greater trauma. In such a situation, the male partner operates from a position of privilege and thus plays a crucial role.

Sex education at school level has attracted strong objections and apprehension from all areas of the society, including parents, teachers, and politicians, with its provision banned in six states which include Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka. Legislators contend that it corrupts the youth and offends "Indian values," leading to promiscuity, experimentation, and irresponsible sexual behaviour. Some opponents argue that sex education has no place in a country such as India with its rich cultural traditions and ethos. (Ismail, 2015)

With the rising debate and conversation around abortion from a rights perspective, there have been campaigns worldwide that rally for safe and legal abortions to women.

Launched in September 2015 from Seattle, the hashtag "#ShoutYourAbortion" has been used over 250,000 times to empower individuals to discuss their abortion experiences. It's still in use with Shout Your Abortion's website, which collects abortion experiences from all around the world. (Kramer, 2016)

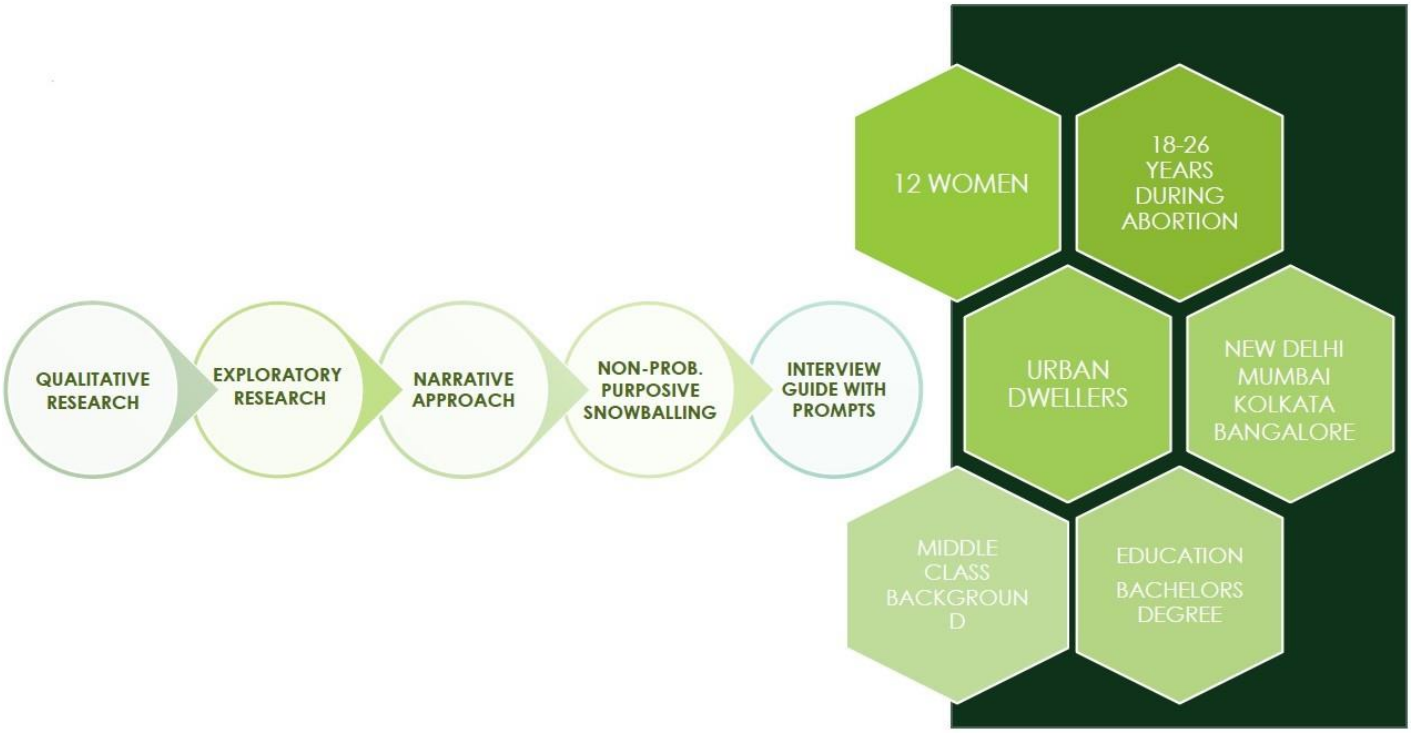
In India, Feminism in India has been leading the campaigns around abortions to help create dialogue and fight the stigma against it. Feminism in India is an award-winning digital intersectional feminist media organisation to learn, educate and develop a feminist sensibility among the youth. They have two main social media campaigns going on.

#AbortionMeraHaq, translating to 'abortion is my right', is a campaign demanding safe, legal and affordable abortions for all who require it, because safe abortions save lives. Feminism in India and Asia Safe Abortion Partnership came together to start a dialogue around abortions. Asia Safe Abortion Partnership (ASAP) is an abortion rights advocacy organization committed to capacity building at the regional level by connecting and boosting the work of abortion rights activists across Asia.

Feminism in India also started a campaign called #MyGynaecStory in collaboration with HAIYYA, Health over stigma, which is an organisation that works for the sexual and reproductive rights of unmarried women. The campaign encourages women to talk about their experiences with healthcare professionals and create a dialogue around the biased practices in the healthcare sector.

Amidst the COVID-19 lockdown, Hidden Pockets has also started a helpline number for women who are seeking an abortion under 20 weeks. They provide the women with the details of the practitioners that are licenced and open in their respective cities. Hidden Pockets is a health and wellness organisation that seeks to provide healthcare practitioners to sexually active people in the country. They have a right-based approach towards women's sexual health perspectives and often create discussions around abortions.

CHAPTER THREE: METHODOLOGY



QUALITATIVE RESEARCH

The study design used for this research is Qualitative. Qualitative research can mean different things to different people. “Any attempt to establish a consensus on quality criteria for qualitative research is unlikely to succeed for the simple reason that there is no unified body or theory [i.e., an accepted paradigm], methodology or method that can collectively be described as qualitative research; indeed, [I believe] that the very idea of qualitative research is open to question” (Rolfe, 2006 as quoted in Roller, 2018)

We need to concentrate not only on the product of development but on the very process by which higher forms are established. To encompass in research the process of a given thing’s development in all its phases and changes—from birth to death—fundamentally means to discover its nature, its essence, for it is only in movement that a body shows what it is. (Vygotsky, 1978 as quoted in Moen, 2006)

Qualitative research is chosen if the objectives of the research demand it. This research is based on understanding the experiences of the women outside marriage seeking abortion who have underwent abortion, thus, qualitative analysis was chosen. Abortions for women outside of marriage involve a lot of systems and along with those, their own understanding of women accessing abortion outside marriage. To understand how that affects the women, and how they navigate it requires qualitative research because each experience is personal, unique and elaborate. It cannot be measured in numbers and one cannot understand the subject in a wholesome manner by reducing the women to statistics. It is essential, for a better understanding, that the women have space to talk, in the manner they see fit.

Quoting Strauss and Corbin, 1988 for why one chooses qualitative approach, “Another reason, and probably a more valid one, for choosing qualitative methods is the nature of the research problem. For example, research that attempts to understand the meaning or nature of

experience of persons with problems such as chronic illness, addiction, divorce, and the act of "coming out" lends itself to getting out into the field and finding out what people are doing and thinking. Qualitative methods can be used to explore substantive areas about which little is known or about which much is known to gain novel understandings (Stern, 1980). In addition, qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods."

NARRATIVE APPROACH

As Catherine Kohler Riessman (1993) explains, narrative researchers attend to the ways that culture speaks itself through an individual's story (Atkinson, 2001)

Every second that we are alive, we are constantly interacting with ourselves and the world around us. The world which is full of different people, different norms, different ways of living and multiple systems that help it operate and continue to function. One is constantly trying to survive in their own surroundings, by complying to it, or by making one's own rules. These interactions of multiple systems, and of the individual with the system can sometimes feel overwhelmingly complex. One way of untangling these experiences is through narratives.

Many writers invoke the terms "story" and "narrative" to convey a sense of our human involvement in the creation of the realities we live and perceive. (Atkinson, 2001)

We create narrative descriptions about our experiences for ourselves and others, and we also develop narratives to make sense of the behavior of others (Zellermayer, 1997 as quoted in Moen, 2006).

I chose to take the narrative approach because it allows the participants to tell their experiences in their own words and order. There is space for emotions and the organic flow of

the journey in narrative approach. It also helps the individuals to analyze and realize more about themselves and their surroundings. Narrative methods can be considered as "real world measures" that are appropriate when "real life problems" are investigated.

According to Polkinghorne (1988), people without narratives do not exist. Life itself might thus be considered a narrative inside which we find a number of other stories. (Moen, 2006)

Graham (1984) suggested that story-telling provides an alternative to more structured interviews, whose format is determined by the researcher. Graham therefore advocated stories as the basis for informant-structured interviews, which 'more effectively safeguard the rights of informants to participate as subjects as well as objects in the construction of sociological knowledge' (1984: 118) and argued that because the narrator is aware that he or she is providing information, the 'story marks out the territory in which intrusion is tolerated' (Elliot, 2005)

OBJECTIVES

- To understand the impact of various social, economic and legal structures on abortion as an experience.
- To study the impact of the decision to abort on the well-being of women outside marriage seeking abortion in urban settings in India.
- To understand the range of reactions, emotions and coping strategies utilized by the women.
- To analyze the role and impact of practitioner in the process.

RESEARCH QUESTIONS

- How do women navigate in the patriarchal setup to enforce their choice and approach their rights?

- What are the consequences of the MTP act in India on the access to legal and safe abortions?
- How much information do the practitioners give? How much power do they hold over deciding the cost of the procedure?
- What are the attitudes of practitioners towards the women and what is its impact?
- What are the impacts on the mental wellness of the women, post abortion?
- How much importance does family and partner support hold in dealing with post abortion triggers and stressors?

METHODS AND TOOLS

The method used for data collection was in depth interviews and the tool used was interview prompts.

In the paper, 'In-depth interview' (Showkat, 2017) defines in-depth interviews as long-duration, face-to-face, interviews conducted to achieve desired goals. "In-depth interview also known as one-on-one is a method of extracting more detailed information or deep understanding of a subject or concept.

As per Kvale (1996), in-depth interviewing can be approached through two alternative outlooks, namely the 'Miner's Metaphor' and the 'Traveller's Metaphor'. The former position understand knowledge as a "buried metal" (Kvale 1996), and the interviewer in equated with a miner who had to extract the required information from multiple encompassing layers and themes. On the other hand, the traveler's metaphor views the interviewer as a "traveler who journeys with the interviewee" (Kvale 1996), and the denotations attached to the subject's comments are unraveled over time. In this understanding, interviewing is a dialectical process through which the subjects pass on information to the interviewee, and themselves develop new insights during the process.

The interview is based on questions which can be used as a checklist or probes when women talking about their experiences and cover several points on their own under a single question.

The interviews were spontaneous and often tailor made to the individual. They were asked questions based on their responses along with the interview guide.

SAMPLING

Sample includes 12 women who were chosen by a word of mouth over several social media platforms. The participants all approached the researcher after the message was put out on various platforms and were then made a part of the research.

The sampling is non-probability purposive sampling.

In contexts where the intention of sampling is to reach targeted groups efficiently and where proportionality is not of much concern, non-probability purposive sampling is quite effective. Through the method of homogenous purposive sampling, the sample selection is done based on certain shared characteristics (Crossman 2020).

Some women also knew other women who have underwent abortion outside marriage. If they agreed to talk to the researcher, their contact information was shared.

Sampling frame: The sample consisted of women who were 18-26 years of age and unmarried when they underwent abortion. Currently, none of the participants were above 29 years. The women were urban women from middle class households and holding bachelor's degrees.

The research is done within four metropolitan cities, namely New Delhi, Mumbai, Kolkata and Bangalore. The women are either the residents of these four cities, or were pursuing their education or working in the given cities at the time of the abortion. The location specificity is for where the procedure was performed and not from where an individual belongs.

PROCESS OF DATA COLLECTION

The mode of data collection was either face-to-face or telephonic. Because of the approach being narrative, the interviews were more like conversations. I was talking to women who I

have a lot in common with. We fall in similar age groups, similar educational qualifications, exposure to big cities which give women relatively more freedom than our hometowns and financially stable family backgrounds. Typically, this is not a group that you would classify as 'vulnerable'. However, being women outside marriage seeking abortion trying to access abortions comes with its own unique set vulnerabilities; same old biases, in different form and medium. They come to women who are aware enough to not go for illegal abortions, and yet the legal ones require crossing social and economic obstacles. They come to women who are women who are not 'poor' as per family income but do not get familial financial support when it comes to getting access to abortions, a public health issue. These vulnerabilities are unique because they are latent. They are latent because these women are far more privileged than most, and they cannot afford to talk about their experiences because they are much more than an individual who wanted an abortion. They are their family's honour and a role model for future generations of women. They cannot afford to 'overstep' their bounds.

I couldn't have asked for more from my participants, because they trusted a stranger with the most intimate details of their lives, on a promise of confidentiality.

My data collection did not feel like a process. It was a conversation. With each of these women, it was an exchange; of experiences, emotions, learnings and coping.

I was also lucky, to have been of the few, and in some cases, the only person they have talked about their experience at length. For some, the experience was cathartic, and some learned more about their own emotions. And it had nothing to do with me, it had everything to do with having a space to say things out loud, without fear.

During the course of my interviews, I could see myself grow and evolve along with the narratives of my participants; not only as a person but also as a researcher. The women added more information than I asked for and it turned out to be extremely vital to my analysis. They gave me inputs on what more they felt could be added but most importantly, they told me that they would like to read my work and appreciated my efforts. This has been the sole driving force for me to complete my dissertation during the pandemic.

DATA ANALYSIS PLAN

Scholars such as (Thorne 2000 as quoted in Lorelli 2017) have identified data analysis as the most complex part of a qualitative research, and have berated the fact that the literature often pay least heed to methods and themes in data analysis.

Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail. However, it also often goes further than this, and interprets various aspects of the research topic (Boyatzis, 1998).

Braun and Clarke (2006) argued that thematic analysis should be a foundational method for qualitative analysis, as it provides core skills for conducting many other forms of qualitative analysis. (Lorelli, 2017)

The data analysis includes transcription, coding and analysis of the themes that emerged from the data. These themes are separated into categories and chapters and understood within relevant context and their impact on one another as well as the individual.

ETHICAL CONSIDERATIONS

As is helpfully highlighted by the British Sociological Association's (BSA's) *Statement of Ethical Practice*, 'Sociologists, when they carry out research, enter into personal and moral relationships with those they study.' This is perhaps most evident in the data collection stages of qualitative research when the researcher is likely to come into direct contact with the research subject. However, this relationship arguably continues throughout the analysis and dissemination stages of research.

The narrative approach however, puts the interviewees, especially women, in a very vulnerable position. In (Elliot, 2005) Finch writes: 'I have…emerged from interviews with the feeling that my interviewees need to know how to protect themselves from people like me.

They have often revealed very private parts of their lives in return for what must be, in the last resort, very flimsy guarantees of confidentiality' (1984: 50).

However, in contradiction to the assumptions usually made, the distress experienced during the course of an interview dealing with a traumatic subject might not necessarily be harmful for the respondent. In fact, scholars such as (Hollway and Jefferson, 2000) have argued that the interview can be turned into a safe space which allows the respondent to talk about the trauma in a therapeutic manner. This, of course, is based on the interviewer experience and capabilities to manage the interview in a manner which minimises any long-term negative effects that the interview process might have on the participant. At the same time, the possibility of the interview being a traumatic experience for the interviewer themselves is also ever present, owing either to empathy or the experiences of going through similar trauma. However, without understating the negative effects that the process might have on the interviewer, it is also to be kept in mind that just like for the participant, the interview can work as a safe space for the interviewer too, and they can benefit from the opportunity to reflect and talk about their own lives (Elliot 2005).

Consequently, in this research, an attempt has been made to examine the past life experiences of the participants, particular focussing on existing relationships with family and partner as well as traumatic experiences of childhood in order to generate a deeper understanding of the emotions and reactions that were displayed during the incident in focus.

- The subjects were informed of the aim and purpose of the study. They were also given a written detail of the study and then explained before the interview as well.

- No participant was forced; directly or indirectly, to reveal any information they do not wish to. It was constantly re-emphasized that they can choose not to share anything they do not feel like sharing. An apology was made beforehand if there were follow-ups on some extremely personal questions.

- Complete anonymity of the participants was ensured. Women have also explicitly asked me to not reveal their names. However, A lot of participants have followed me on social media. Apart from being conflicted about if this would be fine, I also informed them that becoming friends on social media might result in the mutual friends knowing that the said person is my participant. Only when they agreed that this would not be an issue for them did I agree to stay connected on social media.

- In the point above, I acknowledge the power that I hold as a researcher, to be able to tell women what they should and should not consider, despite it being for ethical reasons.

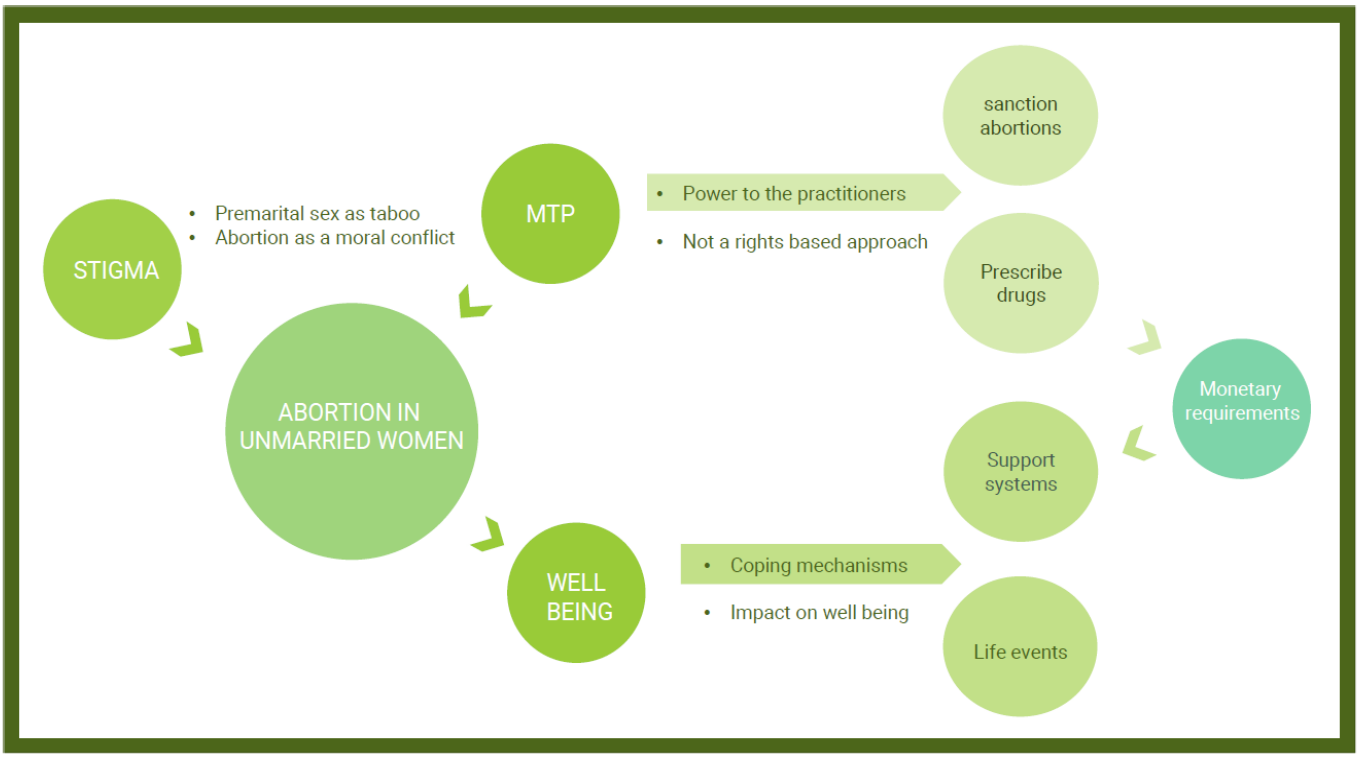
- The women interviewed can withdraw their participation at any given point in the interview and will have access to the progress of the research if they wish to. Most of the participants has asked for the final thesis.

- This interview was the first time a lot of the women were talking about their experience at great length. Thus, it was a cathartic experience for a lot of women. They also realized a lot of things about their own coping and understanding. It was important that they get the space for their emotions during and after the interview. I received several call backs which I addressed where the women were unfolding and unpacking their emotions and also their anger towards the system.

- The researcher will try to do justice to the narratives by editing them to the least and will seek permission before doing so, if absolutely necessary. The purpose of the research is to put the participant in focus and give a complete picture of the journey. No such edits have been made until now.

- All the secondary sources have been cited and given due acknowledgement. The researcher did not show any bias towards or against any participant. It will be ensured that the research is free of plagiarism.

CONCEPTUAL FRAMEWORK



THEORETICAL FRAMEWORK

1. Systems theory is based on concepts that emphasize reciprocal relationships between the elements that constitute a whole. These concepts also emphasize the relationships among individuals, groups, organizations, or communities and mutually influencing factors in the environment. Von Bertalanffy believed that all things, living and non-living, could be regarded as systems and that systems have properties that are capable of being studied. A system is defined as “an organized whole made up of components that interact in a way distinct from their interaction with other entities and which endures over some period of time” (Anderson et al., 1999, p. 4).

This research fits in the Systems theory as it focuses on relationships of the individual with partner, family and friends and their interaction with the society as a whole. A huge part of the

research is based on these interactions to understand how they work and what impact do they have on the individual.

The ecological environment is conceived as a set of nested structures, each inside the next, like a set of Russian dolls. At the innermost level is the immediate setting containing the developing person. The next step, however, already leads us off the beaten track for it requires looking beyond single settings to the relations between them. (Bronfenbrenner, 1979, p. 3 as quoted in Allen, 2014)

In essence, this view states that human development cannot be seen in isolation but must be viewed within the context of the individual's relationship with the environment. In addition, each individual's environment is unique. The "person's development is profoundly affected by events occurring in settings in which the person is not even present" (Allen, 2014)

The two theoretical models to the ecological systems perspective were adapted to social work literature by Germain, who argued that the cultural, historical, communal and socio-economic contexts need to be kept in mind while analysing the biopsychosocial developments of individuals or families. This basically implies that in order to understand and make sense of a particular event, it might be very important to analyse all other events in the person's life that led up to this point. This also implies that in order to make more accurate assessments, the individual should be studied in the broader context of public policy, practice and research in which they are situated. Germain (1991) has characterized the nature of these relationships between different systems as transactional and depicting a "reciprocal exchanges between entities, or between their elements, in which each change or otherwise influences the other over time" (p. 16). She further argues that these relationships no longer can be seen as linear, but should rather be understood as an intricate web of interconnected and co-dependent outcomes, where each interaction affects the others.

In accordance with this line of thought, this research also aims to examine the broader social, political and psychological contexts in which the question of abortions is situated in India. This includes looking at the policy frameworks governing abortions, as well as the general

perceptions that the society at large has about themes of pre-marital intercourse and pregnancy. The systems theory is applicable to the first chapter of analysis which talks majorly about the contributing factors in the abortion process and the interactions between the various systems that affect the experiences of women and hold a lot of power to influence and colour it.

2. Emotions have a central place in human behaviour. They drive our actions, reactions, coping, healing and well-being. This research not only tries to understand and cut open the wide range of emotions that the women felt, but also understand it in terms of their environment and surroundings. The model that sits well with the approach is the coping complexity model.

According to (Hudson, 2016), coping was defined by Lazarus and Folkman, (1984, p. 141) as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person."

The theory not only talks about coping, but also decision making. According to (Macy, 2007) Within a given situation, decisions or potential response options consider details such as: the overall capacity to respond, influences of previous experience, and related current thought and affect properties. Coping responses are potentially cognitive, emotional, and/or behavioural.

Coping was defined as managing stressors (internal and external threats) via cognitive and behavioural efforts; manifested in actions, emotions, and thinking responses which can be adaptive or maladaptive.

Another key aspect for using this theory for my research framework is the idea that the dominant discourse naturalises, normalises, problematizes and individualises stress. According to Donnelly and Long, 2003, the fact that the healthcare professionals and the lay public, hold the same views. This is indeed true in a lot of cases in the research where the healthcare professionals hold the same biases and judgement as the society and contributes in creating a sense of taboo around a public health procedure.

Nilsson, 2007 (Hudson, 2016) says that the unique differences between the individuals provide an explanation for why some people respond to a stressor as a threat while the others perceive the situation as a challenge for them. This is rooted in the assimilation of many relationships and the current coping models should be able to demonstrate this in a broader schema. They should include the impact of the social, cultural and economic aspects that define and perpetuate the stressors in the environment in which the stressors are occurring. This indeed is the exact lens that the research holds and tries to understand how the various factors affect the decision making, how the women navigate its consequences and how it impacts their overall well-being. It also interesting to see different women having different outlooks and approaches to their experiences and how they cope, if need be, to continue to function in the society.

3. Another approach, which I feel would be essential would be the feminist approach that we are taught as a lens in counselling and therapeutic interventions. Since our society does not overstep its bounds and functions only in the normative binary, wherein the women are the inferior gender and have to move and behave within the, acceptable framework', a lot of those biases have seeped into the apparently neutral objectives of healthcare setups through personal beliefs and biases.

To accommodate the ideas and concepts that fall beyond the understanding of conventional methods, the lens of the researcher and the research itself should keep in mind the biases and stigma around each and every topic that the research explores, and also the surrounding factors that are laced with gender bias and expectations.

PARTICIPANT PROFILE

NAME	AGE	LOCATION	EDUCATION	FAMILY TYPE
AI	22	Bangalore	Post Graduate	Grandparents, parents and brother
AH	26	Delhi	Graduate	Divorced parents, lives with mother
SH	27	Bangalore	Graduate	Parents and a sister
AD	27	Kolkata	Post graduate	Separated parents and a sister
C	26	Delhi	Graduate and Diploma	Mother and sister, father deceased
V	26	Delhi	Graduate	Parents, rest not known
SO	27	Bangalore	Post graduate	Parents, rest not known
SU	24	Mumbai	Post graduate	Parents, rest not known
AP	23	Bangalore	Graduate	Parents, but lives with grandparents
SN	22	Kolkata, Delhi	Post Graduate	Parents and a brother
B	22	Kolkata	Post Graduate	Parents and a brother
M	25	Delhi, Mumbai	Post Graduate	Grandparent, Parents and a sister

OPERATIONAL DEFINITIONS

- Middle class: Middle class, in this research, is used to refer to the families of the women, where her parents are in stable jobs in organized sector with regular salaries.

- Urban women: women who have lived in urban settings, including towns are classified as urban women.

- Formal Professional Consultation: women have taken consultation from friends or acquaintances of call. Formal professional consultation refers to the women going to a clinic and accessing abortions through legal and safe means.

- Anticipated: The researcher used anticipated for the instances where the women did not go to the doctors because of pre-conceived notions of practitioners being judgmental or biased.

- Passive: Passive is used for instance where the practitioner did propagate stigma in some form and that is acceptable to the women.

- Conservative: conservative is being used to address the inability of the people to accept two very common occurrences, of both premarital sex and abortion. So much so that some people do not approve relationships outside marriage. The woman is looked upon as the honor of the family members and any involvement outside marriage would be seen as gross mistake.

RESEARCH ANALYSIS

The chapter explains in details the findings of the research and tries to bring together the various themes to explain the deep interconnections between each one of them. It is essential to remember that no one theme can be seen in isolation as all these themes are deeply entangled. A few overlaps to note and keep in mind have been listed below.

- Financial dependence on family is not only for abortion procedure, but after care, hygiene products and mental health services. Thus, distancing from the family not only puts pressure on the women, but also impact their physical and mental well-being in the long term.

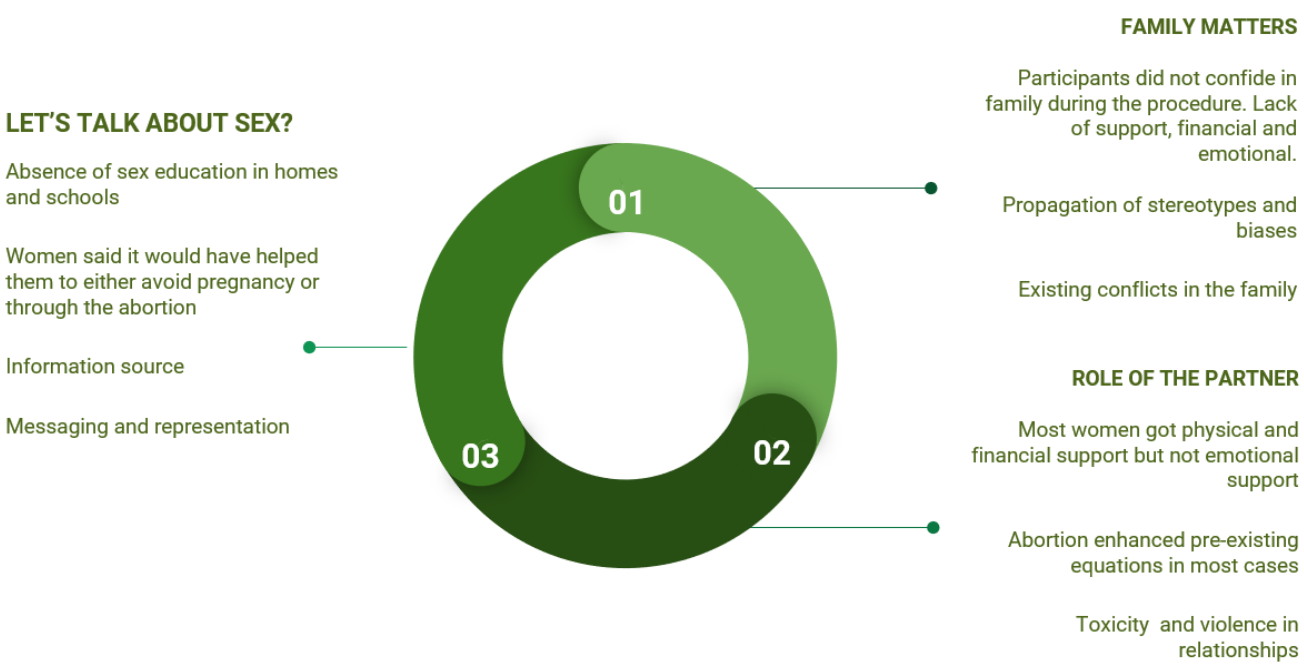
- The stigma and taboo around premarital sex and abortion are propagated primarily through family and practitioners. Gender roles and violence can be seen in the relationships with the partners. These patriarchal and regressive ideas are then internalized by women which makes this process all the more difficult.

- It is essential to keep in mind, that once pregnant, the women cannot escape being judged as morally corrupted. A woman who aborts a child is as passionately rejected as an unmarried mother. It is a typical devil and the deep blue sea situation. Abortion, however, can be hidden and last for a shorter time span.

- Practitioners hold the power over the women because they are the interpreters of the law. The stigma from the society, family and the urgency of the women to get it over with enables the practitioners to exploit the women, financially and morally.

- The importance of partner goes up in such situations because women mostly have nobody else to turn to. Even in toxic relationships, women tend to stick with the person through the procedure to hold on to some form of support.

CHAPTER FOUR: THE INPUTS



HUM SAATH SAATH HAI: THE ROLE OF FAMILY

"My dear young cousin, if there's one thing I've learned over the eons, it's that you can't give up on your family, no matter how tempting they make it." (Riordan, 2006)

There is a vast literature around abortions in India and the world, but few studies that talk about the role of a family in the decision making to choose abortion, in detail. This aspect is important, especially in a country like India where the individuals exist deeply intertwined with their social roles and responsibilities. According to Bowen's family systems theory of human behaviour, "The family is an emotional unit and systems thinking is used to describe the complex interactions in the unit. It is the nature of a family that its members are intensely connected emotionally. Often people feel distant or disconnected from their families, but this is more feeling than fact. Families so profoundly affect their members' thoughts, feelings, and actions that it often seems as if people are living under the same emotional skin." (Kerr, 2000) Thus, an individual cannot be looked at and understood in isolation. They are to be looked at, as a part of a family, as family is an emotional unit. Similarly, when we see the process of abortion as a whole, we cannot overlook the part that a family plays in the process. It is also important to look at the role of family, outright or latent, for better implementation of the laws and to incorporate it in awareness and accessibility programs.

Families are extremely complex structures. More so, in India. Most of the family systems in India are patriarchal, conservative and controlling. There are multiple social obligations that each individual carry. Families are also how the expectations of the society, of how an individual should be, are reinforced. The Indian family structures make a young adult extremely dependent on the unit. Irrespective of religions, class and caste, patriarchy finds its way in family structures.

However, it has also caused conflict. young, middle class women are now going out to different parts of the country and the world for better education and job opportunities. This physical distancing from the families gives the women a chance to explore their own identities and asset their choices and self-expression.

"The most important unit of an Indian family, parents have traditionally been very domineering, making choice about career and marriage for their children. Family obligations

are strong. Unmarried people in the 20s tend to live with their parents rather than on their own." (Jefffrey Hays, 2008)

"We asked the respondents the main factors that influenced the choice and location of the abortion facility or provider, in terms of travel time from their home. Fear of disclosure was frequently reported by the unmarried young women in the in-depth interviews." (Jeejabhoy, 2010)

In all of the interviews, the question about involvement of family was almost rhetorical. When the participants began to answer, it mostly started with a sarcastic chuckle or a repetitive no, as if to suggest how illogical or redundant the question is in the context.

The experiences of women who underwent abortions outside marriage, in this study, were quite different from each other. However, there is one thing that is similar across all participants, irrespective of social and geographical location; lack of family support. Not only did the women get absolutely no financial or emotional support from their families, the family structures here worked to add to the mental stress that women went through due to multitude of factors. Upon asking them if they could talk to their families about abortions, women mostly replied with a no for being able to talk to parents. Three participants said that they could have talked to their siblings, but chose not to.

"I was scared because how will I face my family? He will face so many questions. It was this whole thing about family. It was not just about the two of us. I could have told my cousin; we are very good friends. But my parents would have been shattered."

The women hesitated to tell their parent primarily because of fear of making the parents angry or ashamed and the fear of disappointing the parents and hurting them.
Two women were able to talk to their parents after the procedure was complete, and did not confide in their parents at the time of the procedure. However, the confrontation was not entirely out of choice. They considered themselves lucky because their parents did not take any extreme measures.

"Eventually, after a year, I told my mom under the influence of alcohol. She did not scream at me or was mad. She felt just very bad. There was a little bit of judgement but she was very emotional about it that you went through it alone."

"He told my parents. After the entire abortion, after it was all done. When I told him, I don't want to be with you, he told my parents that I got her pregnant and this is what she is doing to me. My parents were surprisingly very understanding. He also told them that this is not her first time but they did not believe him. They told me that I need to stay away from him and when they did give me a shit about abortion, I told them that I did not tell you and did this on my own for a reason. I was not just protecting myself but also you guys from feeling this. So now when something happens, my parents are like, you know what you have put us through. So, it is there and we never really talk about it and my parents very supportive about it. Not like they let me get away with it, especially my mother. But it is never more than that. They have shamed me also for having sex."

For most of the women abortion was the only option for numerous reasons. One of the major reasons was the fear that the family might come to know about the abortion and thus, an aspect of their sexual lives. No woman was confident enough to confide in their parents during the procedure and expect their support. Though the consequences of such events are never discussed because they are not supposed to happen, but everyone felt it is better to go through it without the emotional or financial support of their families.

"I was pretty close with my dad but when he passed away, the whole dynamic shifted drastically. My mom is sweet, she is caring and stuff, but the fact is that I managed to go through an entire abortion without them getting to even know about it. So, it is kind of distant. That you don't really know what the person staying with you is going through. So, my mom has always been like that. She is engrossed in what is happening in her life. She does care

about her kids, not saying she is a bad mother but she does not have a lot of maternal instincts."

None of the participants reported talking to even a sibling or a cousin about their abortion, let alone parents or any other elderly member of the family.

"There was also a gap between me and my brother, 7 years. And he has always seen me as his child. So, I could not have told him back then but I could have told him now."

"I don't really connect with cousins. I did not tell my sister because in my head back then I was like, I need to be a very good example and I did not want to set this precedence."

"My sister is pretty close to me and we talk and connect on emotional level too. She kept asking me what is wrong but I just could not come to terms with the fact if I should speak to her about it. She is my younger sister, three years younger. I don't think I can tell her right now also."

The reactions of the family members, despite the family composition, religion or age of the participant, were assumed to be quite similar; extreme.

"I come from a very orthodox family so telling them about this was never even a thought. They have no idea about who I am. There is no way in reality I would tell them even about dating someone, let alone being sexually active or getting pregnant. No way. It's a very different family."

"My mother is a gynecologist but I still could not talk to her."

"Oh, no. my cousins are so orthodox, one of them looks down of women that drink also. So, I could not have told them."

It can be inferred from this, that the women feel that the consequences might impact the aspects of life that matter to them the most. It might also mean discord in the familial

relationships. This knowledge of what the consequences might be, come from their lifetime experiences. Even the ‘progressive’ and ‘chill’ parents could not provide their daughter with a trust that they could come to them in times where they need assistance and more importantly, care.

Family interactions are nowhere near their glorious portrayal in our cultural settings. They not only take away the cushioned support of a family that one might need to navigate abortions, but also supplements the existing pressure and stigma. The women are also cut off financially and find themselves going for treatments that are cost effective and not particularly safe, however legal. Women have reported skipping follow-up tests and self-medication. It is obvious that these women would have had access to better healthcare facilities and aftercare, if the family members were a part of the process. If these families were to be ideally involved, like in any other medical procedures; consultation, best possible services and a follow up would have been ensured because of better affordability and optimum after-care from family. Apart from what the participants feel about their families in the context of abortion, a lot of them reported conflicts in family, disturbances in relationships with or among the family members and difficulty in navigating self-identity due to family ideologies and interference. These have not only shaped them as individuals but also factored into the decision of not being able to confide in their families during the time of abortion.

“They are supportive but insensitive in ways they are expected to be. Like for example, when we have a fight, she knows I want to go to a therapist, and she has been to one with me, and she says that you are crazy. So, I have realized that I also have to deal with them being controlling and all because I have put them through a lot.”

“I don't know if you need to know this but my parents are divorced and I live with mom and her family but not out of choice. My parents used to work together. The company shut down so now dad and I are out of a job. Mom is also a dance teacher and practitioner so she has that going for her. I knew I wouldn't share such stuff with mom's family. They make a mountain out of a molehill and this was already a mountain.”

"My family is very dysfunctional. Back then I was living with my grandparents and not my parents and I was also not talking to my sister due to some personal issues. It's a very orthodox Muslim family."

There were two instances of childhood sexual abuse and one of harassment, where the parents knew about it and did nothing to ensure the physical and emotional well-being of their daughter. Instead, their reaction, or lack of, made it worse. In one instance, it was a family member.

"I was raped when I was a child. And I was class 7. Surprisingly I did not get pregnant from it, god knows how. I was too young. I was diagnosed with clinical depression from class 7 to class 10. I even attempted suicide. My parents knew about it. Since I was young, I went and told my mum about it. My mom, being the person that she is, had a different reaction. But my dad was supportive."

"There was child abuse. My mom's cousin, he abused me as a child. I think when I was around in 8-9 standard. It wasn't exactly rape but it was almost there. I told my parents and everyone spoke about it but nobody really confronted him. My mom stopped talking to him but once the issue was out in the open, everyone was like we understand but don't bring this in front of everyone. Everyone else started being nice to him and it was all okay. That made me aware that they were not going to do anything about it. I think the major part of it is religion. My family is very religious and everyone follows it. I was the first person to doubt it. Then I was aware that no matter what I am going through, they will put relations and what society thinks above that."

"I was sexually harassed by a professor. Initially it seemed very innocent. I used to talk about studies and he used to change the topic to ask me if he could touch my hand. One day I went to his office and I was wearing a skirt and I scratched my leg because there were mosquitos. He felt the need to kneel in front of me, and rub up my leg where I was bitten and asked me if I was okay. I can't imagine ever telling about this to my family. About the abortion or even the

sexual harassment. I've faced it even in school and the family was of the opinion that I'm the reason it happened. Never spoke to them about any of these topics ever again. Due to other reasons, I've never been very close to them."

Such violations of trust and boundaries by members of a family makes the role of families all the more crucial to be analysed. It is with these instances, that the directives of their role in the family is communicated. Despite the women reporting that some family members were there for them, none of them took measures to ensure closure.

One of the participants also shared a story of her sister and her visit to a gynecologist, which shows how rampant these biases are, and how people see it fit to take actions to police and discipline the women who seem to have forgotten the rules of the community. This is an example of moral policing by the parents and taking the words of a third person and the girl having to explain the choices she made regarding her own body.

"My sister had gotten an infection and gone to a gynaecologist; her reports needed to be collected. She is not sneaky in general so she got my mom to pick up the report. It was a routine UTI report. And you get it even if you are not sexually active. The receptionist encouraged my parents to meet the doctor and the doctor told my parents that your daughter is sexually active and that she came here with a boy. There was an entire episode with my family where she had to sit and show the texts to the family that there was nothing happening and he is just a friend."

Families are conclusively inseparable part of the lives of the Indian women. Even in their most personal decisions, family does play a role. Despite not consulting any family member in their decision making, everyone did keep the reactions and feelings of their parents in mind. It is perhaps because of the life-long conditioning of consideration and compassion and family integrity. The family structures, hence, are not a part of the support systems that women can turn. Despite the fact that the primary duty of a family is to care and nurture, here we see families being the source of distress to the women.

Both, oppression and empowerment of women, start from the smallest unit of the society; a family.

MANNING UP: THE ROLE OF THE PARTNER

For the woman, the fear of her parents finding out makes the man the fulcrum of her support. Hence, his role becomes crucial in such situations of premarital pregnancy. (Kedia, 2018)

When it comes to the role of the male partners, there are several aspects that play a part. Majorly, the role of a partner can be divided into physical availability, emotional availability and financial support from the partner. It is also interesting to note how the relationship was prior to and apart from abortion and if there were any changes in the relationship after the couple goes through the abortion.

Physical availability includes being a part of the process, arranging for medicines, visits to doctors, ultrasounds and after care. After care can also have various types of support but here it means being there and taking care of the woman's physical health and needs for example adequate rest space, food, sanitary napkins, medicines and anything else required.

"He was around and very caring and gentle. But I tried to keep him away because I felt severe aversion towards him and kept contact to minimum. He used to come over and take care of other things."

"My partner, he accompanied me in the visits after I took the pill."

"Partner did everything. From booking the appointment to getting the cabs. He took everything off my hands. I was just following him around like a lamb."

"We unanimously decided. I don't remember any conversation about this because both of us knew that it had to be done and he was feeling much worse because I was the one who actually had to do it so he felt much worse. As a result, he was around me 24/7."

"Since he was there in the entire process, he knew what the doctor was saying he knew the precautions he would make sure that you know, everything was being followed by me."

Out of 12 participants, three reported having no physical assistance from the partner. Two of the women were in their hometown which made it more difficult for them to navigate the space without support because of the accountability of whereabouts, restriction on movement and constant check on daily activities is a feature of most Indian households, especially for women.

"He was not there. He just came with me on the first day, acting all paranoid. And then on the day of abortion, and he had to leave that evening. Rest I had to do alone."

"He was with his friends when I was undergoing the procedure that he will be leaving and won't be able to meet them"

"Initially we were pretty close but later he did not really care for me. In those 12 days, he did not show up once. And he stays close."

"The first time around, he was there for everything. He would stay up at night and massage my legs because I was unable to sleep because of the pain. The second time, I was in Mumbai and he was at home. So, it was very difficult. I realised how much easier things were when he was around. I had to do everything on my own, despite the pain, the work and the mental pressure."

Wherever there was a lack of physical support, if possible, there was a definite lack of emotional support. The last case of physical unavailability is an outlier, due to the circumstances. Even though physical and emotional support are very different things and can be seen exclusively, they are intertwined in a lot of ways. A manifestation of emotional support and care is physical support. It can be seen in instances of the person doing more than the 'required' basics and going the extra mile to ensure, in the best way they can, the well-being of the women.

Unlike physical support which is tangible and does have some understood 'guidelines' about how to be there, providing emotional support requires a lot of understanding. It is also individualised because women go through a wide range of emotions and concerns.

Women who were in compatible or long-term relationships received more emotional support than the ones with discord or lack of attraction. Out of the four women who reported emotional support and care from their partners, three of them are currently with the same partners.

"My boyfriend at the time was very supportive and that helped a lot. I can't even imagine going through it alone. I am currently not with him. He was a hundred percent supportive."

"My boyfriend was very supportive. He was like we will manage and I will look after everything, even the money and all. He said he will take care of everything. I could see guilt in his eyes. And both of us were having mixed feelings. He was unable to talk to me because I was going through the pain and I knew that something was coming out of me."

"My partner was there for me through and through. The first time I told him, he was shocked and did not talk to me for an hour. I was very scared that he will leave and I will have to deal with this on my own, but then so was he. He then came over, apologised and has never left my side since. During the second abortion he felt guilty for not being there physically but he was there. He also stayed on call during my visit to gynaecologist and my ultrasound even though he could not hear a thing."

"He was actually calmer than me, and very supportive. He was like, okay we will get through this. The doctor told me not to smoke so he also quit smoking so that I would not be tempted. he did all the research also."

One of the participants who underwent two abortions with different partners had different experience in terms of emotional availability. While both her partners were physically available but emotionally unavailable, it gives a clear picture of the kinds of emotional unavailability that women go through.
For her first relationship, and other respondents also have similar narratives, the woman had a partner who did try to be there for here, but could not be there because of lack of

understanding of her emotions and also, his own. However, in the second relationship, the person was actively unavailable and was toxic and violent.

"In the first abortion, my boyfriend was there for me. He was very supportive. He did everything but here were a lot of breakdown involved, not on my part but my boyfriends' part. He was shit scared and one-year younger to me so he was underage. And I was very hostile towards him that this is on you, you did not use protection. Which is in retrospect, also my fault. Second one was with someone who was very abusive towards me. It was like another dependency on him. he got the kit and we booked an Oyo, of all things. I stayed there for four days. He did not ask for room service at all, we did not leave the room at all and we were just there. He also hit me while I was bleeding and in pain. But I always felt like I deserved it."

Out of the three women who did not receive physical support, one reported there being no contact at all. The other two talked about the added emotional labor their partners made them go through. There is visible toxicity and abuse in the relationship.

"So, I told him and he was not ready to believe it because he kept asking those questions like you just finished your period, there is no chance that you were ovulating so early. Then he said that you are not able to manage your own life at this point of time; how would you take care of another responsibility altogether. Then we both decided that it was not the best time to bring a baby in this world."

"After that he also acted a bit cocky, asking me if it was mine. I was very upset at that time. While I was bleeding, he also hit me constantly wanted to have sex."

The above are examples of more than emotional unavailability and labor. There are clear signs of intimate partner violence. The second account is of the person who also faced physical and sexual abuse in her relationships, and also while she was under the medication and bleeding heavily. This clearly has a definite, long lasting, and visible impact on the woman, and makes coping extremely difficult, especially with the lack of acceptance and access to mental health care.

Apart from the women who did not receive emotional support, there was one respondent who did receive complete physical support, but underwent a very emotionally taxing and abusive experience.

"He was pretty much adamant on abortion. I was kind of not okay with the idea, but I didn't have the resources required to go through pregnancy or like family supported, nobody would like have my back right, if I would take that decision, which is why I went ahead with this. I think I kept bringing this up a lot and he kept discarding it or side-lining or getting mad at me."

There are also instances where the partner was not toxic, and did not intend to be emotionally unavailable. It was merely due to lack of understanding of one's own emotions and inexperience in how to respond in sensitive situations.

"Did not get the emotional support throughout the process but that is not the case in general. He is there for me, talks to me, understands me. but in this situation, also because of the fact that he did not physically or mentally go through it, he could not really comprehend what was I going through and why was it such a big deal for me. it was a big deal for him only until the fact that his partner was not feeling good. But beyond that, there is nothing much he could say."

"He was very upset about it but to be frank I was also very upset but I did not get the space for it because I was taking care of him."

In managing the cost, four women reported having to do it on their own, including the three women who had no physical support. Seven women reported splitting the cost, equally or unequally, and one woman said that the partner bore the entire cost.

"Yes, to some extent."

"It was taken care of by him at that time because I was low on funds. But yes, eventually we split it up, but not evenly. I still spent a lesser share. And another friend of his who really sympathises with such cases, was kind enough to lend us 5k (without us asking). She's his best friend since school days and has always been by his side. She was the only one he'd told this to, and immediately after that call she transferred 5k to him, which we returned the following week."

"No, I paid for all of it."

"Approximately 10k, and I paid for the entire thing. He did not even offer to. He had no money at that time. Somehow it was understood that I will be paying."

"But on the note of the pregnancy the person who figured out what to do, how to go about it and the money to spend; everything came out of my pocket."

"If my boyfriend would not have helped me financially no, I would have been fucked because the medicines are so expensive."

Abortion is an intense experience to go through, not necessarily in terms of the decision to abort, but in terms of navigating the stigma, the expectations from a partner and also the process in itself. It is very interesting to note that abortions, mostly, did have a major impact on the relationships. One common change throughout all the respondents was the use of contraception and practicing safe sex. These changes came in the relationship, where both the partners changed the pattern, or in the women, who carried it outside the said relationship as well.

Five women reported feeling closer to their partners, six feeling disconnected and eventually breaking up / breaking up immediately after the abortion and one person reported no change in the relationship.

“We definitely became much closer. It was like our relationship instantly matured. It was kind of then that we decided that we would marry each other. Not because of the child but just because we felt like a team. At least it was the first time I realised I could absolutely trust him with anything. And that this is the man I want to be with. The guy who was willing put his child before his career, not once bothering about what the society would say. I can't talk for him, but for me, I definitely felt much closer and suddenly felt much more secure in this relationship.”

“Surprisingly, it brought us closer. Because we weren’t exactly a relationship before that, we were friends with benefits and I was in a dark place. I had gone through a really bad breakup and he was a friend that I turned to and this turned it into a relationship and we took each other way more seriously. It got us much closer than we ever would have.”

“It was pretty okay for him. It changed my whole life. Because physically, mentally, emotionally, I am a changed person now. I am no longer the girl I was a year back or two year back. It changed me in a lot of ways. I felt completely vulnerable in those 10-15 days.”

“Broke up after the abortion. Felt free after getting out even though he was a nice person and did not harm her in any way. Felt right because love was unequal and It was unfair.”

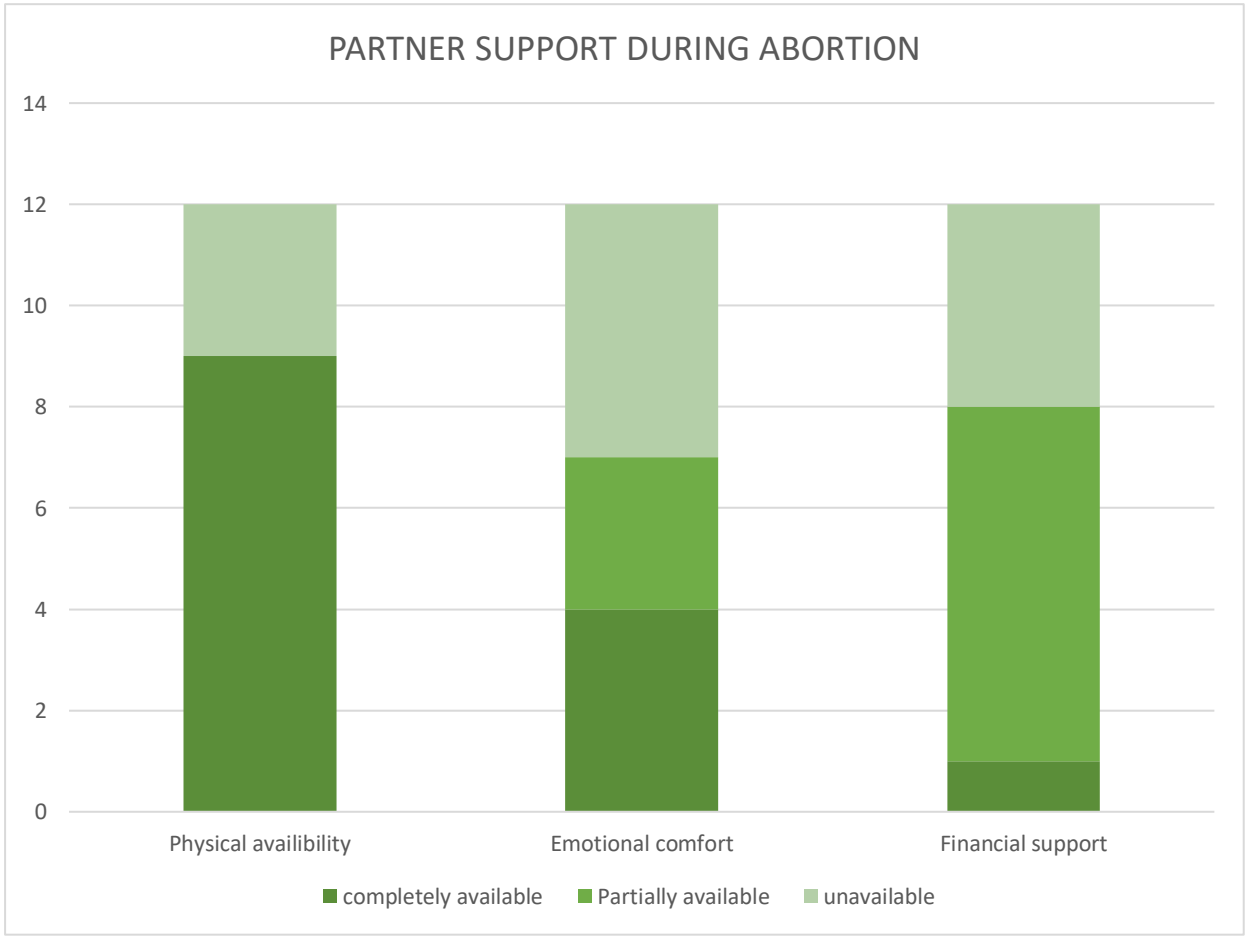
“After that, I developed PCOD. My relationship had gone into a slightly toxic level at that point. When I say toxic, it is more from a financial point of view and emotional point of view than anything else.”

“After that it took a very bad turn. He would not follow up on me. He would talk about random things. We never spoke about what I went through. He was very uncomfortable. We then broke up.”

“I think I was also slightly scared of his presence, which I realised were later because of which I didn't do anything. But once he left because he wasn't around, that gave me a lot of

confidence. And I broke up with him. But I think primarily it had to do with one him not being around so that feeling of threatened right away and Second, just the fact that he never addressed it right. Every time I spoke about abortion, he kept side-lining it later, I also started reading a lot about how when a couple loses a child, they always almost always drift away. He stalked me for two and a half years. Even though it was in Qatar, he came back in between and started calling my parents. He started calling my friends and everyone that was related to me because I blocked him everywhere."

"After the abortion, there were no changes in our relationship. In both the relationships it was like a blip for us. It happened and we never really looked back. Positive or negative, no changes. We were glad it was behind us and we never even talked about it. I never even said that I shared this bond with you. It was more like an unsaid sort of a thing but we never focused on it because it was a really bad times in our lives."



DRIFTING AWAY FROM KAMASUTRA: THE SORRY STATE OF SEX EDUCATION

Answering questions is a major part of sex education. Two rules cover the ground. First, always give a truthful answer to a question; secondly, regard sex knowledge as exactly like any other knowledge. (Russell, 2014)

Sex is a taboo in India, and so is sex education. There is a lot of discussion around the need for a comprehensive sex education for teens and young adults, however, very less is being done in that direction in India. Almost all of the participants reported that they received no sex education and the closest thing to sex education was human anatomy.

According to Ismail, 2006, recent literature has suggested that adolescents are highly likely to experiment and engage in the types of risky behaviours that have the potential to influence the quality of health and probability of survival in both short- and long-term over their lifetime.

Therefore, meeting the needs of such a vulnerable group and overcoming existing shortcomings in the delivery of tailored primary preventative measures would significantly improve the survival and general health conditions, nutritional status, and sexual and reproductive health of the future Indian adult population. This encompasses issues such as early pregnancy, unsafe abortions, STIs including HIV, and sexual abuse and violence.

Women agreed that the situation could have been navigated better, if they would have received sex education.

With the coming of SRE (Sex and relationships education), sex education is already a thing of past. We can only think about how effective a strong SRE would be and the impact it would have had on the well-being of the women who underwent abortion, and survived toxic relationships.

Indian households are extremely conservative in nature and the families do not sit and talk about sex to their children. In fact, a lot of women have no idea about menstruation, until the

start menstruating themselves and they still do not know why it happens. Because of a lack of safe environment in households where children can engage in conversations around sex, they turn to methods that have serious harmful impacts in the long run.

"There was nothing as sex education. Sex, marriage, even kissing, it's just stuff we just didn't talk about. Even now I can't talk to my parents about getting married. Or sex for that matter."

"Via parents, zero."

"My parents were very awkward about it, no discussion. Stay away from guys, were very narrow minded, especially my dad".

"At home, there was no sex education but the moment they found out we were sexually active, yes. Okay, nobody in my family would open their mouth about sex. Okay. It's a taboo subject. Doesn't matter how educated you are."

However, there were instances where parents were the source of information which ensured that the child has correct information and does not look at sex as a taboo. The participant also reported better understanding of the subject. However, the participant did not visit a professional for abortion and self-monitored her abortion because of her aversion to hospital spaces and her fear of being discriminated against and judged. Despite having an open environment at home, she could not talk to her parents when she was actually in need of a professional.

"I asked my parents about it when I was ten, and right away they told me everything about it, almost. They do not have a sense of shame about talking to sex. Contraception and abortion, I don't remember when I came to know about it but it way before my peers. My mother also had videos of deliveries and she never tried to hide it from me or my brother, even when she was making presentations. My father also, he is also a doctor. I remember my friend did not know how sex works in tenth grade. I did not tell her because I thought she should know about it from some source. When I grew up and hit puberty, I got exposed to porn but I lost interest

very fast. It was very unreal for me even though it did evoke feelings. It was weird, not morally, just weird. But I got most of my information from my mom. I don't remember the first time I saw porn so I don't remember my reaction to it but I did have a conversation with my mom about a girl who found condoms in her parent's bedroom and she was very okay. She told me it is very natural thing to feel like having sex even when you are old. My memory is very blurry so I might have gotten a lot of information from the internet but I did not have to in the first place."

"Since most parents are reluctant to talk about sex, schools have tried to fill the gap. When we decide to ignore a subject, our favourite form of denial is to teach it incompetently. Familiarity without true understanding is not only the basis of our families but of our educational system as well." (Smith B. , 1999)

The state of our sex education in educational spaces is abysmal. Participants reported that all the sex education they got was anatomy in biology class. Despite there being a basic chapter on reproduction in NCERT, most students were asked to skip through it and it was not explained in the classrooms. One cannot expect schools to provide the students with nuanced understanding of such subjects to include various orientations and power dynamics which impact the students negatively in their future, when the basic sex education is non-existent.

"Sex education at school level has attracted strong objections and apprehension from all areas of the society, including parents, teachers, and politicians, with its provision banned in six states which include Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka. Legislators contend that it corrupts the youth and offends "Indian values," leading to promiscuity, experimentation, and irresponsible sexual behaviours. Some opponents argue that sex education has no place in a country such as India with its rich cultural traditions and ethos." (Shajahan Ismail, 2015)

"I don't remember anything like sex education in school but mainly it was about the problems and all, but I was informed early about this."

"There was no sex education, none at all, in schools also.".

"Sex education in school never really happened. Other than standard bio classes. Yeah. That's where they actually be, they talk about safe sex and what would happen with unprotected sex? very technically, very briefly."

"Not at all. The only sex education we had in school were those chapter which the teacher was also adamant to teach us. Sex education was not a part of those books. It was only about reproduction and ovulation. There was nothing about safe sex and sexual methods and practices, doctor's help, what to do what not to do was never taught to us."

"Via school, also zero because I wouldn't call it sex education. In my tenth grade, the basically explained the anatomy. They separated the class in girls and boys and they had different sessions. I did not really understand anything at that point because I did not get my periods till then, I was a late bloomer. She explained something and then I remember her telling us that even if you are asked to do something like this before you get married, you should not. This was the extent of my sex education. I am not even kidding."
"So, I went to a convent school for 12 years, where sex education was like, kind of, teaching bad things to girls. So, it was close to zero in that school because it was dominated by nuns. So, talking about sex education was like talking about sin. My mother taught me things. She explained to me the whole menstruation, what is condom, what happens during childbirth. When I switched schools, there was more about sex education."

"We need sex education. they teach about menstruation max. Not good quality schools that I attended. I remember in high school I think high school biology had just basic human anatomy and sex related stuff right but not like a proper education. And I think our teacher kind of explained but considering how much as a high school kid I used to pay attention I remember my friends telling me stuff. I think that's the most basic way we learn."

One participant said that she felt that the NCERT text books were enough for the sex education in schools.

"In school they do have chapter on reproduction in NCERT so yes. I feel it was enough. I knew the basics."

MONKEY SEE, MONKEY DO: MESSAGING AND REPRESENTATION

"Learning to have sex from porn is like learning how to drive from the Fast and Furious. A bloody horrendous idea." (Jameela Jamil, goodquotes)

"Despite India pursuing an aggressive family planning program and the fact that we live in an age of information, abortion rates are showing no signs of slowing down. How does one explain this anomaly? Could it be that the condom lived up to its premise of a 2-12 % failure rate, or was it never used to begin with? What about female birth control? Is the information out there and easy to access? Is it always the women's problem to deal with the messy aftermath of sex, while the male enjoys unbridled pleasure? Can actual abortion figures ever be determined in a country where self-induced abortions are still performed and go largely unreported?" (Desouza, 2016)

A lack of elaborate and comprehensive sex education does not mean that the youth does not indulge in sexual practices, it is natural to. What it means that the men and the women do not have a wholesome knowledge to do so, which leads to complications, toxic relationships and unwanted pregnancies. Up until now, people have resorted to internet, peers and magazines for support. However, these sources promote dangerous behaviours like unprotected sex, toxic masculinity and submissive nature of women. Young people need to be better equipped about information on contraceptives, STDs and safe sex practices; which are the basics to a healthy reproductive life.

"I understood everything from Google. I was in tenth when I finally understood."

"Most of my information about sex was through friends and magazines and we read on the internet. And these sources of course are the most fucked up sources ever."

"Honestly, I learnt everything by reading sexpert columns in the newspaper and magazines. At that point I did not have internet at home. Then in twelfth I got access to internet and then I went to college. Sex education here is just, aaah. I don't think people realise that it is so important in a way that it would actually prevent things from happening. Also, everyone feels

like, if they introduce the subject things happen. But things already happen. Talking about the subject will help them be smarter about things."

"Sex education? No no, nothing. Nothing at all. Now people are starting to talk but not ten years ago. We haven't been told about our bodies. I was always heavier than my peers but nobody told me this is okay. I was made to feel like I was abnormal. When puberty hit me, it was horrible. Forget sex education, I was slut shamed since I was 14."

"Most of my actual understanding about how things would be between a man and a woman came from erotica, literature. Personally, I'm not into movies or visuals. So porn was never attractive for me."

"All the sex education I got was honestly from my boyfriend. Because he is a very insightful biology student. He knows about human anatomy to a very great detail. So that even if something is happening to me now, he would unfold everything and make me understand how the medicines working. Why are they working? So, whatever I understood, I understood most of the things about my body from him. He made me realize a lot of things. I did not know that much about myself also. I would have gotten better. It's not like it's a shock to me as of now. But whatever fear I had developed, if there had been a proper sex education or like I had the scope of talking about it. Like, it's not like I don't want to talk about it because it's nothing unnatural to me. It was back then,"

Women have also reported feeling that a better sex education would have helped them avoid this situation or navigate it better. Sex education is important not only for self, but also to teach appropriate sexual behaviours towards others, which is a necessity for our country.

"A better sex education would have definitely helped me in this case."

In the paper 'Adolescent sex education in India: Current perspectives' (Shajahan Ismail, 2015) There is a mention of mass media and the powerful influence it holds over the Indians.

The paper says that it has had mixed impacts on the Indian way of life. The premise here is extremely interesting because on one hand, mass media and internet are responsible for creating a dialogue around sexual and reproductive health, abortion and rights and the women centric approach towards sex. but on the other hand, there is portrayal of non-consensual sexual encounters and as well as poor representation of contraception use in porn. It has propagated unhealthy sex practices, along with normalizing it. This has in process, normalized the practices like women being submissive and contraception not being used during sex.

When asked about their contraception use, ten out of 12 women reported not using contraception. They also stated the various reasons they did not use a condom.

"I was continuously monitoring because we did not use protection, I came to know fifth or sixth week. We used protection only in the initial stages of the relationship and later switches to pills. I was sure this will happen this time because I did not take pills on time either"

"We don't like having protected sex in general, because well, unprotected just feels much better. And then like that's what led to me getting pregnant"

"Actually, the problem with me and my boyfriend was that condoms could hardly fit in. it was because of the girth. So, for the past three months we had been having unprotected sex. I thought it was alright until he did not ejaculate in me and as long as he uses the pull-out method, it is going to be alright. And going to my history of PCOD, I really thought that ever in my life I am going to conceive through normal methods. We had unprotected sex, right after I finished bleeding. And I was pretty sure that there is no way in hell that egg production can start this early in my cycle. I was not aware that that can happen. My cycle is 27-28 days only so it is not a really long cycle. So, after that I did not take the pill."

"We did not use protection. I took an I pill immediately after so I thought I was safe but we did not use protection. I have lost my trust in that brand."

"See, everyone likes to have sex without condoms, right?"

Women majorly reported pregnancy due to unprotected sex. There were also instances of contraception failure but it was dominantly due to unprotected sex. The reasons for having unprotected sex ranged from condoms not fitting, allergy to latex, PCOD, reliance on withdrawal method, having sex on the day menstruation ends and just because it feels better. Women usually relied on withdrawal as precaution in case of unprotected sex.
All of these responses show that the there is a lack of understanding towards the importance of contraception, and also undermining its importance. Most of the women reported getting their knowledge about sex from internet, magazines or peers; none of which are a comprehensive provider of sex education. In fact, there mediums, especially pornography, encourages unprotected sex among males and females. It is supposed to be more intimate, spontaneous and feel better.

The women who reported contraception failure as the reason got their education from erotic literature and not internet, and other woman also reported being a student of biology in high school.
The notion that everyone likes sex without condoms and that it feels better can be linked with how sex is being portrayed in the places where it is most consumed and used for as a learning medium by the participants. Not only a lack of proper contraception, porn in general does not promote respect for women, sex as a pleasurable occurrence for women and women are more seen as an object. There are numerous videos online that promote high disregard for women and extremely violent representations of sex.

There are, in a small set of 12 women, multiple cases of abuse, harassment and mistreatment by the partner. Lack of emotional unavailability is so common that the ones available are hailed as men who are heroes. Women themselves have said that they wonder how other women do it without support. It is a well- known reality, almost general knowledge. Sex education, a compressive one, should not only talk about sex in isolation. It should include relationships and health and target the stereotypes that are already in the minds of the adolescents. Quality sex education should be women and queer friendly.

With the increasing dependence of internet for understanding sex, Netflix has come out with an extremely comprehensive series called ‘Sex Education’ which has talked about various genders,

orientations, fetishes, STDs and the depth of the nuances of the relationships of the youth. It can easily be termed as the most comprehensive sex education material Indian students have access to.

These messages and representations do not only come from the media but also the society. it has been very well communicated to the women that sex, if not with your husband, will not be approved of and entertained. Thus, it is already been seen as engaging in something which cannot be talked about outside closed circles and thus, restricts the access to formal and more reliable sources of learning about sex. The impact of such messages and lack of awareness and information is elaborated on in the next chapter.

It is also important to note that healthcare professionals play an important part in such cases. It is with them that a major part of responsibility of information dissemination and the ability to provide a safe space lies. This is in the knowledge of the fact that the participants of the reseach either had a professional to get the information, or the spaces of internet where there is no guarantee of the content on finds and chooses to believe.

HOLDING BACK OR LETTING GO: WHAT GOES INTO THE DECISION TO ABORT

The above discussion was focussed entirely on the systems, relationships and information that the women had from before they underwent abortion. These systems are extremely significant in the lives of the women, so much so that they had a huge impact on the decision of the women to abort the child. It is not to put a label of 'morality' on the women who wanted to keep the child but could not, but to point out the sheer fact, that women have no autonomy or power to decide for their bodies, even though in a literal sense, the decision was independently theirs.
There were primarily four reasons to why women went ahead with the abortion. They existed in isolation as well as along with other reason.

Despite a moral stand of the society backed by religion that abortions are immoral (Masci, 2016) and thus is shrouded in shame in our country, we fail to provide a safe space for women who do not have economic or social stability in case they were to raise their child. On that train of thought, if abortion as well as being an unmarried single mother are both looked down upon, the true problem lies in women engaging in sex.

"Of course, I considered keeping it. A lot of social stigma is attached to it. Being 25, being unmarried. I was not earning at that time, was not in a professional job. I was stable financially but only through my family. I did not have a lot of cash surplus of my own. Even if I thought that I will move out of the house and not let my mom know, I would bring up the baby on my own, I still had nowhere to go and nothing to do."

Women were mostly scared about their family coming to know about this. The families, except for two, were mostly conservative and the women would have had to face consequences if the family would have come to know.

"*I was scared that if my family knew, it would probably mean the end of my freedom, education and career. I think my mother would have been better but I can't say, who can?"*

“I did not think much about it because I do not have the means to support the baby and It would be an issue for the family. It would not have been an Issue for me but no resources are a problem. Also, I am currently pursuing my masters which would be unfair to both me and the baby.”

The partner was not supportive or the relationship was not stable.

My factors were more on that he was to go to training and keeping in touch and getting marries was difficult. He was also getting very paranoid.

The women did not want to keep the child because either they did not want a child, or having a child would interfere in their own education and careers.

CHAPTER FIVE: THE IMPACT

IMPACT ON WELL BEING

Coping mechanisms range from productive to destructive

Significant impact on other aspects of life

Did not feel the need to go to a professional, specifically for this.

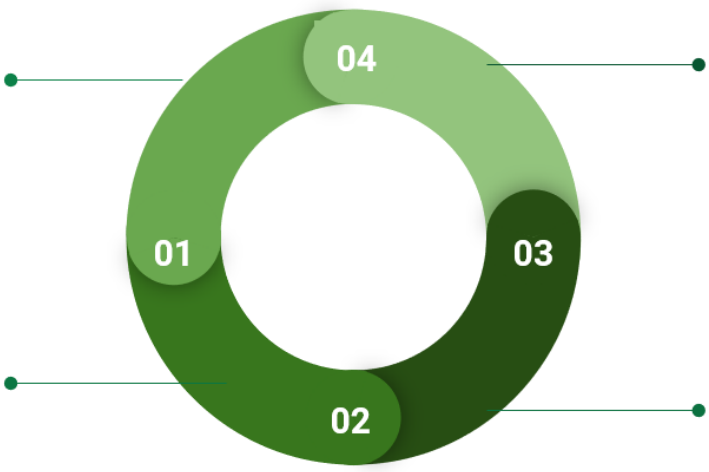
JOURNEY OF CHANGE

Physical changes like weight gain and acne

Low self esteem

More careful and cautious; regular use of protection

Pro-choice



EMOTIONS AND THEIR EYE

Premarital sex guilt

Idea of motherhood

Decoding the feeling spectrum

POWER OF THE PRACTITIONER

Regulates the prices

Moral judgements

Ease of access and procedure

No faith in government hospitals

KABHIE KHUSHI KABHIE GHAM: EMOTIONS; WHERE DO THEY COME FROM AND WHERE DO THEY GO?

I want to talk about the fact that we all, at least me, feel totally unsuited for the world we live in. How we are confused, eternally, because we often don't know where we fit in, or who understands us and loves us for us—as opposed to the idea of us—and the gender norms that lock us in. Or the fact that the society we live in caters to able-bodied hetero-normative individuals—and anything else is deemed as "other."

How often do we simply contain ourselves and compartmentalize our connections and passions to fit in neat little boxes? That is the way we're taught to live, if not an idealized way to live, but it's a way I abandoned a long time ago. I abandoned it the second I became a mother. And then, unbecame one. (Valente, n.d.)

The women who went through abortion underwent a whole spectrum of emotions; from grief to relief, and sometimes both. 10 women reported feeling guilty or upset about the abortion. Even with the women who were mostly reporting grief, none of them felt that they could use professional mental healthcare services. Three women who did talk about going to counselling did not require counselling solely because of abortion, but because of other aspects of their lives as well.

"I think I underwent the abortion in Feb and conceived in December. So, every year these three months I kind of spiral. For one, one and a half years, I was just sleeping around.

I started getting involved in a lot of things that would keep my mind off it like reading and rap music. Eventually, after a year, it started hitting more than I thought it would. I started talking to people about it more and the thing with grief and trauma is, the more you talk to people; the more you realize how it is affecting you. I lost a lot of friends because of it and felt that it is a reflection of who I am. It was not actively in my head, but if someone would ask my life story, it would come up."

The women who were talking about feeling grief and relief at the same time, also talked about a sense of doing something wrong.

"*It was a mixed feeling sort of a thing. It was all clear but at the same time I had got rid of something which was growing inside me. so, it was even more difficult during that time. I did not know how to feel about it. Do I feel happy about it, or do I feel sad about it?"*

Some other women were very clear about feeling a sense of relief and did not feel shame because of undergoing abortion.

"*First thing, for that particular night I was very tensed. But the next morning when I knew I was meeting him and will talk, I was fine. I was numb but fine. And decide we keep it, I was scared about the procedure but not about being pregnant."*

"I felt great after the abortion was done. Brilliant. I was so relieved. I did not go to the doctor again for the first time because I did not want to revisit it and I felt fine so why should I go. And I felt that whole stigma they had exhibited towards me. I had no such feeling about myself but they did. Both times I felt I could just move on. It was almost escapist."

Finding that women feel relief or happiness after abortion can be seen as a defiance of the norm. It can be seen as a sign that women have moved further from 'what is expected' out of them to how they genuinely feel about the decision, given their circumstances. Women are now giving themselves the space to navigate their emotions in individuality, and it may or may not co-exist with the norm and the expectations of the society. The feeling of relief can be attributed to being free of fear of people coming to know about it, but also the sheer fact that they no longer have to bear a child.

Talking about the feeling of fear, another primary feeling was that of fear, for various reasons. Fear of people knowing about it, unsuccessful procedures and what might happen during the procedure.

"Yeah so apparently abortion becomes more difficult after the third month, or so I had read (still haven't had the courage to read up fully about it) and so I was super worried that maybe the pills didn't work."
"A part of me was ready for abortion but I did not process it. A part of me wanted to have the child, but I did not know how to go about it either. The primary factor was fear. It was my initial predominant reaction. It led to me accept this decision of abortion."

Four participants underwent negative emotions because they wanted a child sooner or later in their lives.

"I was bewildered to say the least. I just could not come to terms with the fact that it was my body and it was a human being growing inside my body. I just could not accept the fact. I was really happy, Sana, I was really happy. I know there were feelings of fear attached to it, about from what is going to happen but apart from that I was really happy that this is an extension of myself. "

"The saddest part was that I've always wanted a daughter of my own and all this while, I didn't think about my possible child even once. It was only about me, my family and the society I live in. Once the doctor confirmed that the abortion was successful, I thought I'd have been elated. But I had this sinking feeling in my heart that I technically killed my child. It could have been my daughter. It's something I've not exactly been able to forgive myself for. I felt really bad for aborting my first born, but also relieved that I didn't need to confront my family. I mean my possible first born."

"I want to raise kids. I feel much motherly towards them now, especially if I know they're adopted. And I just have this natural urge to protect them. I want to make them happy. Even if they meet me for a moment, I try to make them at least smile. I keep wondering what my

child's smile would have been like. How she'd hold my finger, wrapping her tiny hands around it. I tear up even talking about this which is why I haven't spoken to anyone about this."

However, subtle hints of connecting abortion to lacking maternal instincts are visible. Women who are feeling shame and guilt are also exhibiting internalization of the image of motherhood. The conventional idea of how a mother should be is caring, loving, nurturing and above all, selfless. And each and every woman is expected to have these latent feelings, which are to come out whenever they bear a child. A sense of guilt, sadness or shame is 'expected' out of these women when they undergo abortion. Women reported feeling these emotions because they were conditioned to, or felt the pressure to, in order to validate themselves as 'morally higher'.

"Due to conditioning, guilt. My first feeling was that of guilt."

"A cumulative feeling of guilt because first of all, I am not supposed to have sex. The values taught at home, don't adhere to them much but still has this voice. Never felt guilty about sex but It came to this and Indulged Into a risky behaviour of not going to a hospital also thus the guilt Increased. Guilty about being irresponsible also. Moral questions were also in the mind because It Is about aborting a life which now has a heartbeat.

I was in that guilty cycle for a while but now I don't have that guilt because there Is nothing that I can do about It. I used to think about how It would have turned out of I would have kept It. I used to have dreams also. I have had a couple of dreams where I had a child and the child Is blaming me for leaving him or her. Those days I felt very guilty. But not now. But I did feel free. There was a sense of relief also."

"At that age I thought every girl dreamt of becoming a mother and having a baby, all that conditioning. so now when I unfold a lot of things, I see but back then when I was younger

and had that conditioning, that feminine conditioning, that it is not my body but someone else's life."

"Moral conflict in the center of this. I know I did the right thing, but do I feel selfish about doing it, yes. Do I feel guilty about doing it? Yes. Even though the logical side of my brain tells me that it would not have been fair for either of you at that stage, the emotional demons haunt. That never really stops."

"I know people get sad about it, nice people at least, but it was never my feeling. I just wanted to get rid of it because I knew the amount of shit I could get into if they found out."

"I remember that I was a little sad about it for a few days. I talked to a friend about it and she talked to me to see how patriarchy works, that I have to feel bad about it. This is what everyone around you has told you. From that day, I thought about it and never regretted it. I just did not like the consequences that it happened to my body."

The women show clear signs of internal struggle of feeling that they did the right thing, and of the guilt they recognize as somehow external to themselves. This can be looked into deeper, for women who feel both guilt and relief, to understand if the guilt is their own, or is it extrinsic. More often than not, it is not so easy to identify the source of one's emotions because we all have deeply internalized the norms and expectations of the society. Any deterrence is bound to make one uncomfortable. Another point that can be held as a mirror to this dialogue, is the fact that women usually chose to abort a child, because they would not have been able to support one. It is for the well-being and in favour of the foetus. Abortion is a parenting strategy that nobody talks about. Since the decision was taken by keeping the child in mind, who is to say that abortion necessarily translates to absence of maternal instincts?

An excerpt from an article about abortion, shows beautifully, how a woman could feel the expectation of being motherly because that is what is expected of her, when she clearly does not feel so.

‘Some women are the opposite of me—they simply want to be mothers—and they’re great at it. And part of me wishes I was that woman—but merely for the fact, I think, that I am told to be by my family, and by society. That there is something wrong with me for not wanting them. Yet I do find it incredibly problematic and sexist that women are expected to have a biological clock that will always “make her” want kids, as if women don’t have a choice of their own, as if it’s merely a bodily function—as if women are just wombs in waiting. There is a pressure, as a woman, to have children, to have your entire life figured out early—as if you are more of a woman if you mother someone.’

The negative emotions around abortion, and the external problems that the women have faced during the process also has its root in the belief that premarital sex is a misdeed. Women have not been able to talk to friends and family due to the fear of being judged, shamed and alienated. The impact of viewing premarital sex as a taboo in the society can be seen taking up space when it comes to abortion as well. The women often blamed themselves for ‘letting this happen’, while expressing grief.

“I was actually feeling bad, I was feeling guilty that we let it happen. A part of me was blaming myself.

Um, I have to selfishly say that I was a little relieved because there was all this worry about what if this does not happen. What will my parents and friends say? Will I be able to take care of the child? And the taboo of being an unmarried mother. I was actually relieved. At the same time, I was a little sad.”

Women also reported that their emotions were becoming more vivid and concrete and because of several instances that happened during the procedure namely; looking at the ultrasound image of the foetus before the abortion, knowing that the foetus has a heartbeat,

the foetus being referred to as a baby, looking at the expelled foetus and involuntary expression breast milk.

"So, I am the kind of person who decided at 16 that if I ever want to have a child, I would adopt. I would not have a kid. Kids were never really in my head, at all. Like logically thinking, it sounds like it should have been an easier decision but unfortunately even to this day, it is not. There is always that sense of guilt of choosing myself and feeling selfish. When I went to the doctor and the ultrasound, there was heart activity, cardiac activity and that sort of broke me."

"There was a discharge that started coming out of my breasts. It was milky white. And I asked my doctor why this is happening and she told me that this was your body preparing to give birth and that is why some women start to lactate early and those were the signs. It was a major blow to me."

*"When I came to know about my pregnancy, I was still my practical self. But when I saw the ultrasound, and what is going inside my uterus, I had second thoughts. I kind of felt like I failed in some way. After that I just went into negativity about everything, everything becam*e *hard and I had severe depression."*

"So, when I told her and told her this, she was very sweet and asked me if I want to keep the child. So, for the first time someone referred to it as a child. And I love children. So, it was a sudden shock. That someone is calling it a child."

"I remember feeling horrible, mainly because of the cardiac activity comment at the lab and the technician or the doctor who was doing my ultrasound sort of smiled and said everything looked good. There were a lot of niceties over there. To them, I was married and they were being nice. But inside. Especially when you hear it, it becomes all the more real. It feels like

discarding somebody. And that really kills you. I can't explain how horrible it feels, even to this day. That is the part that pushed me over the edge."

"The egg that is formed, even that sort of comes out. And seeing that was not good. Not at all good. I saw it because I ran to the washroom because I felt something and I thought I needed to pee, but it wasn't. so, this thing, sort of like, horrifying. It brings you to reality of what you have done. It is done now; you have done it. And not in the nicest way."

"I was really messed up. Because I saw it happening because you can see the foetus. For a really long time I was under that guilt that it was mine and I killed it. There were no triggers but every now and then it came to me. It impacted my relationships and I felt disgusted with everything."

Another aspect that did come out in the conversation was a feeling that one's own experiences are inconsequential in comparison to others. Women would put in phrase like "But I am still lucky" and "other women have it worse, I have heard stories" in the middle of conversations to put their own journey secondary. They also used the word 'lucky' to have found a decent gynecologist, which is the basic right of every individuals. Though it can be interpreted as compassion, it can also be seen as way that women navigate their spaces and make it easier for themselves to survive.

"I cannot say I wasn't protected in childhood, but I have felt like a victim in my own house in ways that I cannot explain to people because it is not as bad compared to other people. they have always discouraged me, never encouraged. Like you can't do this. But when I compare it to other problem, I feel ashamed about myself and I feel I should be more grateful about my upbringing."

"Most of the people are scared that people will get to know, confidentiality. Lack of awareness on where to go, we just got lucky. It is otherwise humiliating."

Abortion is a process where women undergo a plethora of emotions, in different permutations and combinations. Hence, it is difficult to give one umbrella understanding of the same. However, it is important to look at these emotions from a feminist perspective and see where they are coming from. Each emotion is valid, but perhaps we understand them better if we trace where these emotions were originated; outside in the norms of the society, or in our heart? Perhaps, that requires digging deeper in the lives of the women. However, one thing is clear and common throughout the sample; all the participants are honest with their feelings and have tried to navigate it in the best possible way. Amidst the whole process of abortion and how it is perceived and controlled by the society, this is probably the most empowered and feminist part of it all.

DAWA AUR DUA: THE POWER OF THE PROFESSIONALS

I prescribe contraception, but I do not prescribe the morning-after pill or carry out abortions because of my religious beliefs. I cannot decide which women should have an abortion just based on what that mother feels about the baby. While the law does provide women with the right to abortion, the rules also allow conscientious objectors based on personal beliefs. So, we cannot be forced to provide abortion care. Patients have the right to choose but, as health providers, we also have rights. (Dr Murishe Ledwaba as quoted in Summers, 2018)

Due to the stigmatization associated with abortion, and the freedom to interpret that the practitioners are given by the law when it comes to women outside marriage seeking abortion, the practitioners hold unreasonable power over these women. This allows them to have an opportunity to heavily charge the women and take advantage of their circumstances, and also to propagate their biases at the cost of their mental well-being. The participants reported paying ridiculous amounts, ranging from Rs. 2500 to Rs.12,000 for their visits to the doctors.

Another way in which easy access to safe, legal and feasible abortion is denied to young women is through moral judgement. All the women reported being anxious about visiting the doctor. Some of them were so terrified of being judged that they never went to the doctor and just took pills from abortion kits instead. Out of the women who did visit the practitioner, a few of them reported having cases of blatant judgement and moral policing. For others, the process was easier when the practitioner was supportive. On one occasion, the person had to visit another gynaecologist because of the demeaning behaviour of the practitioner. It is due to these judgements that eight out of twelve women reported not going for follow ups after the termination. Women do not want to go to abortion clinics, even for their own well-being, unless it is absolutely necessary. They avoid it if it is avoidable.

The paper ‘Exploring male engagement in premarital abortion’ (Kedia, 2018) talks about very similar findings. It says that only a few participants mentioned getting post-abortion check-ups. In fact, two male participants said that they did not refer to a doctor at all because of the fear that their secret might get revealed. Service providers too observed that young couples

just want to get done with the abortion and most never show up for post-abortion advice or checks.

Out of 12 participants, 3 reported not going to the doctor at all, and one reported not going to the doctor for her second pregnancy. This was primarily to anticipated stigma; avoid humiliation, judgement and the high costs that are incurred in a visit to a doctor. Even though Mifepristone and misoprostol are not over the counter drugs and are supposed to be handed over by the practitioner to the women, they are available on some pharmacies directly, and on other via order. Two women depended on the doctors they knew to navigate the procedure and avoid any chance of emotional distress. This, in no way is to encourage people to not visit the doctor but to bring to light the fear that women feel while accessing abortions, which is not illegal, and yet is.

"We knew the doctor personally. The doctor told that bleeding will take place and get ultrasound later but did not go to hospital despite that. Got abortion kit from the local store. Had to wait for couple of days because store owner had to order It. He did not ask from a prescription. We took a risk because I did not like to go to a hospital as I grew around hospitals. I kept a watch and monitored myself to see if it feels wrong instinctively. Not sure if I took a follow up test also. I feel like I did not go to the hospital because I was expecting to be judged. And also, I felt like it would be weird if I went to hospital with him and I would have to take care of everything and if he would be able to handle it. I don't know. And he is from Sudan and India is a very racist place so people would judge me for that and judge him for this so I wish I could change this. That I could walk into a hospital and not be judged."

"We even found the doctor through Practo so that we don't need to ask anyone in person. Both the doctors we talked on phone were very sweet. We got the abortion kit from IIT pharmacy, the only non-judgemental store we knew."

"I never went to a doctor. I just had a conversation with a doctor. I was scared of going to a gynaecologist because how would I ask a question, who would go with me. I was pretty

scared. He said that we need to go and see a doctor but then I felt no, I am not in the right frame of mind to go and visit a doctor and to face the humiliation of that sort. A friend of friend's sister is a gynaecologist, she suggested that it is pregnancy, she spoke to me about the symptoms and about the pregnancy test and then she suggested two options. And she told me that this has these side effects and this has these side effects. Now you are the best judge of your body so you decide what you want to do with it and only then go ahead."

"The second time I had an abortion I got pills along with RU-486 in an abortion kit. It was a proper kit.

When I went to get the ultrasound, this lady also told me that you should go to a doctor and figure it out. This is what I found out from people, that normal procedure would be 12,000, even if they give you the medicines. So, I don't know if this was false information then. So, the guy I was seeing then, got the abortion kit for me from a very shady pharmacy. First time I found the clinic through the friends relative. The second time the procedure took four days. I did not go to a gynecologist. It took four days the second time and I took a pregnancy test after it to check. The first time around, after the surgery, the doctor told me to get back to her but I never did. I did not want to relive it"

Women faced stigma on a lot of levels, from radiologists to practitioners. These biases and judgments were at times excessively outright, and at times passive. The practitioners would not acknowledge that the couple is unmarried, or be biased if the woman comes alone as compared to with a male companion. Women often had to pretend to be married to avoid any judgement. In such cases, one cannot call the practitioners truly unbiased or non-judgmental, or even ethical, because they failed to provide safe spaces for women who had sex outside marriage.

"When I was getting my ultrasound done, I got them done on my own without anybody by my side. And the amount of humiliation that I have faced and the questions that I have faced of a pregnancy without a marriage, a pregnancy at such a young age, and that too termination of the pregnancy. 'How did you do this? You are still a child.' I had to look for ultrasound

centres away from my home, so that you know, my mom doesn't get to know about it. Both the times, the radiologists said such things. Both the times I got it done from different places, good reputed centres. But the questions were the same. The humiliation was the same. Otherwise, the access was easy. Considering that I was educated enough to actually read about it and ask the right questions and apart from that, having access to somebody I can speak to regarding this is what made it easier. There was another gynaecologist I went to after taking the pill, and had to show her my scan, and this was at one of Delhi's best fertility centres. She was the head of that place and there was a small piece that was left inside. She told me that I have to do a surgery and that would cost 40,000 rupees and I shat in my pants. That was clearly not happening. Extortion on another level. She said if you don't get it done, it might corrode your ovaries and it might ruin your chances of getting pregnant ever again. She scared the fuck out of me. She told me we would have to give you anaesthesia and you will be in deluxe room with services and it looked like she was telling me a travel package but I was so appalled.

My partner suggested this another lady, she was old and sweet and she suggested that I would have to take two more pills and get the ultrasound."

"I went to Apollo. And I went there and asked her and she said we cannot do this for you if you don't tell your parents because I will get in trouble. Then I realised that these people and these clinics are not going to help me. I will have to find someplace else. I did not go to quacks. There was my boyfriend's friend's tutor or somebody who said I can help and I was a kid so I was like, sure. And I paid him around 5k and he did nothing about it. Finally, his relative is a doctor, so he said we can do it for you. But we can't do it in a proper hospital because then we will need your guardian. I asked them that I turned 18, why do you need a guardian so they said that in these kinds of hospitals you need a guardian because it is not appropriate. So then there was this very shady clinic. And it was a D&C or D&E, there is dilation and evacuation I guess, when they take it out. I had that and it was very bad. Nobody briefed me about what was happening.

. Before abortion, I had no idea how it works. My access to abortion was also not good. It was very shady and there was judgement. Most of my information I got from the internet."

"She was a non-Muslim doctor. So, I think that was also an advantage there because a Muslim going to Muslim doctor would again create issues. And then when we went to the doctor, we posed as a married couple. The first visit where I went alone and she was very sceptical and she was not okay with just giving me the pills. And when she saw male presence, she just stopped questioning me. She just gave the pills. She had the pills in her own office, right. I didn't even have to go to a medical or anything. Apart from that she was very chill once she saw the guy and she didn't check for my roof even though I was lying and I think going to non-Muslim doctrine wasn't as a married couple helped a lot and I think she was trying to make money. That's what it felt like."

However, there were more instances of doctors being supportive, and non-judgemental. The biases were still visible in calling the couple husband and wife without them telling so. It is also possible that women did not face and judgement when they posed as a married woman, but these experiences did not take a toll on the well-being of the women, despite the possible presence of a passive bias.

"We spoke to the doctor and she was quite nice unlike a lot of gynecologists these days. It's very difficult. But this lady was nice. I am pretty sure she knew we were not married but she called us husband and wife. We had to fill a form which he signed."

"My friend was denied abortion at several places but with me, the first clinic we went to was it. Got five tablets, three orally, two vaginally. I did not feel any judgement. It was very formal."

"I already knew about the ways and the medical things and surgical thing but I wasn't too sure. Because I was not too sure. Then I talked to the doctor and she explained me the entire thing. The doctor was very supportive. We told her we will be getting married so she suggested that why don't we wait, we can hide it for a while."

"The gynaecologist was super sweet and told us not to worry but she wanted to do an ultrasound just to be sure. She didn't have the machines at her place so she sent us to this other guy. Now again. It was a male doctor and I was worried sick about being judged for being an unmarried couple having sex. But he was sweet too and didn't make me feel uncomfortable one bit. The ultrasound guy didn't exactly charge us for it. We paid a visiting fee. Which I guess was five hundred, over which we were to pay the ultrasound bill, but he didn't take anything over the visiting fee."

"She was very understanding and she was very calm about it. And she explained everything to me. And she also kind of appreciated the fact that my fiancé was there with me through this. And so she kind of explained it to both of us not only me know, I was wondering what the fudge shapes mean and what his responsibility could be what he could see and make sure that I was doing and what I should be doing as the person was taking."

"I do realise now that more of the women would have, like, approached a doctor if they had a very less stigmatised attitude towards abortion. She was so approachable. Had she not been this sweet, emotional investment would have been way higher. If she had looked at me with judgmental eyes, she did not even look at me. Her concern was like she needs to do it because I need to get it done. That's it."

During the conversation, women mentioned some experiences that they knew of, and a few things they felt could change. These inputs help in getting a more vivid understanding of the sample, and of the experiences beyond those of the sample group.

"I think emotional acceptance and widening the understanding of the doctors and the nurses that things can go wrong and sometime people do not have things under their control. Less judgements and more inclusiveness would surely help, from everywhere."

"Most of the people are scared that people will get to know, confidentiality. Lack of awareness on where to go, we just got lucky. It is otherwise humiliating. So, the denial of abortion that pushes people into mental health issues and illegal abortions. I feel that instead of making it a taboo, people should be accepting."

The

"When you go to a healthcare place, we need to assured of the consequences. Because even if we can afford a better place, we tend to go to shadier places. Like we could have gone to any other place but we went there because one of our friends did and we knew there was no judgement there. We are more scared about judgement and confidentiality than hygiene."

The practitioners hold the power to decide the prices for the procedure. The field is so expert driven, that the providers have high power and control. Despite the fact that the prices for the pills are fixed, the practitioners, if questioned in audit, can pass it off as consultation charges, for which there is no cap. It is thus, unethical and unkind.

"My other friend told me, she was in her hometown, and she had to pay fifteen thousand and had to go to the shadiest place."

"I think the whole hiding away from the world, and trying to find a non-judgmental doctor is very difficult. No fucks are given about doctor-patient confidentiality. Even my doctor said that this is tricky and the parents come and threaten them when they come to know about it. As if the person is not going through enough already. Add more drama to it."

Another trend that was visible was choosing private practitioners over government hospitals. The reasons primarily being the poor services of the government hospital and the higher chances of being recognized and scrutinized. Despite financial crunch, the women did not

choose to go to government hospitals because of the assumption that there will be more stigma, less respect for confidentiality and lower hygiene. None of the participants visited a government hospital.

"I did not consider a government hospital because I did not want to be judged and punished. I had read of a lot of things where the doctors tend to ask you to bring your parents. And where they actually take the ownership of calling your parents. So those are the kind of stories that I read and my priority was to go to someone who was private and had a 'modern' outlook, so to speak. Because even before that, I get my yearly health check-up done and I add my gynecologist pack also and most places in Bangalore say, oh, these tests are only for married women. That is the response you get from nurses and the staff at the imaging lab. They don't even want to say anything about being sexually active, just the general information that this is for married women and I have to insist on getting it done. Even then the experience has never been pleasant."

As a professional, one of the roles of the healthcare providers is to have the best interest of the people at heart. However, with the judgment, misinformation or giving out less information, manipulation of prices and participating in creating a sense of fear in the hearts of the women, they are not doing justice to their role.
Indeed, there are professionals who have upheld the ethics of the profession and not crossed the professional boundaries. In such instances, the women tend to recover better, or have one less thing to worry about in the first place.
One participant in the research was denied abortion, and two of them reported knowing women who were denied abortion. The providers, even the ones who performed abortions, showed a bias towards the women because they were unmarried. It is as if the absolute privilege of reproductive ability, or even conception, is the prerogative of the married.

There is a difference between being a victim and being vulnerable. The participants of this research are privileged enough to not be the victims of the system, but are vulnerable. A lot of them reported not facing stigma even when there were passive signs of some. Similarly, women reported either getting no information from the doctor, which is outrageous, or getting the information. Upon asking what kind of information was provided to them, the women

gave some very basic details like side effects and what the pills do. This does make up even the basic abortion care information, lest they give information on contraception use, which ones would suit them the best and their effects and usage. The women said they received information, because perhaps, they did not know how much information should they be receiving in the first place.

NAME	COST INCURRED	ROMAL PROFESSIONAL CONSULTATTION AND FOLLOW UP		STIGMA FACED	TYPE OF ABORTION
SU	3500	Yes	No	No	Medical
M	5000	Yes	No	No	Medical
	8000	Yes		No	Medical
SO	4000	Yes	Yes	No	Medical
SH	6000	Yes	No	Passive	Medical
SN	17,000	Yes	No	Yes	Surgical
	800	No		Yes	Medical
AP	2500	Yes	No	Yes	Medical
AH	2500	No	No	Anticipated	Medical
AI	2000	No	No	Anticipated	Medical
B	4000	Yes	Yes	Passive	Medical
V	4000	Yes	Yes	No	Medical
C	9000	No	Yes	Yes	Medical
AD	10,000	Yes	No	No	Medical

EKLA CHOLO RE: TOWARDS WELL BEING AND SELF-CARE

"Routine is part of coping." (Scafaria, 2012)

The concept of after-care and professional mental health help are still very far-fetched ideas in abortion processes. Even the private abortion clinics are not equipped to provide a wholesome care to the women. Abortion in itself is a stigma that the women went through. Add to it the stigma and profiling that comes with visiting a therapist or counsellor. Mental well-being for women outside marriage seeking abortion who underwent abortions, is perhaps the most stigmatised crossover. The access to mental health care services is also not easy in terms of the cost of the sessions.

Only three out of twelve women expressed that they did feel the need to go a mental health professional. However, the need for professional care was not solely for abortions, but abortions were also a significant part of the need. The women otherwise found their own coping mechanisms in and around them.

"I did feel the need to reach out to a mental health professional. I did. I still do."

"I did go to a counsellor after 3-4 months, also because I was dealing with a lot of stuff overall. About 6-8 sessions. I did talk about this also. I think I did not realise until the sessions; she was very nice and patient, that I was angry at myself until she pointed it out. The sum total of everything I am going through, that things happen and all the blame is not on me. I don't have to punish myself for it. I wish we could have continued because it was helpful but she moved."

"I couldn't find anyone who would understand what I am feeling because most people are relieved by it. And I couldn't afford therapy, right?"

Coping strategies and the desire to cope came from within the women. They found their own ways of dealing with what they were going through. One of the common things across

all the women, which helped them cope, was time. Time and the involvement of a supportive peer group can make a lot of difference and actually increases the speed of coping.
Women reported having conversations with friends, increased productivity, books, music and mediation to help them cop.

"I did not do anything for it, because I did not feel guilty for my partner at the time. Gradually it came down. But yes, I did spend three months at home continuously. I started to meditate at that point and keeping fit, eating habit and exercising and all. Being productive in general, like reading or organising. It wasn't aimed at this but it did help a lot."

"I tell myself this. I tell myself that maybe once I'm married, I'll feel ready. That maybe I just need to be more stable and better settled in life to feel ready. I used to sing and read. I don't do that anymore. Also, I feel those were all more of an escape. I don't want to escape this. I want to be able to talk about it, to think about it. So, I speak to myself. I discuss it, I analyse it and then I get on with my work. I don't ignore it. I don't push it away. I don't bury it under music and books. I let it out because it needs to be discussed, otherwise I'll never be ready."

"Just my own mind. Because no matter how many times I talk about it or cry about it, there is nobody else in this world who will understand it the way I did. My friends are there, no doubt, they helped me through it but I went through all of it alone. The social stigma, the physical pain, the mental torture, the emotional unavailability of my partner, I went through all of it alone. And that is what I try to tell myself. It isn't the most apt thing to say but this has been an emotional milestone in my 26 years. That if you have surpassed this, there is nothing in your life that you cannot do. You are good to go. It is better sometimes. When I am upset, I can talk to my boyfriend but I try not to. A drive alone, or eating out alone, or taking myself out for coffee helps. Never felt the need to reach out to a counsellor or a professional. In a very self-sufficient space."

"My friends and talking to them. Since they were so loving and non-judgemental, I don't

think it would have mattered if I spoke to them again and again but for me it helped having a lot of people so that does not happen. Ha-ha, can illegal things be said here? I hang out with a huge stoner gang, so getting high helped. Surprisingly, the day I took the tablet, I stopped being nauseous that night. so that was nice because I could smoke up because I was in terrible pain. So that helped, emotionally and physically. I suffer from migraine as well, and trouble sleeping, but since I have started smoking up, I don't get migraines anymore. It's not even a joke. I have other friends with migraine who have had the same experience. It helped me be kinder to myself. Because all I do after being high is listen to music. It helped me be gentle. Going on a walk and sleep better."

"I have been working on being mindful about my patterns. But I don't have the courage and time to. I keep postponing my mental health work constantly"

"My coping mechanisms became very external. For one, one and a half year I was just sleeping around and doing ridiculous things with my hair. It got triggered in these three months (December, January, February). Anything to get my mind off it, looking back that is what I feel like. Then eventually when I started working, my mechanisms changed a lot. They talked a lot about 'what makes you, you?' and 'what experiences shape you' so it came on the forefront of my brain and then I was actively depressed for two years. The quality of the work that I was doing went down. My coping mechanisms were drinking and smoking up. Then eventually I started talking about it which helps. Talking helps a lot."

SAFARNAMA: THE JOURNEY OF CHANGE

"Pro-choice and pro-life activists live in different worlds, and the scope of their lives, as both adults and children, fortifies them in their belief that their own views on abortion are the more correct, the more moral, and more reasonable. When added to this is the fact that should 'the other side' win, one group of women will see the very real devaluation of their lives and life resources, it is not surprising that the abortion debate has generated so much heat and so little light." (*Abortion and the Politics of Motherhood*, 1984)

The pro-choice and pro-life debates have not been very prominent in India, especially in comparison with the west. Among the participants, a few women who reported being pro-choice before the abortions, never thought that they will choose one themselves. Other were very clearly pro-choice and did not feel hesitant in choosing abortion as an option.

"I was always very pro-choice. I don't think I ever had any other idea. I had other friends also who went through it. I am concerned with that people will do moral policing but my personal views were never against it."

"O, abortion, good, great. Pro-choice"

"My overall view and acceptance of being a feminist. I don't feel very selfish anymore. My feelings about abortion might also be because of how we have been conditioned, I haven't really put in a lot of thought about that. I don't really go back and analyse this. I am speaking to you about this after a long time. I don't know if the guilt comes from the expectations. I am not sure if I would feel differently if that wasn't the case."

"Honestly, I was always in favour of it. Because the number of kids in the world that are not being provided for and the kind of situations kids end up in. I have been reading on all of this for such a long time so that sort of influenced my decision to adopt in the first place. So,

if somebody chose to abort, I am in complete favour of that, for whatever reason."

Others were pro-life before they underwent abortions either because they felt that one should not kill a baby, because of religious teachings or simply because 'careless' people should have been more cautious. However, there was at least a slight shift in the view where the women begin to understand why it is important to have access to safe and legal abortions. They report a significant shift in their ideology regarding abortions.

"For me, I am always confused, like not confused but I can see the reason in all the arguments. So, I get it when people say that a life is a life and you should not abort it but I also feel like the life of the mother is also. I am more like your body your choice. I feel that the mother should be able to, when it is a foetus, the mother's health and everything should be a priority more than the foetus. So, I think I am pro-choice. I am from a Christian background. My family is mostly communist but we are Christian. So, we have that thing that you should not abort and I get it but ultimately, I am pro-choice. I also feel that on the other hand, unplanned pregnancies should not be, like because of that, I have seen cases that come to my mom that are like five weeks and want to abort the baby because sometimes they don't know only. But sometimes people know and then change their mind about it so in cases like that, it is sad. By the fifth month it is a living feeling creature so I am confused on that front."

"Of course, I was pro-life. And I thought that people who got abortions done were kind of the most cowardly people you could meet and killing a life is not something that you should do. But you know, when I was standing in those situations and I was in the middle of all those questions, I was thinking to myself that sometimes you have to look at things which are above you. Sometime you'd have to look for the greater good also which does not involve you. You can't only think about yourself. You have to look at the future as well."

"I used to be very judgemental about the entire thing. How are people so careless. I had certain notion. When it happened to me, my views changed drastically. Initially I was against abortions."

"I think very not okay. Because I was always like, I am going to marry and have babies. I wasn't really pro it but I generally don't condemn it for other people. Like not someone else should not do it. Like it's their choice but I wouldn't do it".

One of the participants had something to add around the whole debate and why it is important to talk about these narratives. She feels that the pro-life arguments pathologize abortions and that they are not such a big deal.

"I feel like people are pro-choice but nobody wants to talk about it. It is still a controversial topic which it shouldn't be. A lot of people were not ready to help me out because of me conceiving when I was 17, not realizing that I was desperate. That empathy, and I understand they were bound by bureaucracy, so being very idealistic, empathy needs to increase. If I were in their position, I would do it even if it is illegal. People need to stop making big deal out of abortion. It is not a big deal it is a routine surgery. And people need to stop making it so heavy and loaded. If they stop making it as heavy as the connotations it has right now, women will not be ashamed or scared to ask for it and will be able to talk about it. So even my woke liberal friends, I have seen them pity me. like aww, you poor thing. I don't want that. People make a very big deal about it. If it becomes less stigmatized, people with the pro-choice intentions will stop treating it like it is a huge life event. It is routine. This is what I would want to change."

Short term physical discomfort is a part of going through the abortion. It includes heavy bleeding, cramps, body pain, nausea, vomiting and weakness. However, four women reported long term impacts of abortion on their bodies. In three out of four responses, the change was of weight gain.

"People also say that it changes your body. I don't know. Now that I think about it, I gained around 10 kgs after my abortion. I had to work very hard to shed it. I now think it was an after-abortion body thing."

“I gained a lot of weight and I haven’t been able to shed it off. I never was thin, but I gained weight exponentially.”

“After I took the first pill, I started getting really bad cramps and started bleeding. That was the heaviest bleeding I have ever experienced in my entire life. So, it fucked up my skin for good.”

“After the abortion, I developed PCOD. I had no other symptoms except for weight gain, which also comes from abortions. I developed multiple cysts.”

In the second chapter, the emotions of the women were explored in depth around what they felt after knowing about the pregnancy and after the abortion was successful. However, some women talked about the part of those emotions that they still carry and how it does not stay limited to one aspect of their lives, but invades different aspects in different ways, and sometimes becomes an integral part of their everyday.

“The worst part of it which remains a constant reminder is the fact that you have these period tracking apps right? So, I was tracking that and I had to fill in that gap of 1-2 months where I did not have a period, and by mistake, unfortunately it showed my expected due date, which also happens to be my birthday. So now every year on my birthday, I get a reminder. I haven’t celebrated my birthday after that because it represents something else also now.”

“I want to raise kids. I feel much motherly towards them now, especially if I know they're adopted. And I just have this natural urge to protect them. I want to make them happy. Even if they meet me for a moment, I try to make them at least smile. I just don't know if I am ready to be pregnant again. But I just feel motherly and more protective towards babies nowadays.”

“Still bothers me, every day. Sometimes there are triggers when I see kids with their parents and all of that connects to me not being there with my father and not being there with my

unborn child. So that connect makes me numb. Then there is no holding back the tears. There is also this always present feeling that is there."

"I was actively depressed for two years. The quality of the work that I was doing went down."

"I started going into clinical depression. My mother has depression so I am very familiar with the symptoms and how things happen basically. I also attempted suicide. And this was one of the reasons, the feeling of guilt and failure. I came out of it, thanks to my ego."

As briefly mentioned in the subheading about the role of the partner, there was a visible change in the importance and use of contraception among the couples. The couples who has problems using contraception for various reasons also put in more effort and research to find the alternative methods that suit them. Women and couples also started paying more attention to condom breakage and spills.

"We considered other contraceptive methods because the condom was an issue but it started to affect my cycle so we decided against it. Now we have shifted to these extra-large condoms we found. So, we don't have to have unprotected sex anymore."

"We started using condoms and made sure that we always have one on us. I never ask him to have sex without a condom anymore, at least not for long."

"We just started becoming more careful about it and made sure that you know, there are no slips or mistakes. Even if there was, we made sure we did some form of precaution"

"Then I realised that I have a pattern of not using condoms and that I really should use condoms. So, the first time I had sex, I was 14. The guy I had sex with was also 16 and he had never used condoms with me, he used to pull out. So, I thought that was the way to do it. And I had become averse to the idea of condom and have sex with plastic."

The change in sexual behaviour and contraception consciousness is the most visible and consistent change amongst all women.

CONCLUSION

Despite the increase in discussion and discourse around abortions and premarital sex, in reality, the taboo still exists. We are still hesitant to talk about sex, let alone be curious about it in detail. The discourse and discussion around sex exists in small peer groups. Women are opening up more often than before in spaces that they consider safe and are also benefitting from it. However, these safe spaces are small and finite in number. They also lack the concrete formal knowledge one needs to deal with situations like abortions where information and awareness is the biggest tool that the women have.

Thus, support in form of information or safe spaces is not as easily accessible as one might need it to be. do not exist during the process of abortion When they are needed the most.

From larger systems like the legal structure, social stigmatisation and alienation and the bio-medical community to the smaller social relationships like family, friends and the partner; all become a part of the dynamics that are constantly interacting. A woman is ‘extremely lucky’ if she could go through the process without judgement, with partner support and have the financial stability. These interactions create a severe difficulty in accessing safe spaces for abortion, not only legally, but also ethically. The physical pain that the women experience during abortions cannot be helped much. However, the whole process could be made more women centric, inclusive and sensitive. This requires big strides in the direction of changing the general narrative around sex and abortion and creating wholesome spaces in abortion centres where women’s physical and mental health is taken care of.

TENTATIVE RECOMMENDATIONS FROM THE STUDY

The research can be used to emphasize on various aspects of making abortion rights more accessible for the women. It is also important to ensure that such places are free from bias judgement and become safe spaces for women. A need for a wholesome abortion practice where mental well-being and after care are also given prime importance to ensure optimum recovery.

- BETTER SEX EDUCATION PROGRAMMES

  There is a dire need of a strong sex education programme in the country. Even the most educated group of people in the country are unaware about the basics of sexual and reproductive health. Sex education from a gender lens will not only encourage safe sex, but also give women more control over their bodies and ability to exercise their rights.

- ACCESS TO GENDER SENSITIVE COUNSELLORS IN ABORTION CLINICS

  Abortion is an emotional process on varying scales due to various factors. Be it the process itself or the environment around the whole concept of abortion. It is important that the abortion clinics have a counsellor so that women have access to professional mental health services without having to worry about the financial burden of it. Presence of a gender sensitive or feminist counsellor in the clinics will also make the practitioners more aware, sensitive and professional.

- IN DEPTH RESEARCHES

  Most of the researches around abortion are around rape victims and marginalized section and are quantitative and comparative in nature. However, rich and experience-based researches are required to for the abortion laws of the country to be inclusive and right based.

- THE AMENDMENTS IN THE MTP ACT TO BE RIGHTS BASED

  The current amendments in the MTP Act are not right based and still do not give the woman the power to decide for her own body. The amendments in the act should be truly empowering in nature instead of pseudo-liberal amendments.

- AWARENESS AND SENSITISATION ABOUT PREMARITAL SEX, CONTRACEPTION AND ABORTION

  There is a dire need for an increase in awareness and dialogue around sexual and reproductive health, emphasis on relationships, comprehensive and complete knowledge of contraception and rights of individuals and access to individuals.

LIMITATIONS

- The research aimed at understanding some correlation between coping mechanisms and major life events and family structures. This was not achieved because individuals have a plethora of other factors affecting their coping.

- Coping as a whole could not be understood properly because a lot of women could not point out how and what helped them if they were under stress. It could be seen that women who did not associate with a sense of shame and guilt (internalized world view) were able to cope better with time.

- The importance of intrinsic and extrinsic coping mechanisms was not explored.

- More in-depth understanding of messaging and representation of sex and its impact was not touched upon.

- The telephonic conversations could not capture the non-verbal cues from the participants, which could have enriched the data and made it very intricate and exhaustive.

REFERENCES

Abortion." Opposing Viewpoints Online Collection. (2018). *Gale*.

Agnihotri, S. (2011, April 11). *Abortion Rights In India And The Absence Of The Pro-Life/Pro-Choice Debate.* Retrieved from Feminism in India: https://feminisminindia.com/2016/04/11/abortion-rights-india/

Agnihotri, S. (2016, April 11). *Abortion Rights In India And The Absence Of The Pro-Life/Pro-Choice Debate*. Retrieved from Feminism in India: https://feminisminindia.com/2016/04/11/abortion-rights-india/

Aida Torres, J. D. (1988). Why Do Women Have Abortions? *Family Planning Perspectives, Vol. 20, No. 4.*, 169-176.

Allen, B. D. (2014). Systems Theory. In J. Brandell, *Essentials of clinical social work* (pp. 3-20). London: Sage publications.

Amar Jesani, A. I. (1993). Abortion Scenario and Politics in India. *Economic and political weekly, vol. 28, issue no. 48*.

Amar Jesani, A. I. (1993). Women and Abortion. *Economic and political weekly*.

Amar Jesani, A. I. (1995). Abortion-Who is responsible for our rights. In A. I. Amar Jesani, *Our Lives, Our Health* (pp. 114-130). Beijing: Coordination Unit: The World Conference on Women (New Delhi, India).

Anuradha Kumar, L. H. (2009). Conceptualizing Abortion Stigma. *Culture, Health & Sexuality*.

Arijit Ghosh, N. K. (2017). A Womb of One's Own: Privacy and Reproductive Rights. *Economic and Political Weekly*, 42-43.

Atkinson, R. (2001). The life story interview. In J. F. Holstein, *Handbook of Interview Research* (pp. 121-140). Sage publications.

Crossman, A. (2020, March 19). *Understanding Purposive Sampling.* Retrieved from ThoughCo.com: https://www.thoughtco.com/purposive-sampling-3026727

Dalvia, S. (2019, November 19). *Being A Feminist Gynaecologist In The Patriarchal World Of Medicine*. Retrieved from Feminism in India: https://feminisminindia.com/2019/11/19/feminist-gynaecologist-patriarchal-medicine/

Desouza, N. (2016, July 26). *Abortion and contraception in India: the role of men*. Retrieved from Open Democracy: https://www.opendemocracy.net/en/5050/abortion-in-india-what-men-say/

Dr. Mala Ramanathan, D. P. (2004). Abortion Assessment Project – India: Summary and Key Findings. *Reproductive Health Matters*.

Elliot, J. (2005). *Using narrative in social research.* Minneapolis: Sage Publications.

Freeman, E. l. (1976, May). INFLUENCE OF PERSONALITY ATTRIBUTES ON ABORTION EXPERIENCES. *doctoral dissertation, Bryn Mawr College*.

Gerrard, M. (1977). Sex Guilt in Abortion Patients. *Journal of Consulting and Clinical Psychology*.

Gold, R. B. (2003, March 01). *Lessons from Before Roe: Will Past be Prologue?* Retrieved from GUTTMACHER INSTITUTE: https://www.guttmacher.org/gpr/2003/03/lessons-roe-will-past-be-prologue

Hessini, L. (2011, September 19). *Stigma, Shame, and Sexuality: A Reflection on Abortion*. Retrieved from RewireNews: https://rewire.news/article/2011/09/19/stigma-shame-sexualityreflection-abortion/

Hillary Kunins, A. R. (1991). ABORTION: A LEGAL AND PUBLIC HEALTH PERSPECTIVE. *Annual Review of Public Health*, 361-382.

Hirve, S. S. (2005). Abortion Law, Policy and Services in India: A Critical Review. *Reproductive Health Matters*, 114-121.

Hudson, K. (2016). Coping Complexity Model: Coping Stressors, Coping Influencing Factors, and Coping Responses. *Scientific Research Publishing*, 300-309.

Jeanne Marecek, C. M. (2017). Abortion in legal, social and healthcare contexts. *Feminism and Psychology, Sage publications*, 4-17.

Kerr, M. E. (2000). *One Family's Story: A Primer on Bowen Theory.* Washington DC: The Bowen Center for the Study of the Family. Retrieved from The Bowen Centre: https://thebowencenter.org/theory/

Khasa, S. (2017). Abortion Rights: Impact Of Current Abortion Laws On Unmarried. *A Project Report Submitted In Partial Fulfillment Of The Requirements For The Degree Of Master Of Law in Tata Institute of Social Sciences*. Mumbai, Maharashtra.

Kramer, E. (2016, December 27). *Abortion: The Parenting Decision No One Talks About*. Retrieved from Parent map: https://www.parentmap.com/article/abortion-mother-motherhood-parenting-decision

Manisha Gupte, S. B. (1999). *Women's Perspectives on the Quality of General and Reproductive Health Care: Evidence from Rural Maharashtra .* India's Family Welfare Programme .

Masci, D. (2016, June 21). *Where major religious groups stand on abortion*. Retrieved from Pewresearch.org: https://www.pewresearch.org/fact-tank/2016/06/21/where-major-religious-groups-stand-on-abortion/

McCurdy, S. A. (2016). Abortion and Public Health: Time for Another Look. *The Linarce Quarterly*, 20-25.

Melissa Stillman, J. J. (2014). *Abortion in India: A Literature Review.* Washington D.C.: Guttmacher Institute.

Menon, N. (2012, May 14). *Abortion as a feminist issue: Who decides and what?* Retrieved from firstpost: https://www.firstpost.com/living/abortion-as-a-feminist-issue-who-decides-and-what-308059.html

Moen, T. (2006). Reflections on the Narrative Research Approach. *International journal of qualitative methods*, 56-69.

NOTIFICATIONS OF CEILING PRICES OF SCHEDULED FORMULATIONS -YEAR 2014. (2014, April 28). Retrieved from NPPAINDIA: http://www.nppaindia.nic.in/en/12/12898/28/11/03/17/2019/

Parker, D. W. (2017). *Life's Work: A Moral Argument for Choice.* New York: 37 ink.

Parthasarathy, M. (2019). Integrating Mental Health perspectives into legal discourse on Reproductive justice in India. *Journal of National Law University, New Delhi*.

Parul, A. A. (2017, July 23). *Child denied abortion, mother asks: What does a 10-yr-old know*. Retrieved from Indian Express: https://indianexpress.com/article/india/child-denied-abortion-mother-asks-what-does-a-10-yr-old-know-4763037/

Patel, T. (2018). Experiencing abortion rights in India through issues of autonomy and legality: A few controversies. *Global Public Health*.

Petchesky, R. P. (1980). Reproductive Freedom: Beyond "A Woman's Right to Choose". *The University of Chicago Press*, 661-685.

Riordan, R. (2006). *Sea of monsters.* Miramax Books.

Roller, M. R. (2018). *The Meaning & Essence of qualitative research.* Retrieved from research design review: http://rollerresearch.com/MRR%20WORKING%20PAPERS/The%20Meaning%20&%20Essence%20of%20QR.pdf

Russell, B. (2014). *On education.* Routledge books.

Sapna Kedia, P. B.-W. (2018). *Exploring male engagement in premarital abortion: Perceptions and Lived Experiences of Young Women and men in New Delhi, India.* New Delhi: International Centre for Research on Women.

Saurabh. (2018, July 14). *A Critical Analysis on the Abortion Laws in India*. Retrieved from Ipleaders, intelligent legal solutions: https://blog.ipleaders.in/critiquing-indias-abortion-laws/#_ftn2

Scafaria, L. (2012, June 23). Interview with Mike Ayers, www.cnn.com. (M. Ayers, Interviewer)

Sen, R. (2016, March 14). *Maneka Gandhi tells us marital rape isn't rape after all*. Retrieved from Livemint: https://www.livemint.com/Opinion/jdWYjEBWesSGEPl7aDgMbJ/Maneka-Gandhi-tells-us-marital-rape-isnt-rape-after-all.html

Shajahan Ismail, A. S. (2015). Adolescent sex education in India: Current perspectives. *Indian Journal of Psychiatry*, 333-337.

Shireen J Jejeebhoy, S. K. (2010). Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages. *Reproductive Health Matters Vol. 18, No. 35*, 163-174.

Showkat, N. &. (2017, July). In-depth Interview. e-PG Pathshala (UGC & MHRD).

Smith, B. (1999). *Openly Bob.* Harper paperbacks.

Smith, L. (2002). Feminism and abortion politics: Choice, rights, and reproductive freedom. *Women's Studies International Forum, Vol. 25, No. 3*, 335-345.

Soumya Gupta, I. T. (2017, November 10). *Abortion comes at a steep price in India*. Retrieved from LiveMint: https://www.livemint.com/Science/a5QMsT48DwglFGzgIzIQ6H/Abortion-comes-at-a-steep-price-in-India.html

Strauss, A. L., & Corbin, J. M. (1988). Basics of Qualitative Research : Techniques and Procedures for Developing Grounded Theory. *Sage Publications*.

Summers, H. (2018, June 22). *Conscientious objection': when doctors' beliefs are a barrier to abortion*. Retrieved from The Guardian: https://www.theguardian.com/global-development/2018/jun/22/should-doctors-be-free-to-refuse-patients-an-abortion-on-personal-grounds

Usha Ram, S. M. (2010). *Youth in India: situation and needs 2006-2007.* Mumbai: International Institute for Population Sciences.

VALENTE, J. C. (n.d.). *Abortion & The Absence Of Motherhood*. Retrieved from Bust: https://bust.com/feminism/15810-abortion-the-absence-of-motherhood-bust-true-story.html

APPENDIX: INTERVIEW PROBES

PART 1: Demographics and rapport building

Rapport will be built beforehand. The subject will be informed about the research, its objectives and how the interview will proceed. They will also be made comfortable and aware of the fact that they can choose to not answer or end the interview at any point.

- Are you comfortable and willing to talk about your experiences?
- Name, age, education, family composition
- Native place, religion, socio-economic background (if comfortable)

PART 2: The process of abortion

A. Knowledge of pregnancy

- How much time has passed since you have had an abortion?
- How and when did you come to know about your pregnancy?
- What were your initial feelings?
- Who was the first person you went to?

B. Decision to abort

- Was were the different options you considered upon knowing about pregnancy? What were the factors that influenced the decision to abort?
- Involvement of partner in decision making

1) 1.Did he accompany?
2) 2.Did he have a say?
3) 3.Did he share the cost?
4) 4.Effects on the relationship after

C. Going through with the process

- Walk me through the process?
- What knowledge did you have about the procedure?
- How easy was your access to having an abortion?
- Where was your information source?
- How did you manage the financial cost involved?
- Time taken in the process.

D. Support systems, coping and impact

- Who according to you were the people you could rely on for help in this regard?
- Relationship with parents, other family members and peers (impact)
- Relationship with partner (the dynamics of the relationship apart from the process)
- What made you confide in some people and not in others?
- What did you feel after the abortion?
- Did you feel the need to reach out to professional mental health care? (in case the subject reports a lot of negative emotions)
- What were the other things or methods that helped you cope?
- Life events

  1.Exposure to sex education (school and parents)

  2.Were there any turning points in your life that you recall?

  3.Any events apart from these that had an impact on you?

- What were your views about abortion before you went through it?
- What do you think has to change to make the process more inclusive, easier and accessible?