QUALITY OF CARE AND ACCESSIBILITY TO ABORTION: A STUDY OF DOCTORS IN WEST BENGAL

Submitted By

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DECLARATION

I, Srabastee De Bhaumik, hereby declare that this dissertation entitled "Quality of Care and Accessibility to Abortion: A Study of Doctors in West Bengal" is the outcome of my own study undertaken with the guidance of Dr. Smitha Nair, Assistant Professor, 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 any other institute or university. I have duly acknowledged all the sources used by me in the preparation of this dissertation.

Date: 22 March 2019

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CERTIFICATE

This is to certify that the dissertation entitled "Quality of Care and Accessibility to Abortion: A Study of Doctors in West Bengal" is the record of the original work done by Srabastee De Bhaumik under my guidance. The results of the research presented in this dissertation have not previously formed the basis for the award of any degree, diploma, or certificate of this or any other university.

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Abstract

This qualitative exploratory research aimed to study abortions in five districts of West Bengal. It is a study on doctors performing abortions, their standpoints, challenges, and experiences, and how it influences the procedure and services offered to women seeking abortion. It also attempts to study how the current scenario around accessibility to abortion and quality of care is, along with the different challenges the doctors face in the field. This study shows that the doctors interviewed have a limited understanding of reproductive rights, and most have a moralistic outlook on abortion. Class bias runs deep, and bias against Muslims is also very prevalent. These viewpoints lead some doctors to refuse some patients on the basis of their reasons to seek abortion, that can lead these women to seek help from unqualified service providers, risking their health and wellbeing. The study also shows that women have limited access to contraception due to social bias and stigma, and abortion is treated as a family planning method. Many women seek abortion due to rampant domestic violence.

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Chapter 1 : Introduction

Reproductive rights began to be discussed in the UN since 1968 with Proclamation of Tehran. Under this, every individual has the right to reproduce, decide the number and spacing of the children, and pregnant individuals have the right to safe abortion. An abortion is the removal of a foetus or an embryo from the uterus before it can survive on its own. A spontaneous abortion is also known as miscarriage. However, abortion has given rise to a moral debate about right to life of a fetus versus right of the mother over her own body, and who should have a right to abort, and when. In the Indian context, abortion also entails and is sometimes a result of economic challenges, social taboos, and violation of reproductive rights. Women are forced to have intercourse without contraception because of the men's unwillingness, religious reasons, or lack of awareness that stems from the taboos around contraception use. The study is a qualitative study, exploratory and descriptive in nature.

This research is designed to study abortions from the perspective of doctors providing the service. Doctors hold a powerful position in making this service accessible to women and play a crucial role in selection and execution of procedures. Current laws on abortion gives doctors total control on the procedure making it mandatory for them to consent (one registered doctor before 12 weeks of pregnancy, two registered doctors from 12 weeks to 20 weeks of pregnancy). Therefore, the whole practise of abortion is controlled by the doctors upto a great extent, and their role is vital in letting women practise their right to safe abortion. This study is conducted in 5 districts of West Bengal: Howrah, Hooghly, North 24 Parganas, South 24 Parganas, and Kolkata. West Bengal ranks quite high in maternal mortality rate (233 out of 100000 live births) whereas the same in India was 178 out of 100000 live births (Bhadra et al, 2019). West Bengal has less than 15% of unmet contraceptive needs (Stillman et al, 2014), however, abortion rates in the above mentioned districts have quite high rates of abortion compared to the rest of the state (3.8% in 2013-14). The reported abortion rates in 2013-14 for the districts of Howrah, Hooghly, North 24 Parganas, South 24 Parganas and Kolkata are 8.5%, 2.6%, 10.6%, 3.5%, and 13.1% respectively. (Johnston, 2014). However, there is little discussion on the phenomenon in the state, and there is a silence around the issue. Women seeking abortion and service providers

providing with related services want to maintain the silence on the matter for fear of being tabooed or face legal consequences. This research aims to address the issue of abortion from the lens of doctors who provide the service.

Chapter 2: Literature Review

Reproductive rights and reproductive health

The concept of women's reproductive health was developed by WHO (International Conference on Population Development, 1994), international women's health movements, and international family planning networks with an emphasis on social as opposed to biomedical approaches to women's health. Reproductive health is reformulated at the International Conference on Population and Development (1994) is defined as "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex and that they have the capacity to reproduce and the freedom to decide if, when, and how often to do so."

Women's Global Network for Reproductive Rights (1993), at reinforcing Reproductive Rights Conference (Madras, 1993) came up with the idea that "Concepts of reproductive rights range from a narrow to a broadly defined focus and working area, from concerns purely related to fertility to all aspects of reproductive health and sexuality and from access/provision orientation (quality care, broadening choice) to questioning the dominant development model and campaigning for transformation of the very conditions which disempower women."

Abortion as a reproductive right

As pointed out by Pillai and Wang (2001), reproductive health and access to basic human rights like reproductive rights can be studied with the help of two dimensional indicators, one indicating marital rights and the other indicating abortion rights of women. As indicated by Moodley (1994), Marwah and Sarojini N. (2011), reproductive rights and access to reproductive health is a political issue to be understood as constituted in through a range of structures and processes, affected by power relationships. Hence, when we study developing countries with the above indicators, we get a clear spectrum of countries which either give only one dimensional rights (i.e. only marital rights or only abortion rights) or no right at all. Hence, it is critical that

we study the conditions of countries like India in order to improve the condition of reproductive rights there, since it is a neglected area.

Berner (1990) says that reproductive rights is about separating sexuality from reproduction. Understanding sexuality and deconstructing women's sexuality's image as something to be ashamed of may be liberating for women, as they will be able to express more freely and become "full human beings", although they will become easier targets for abuse ("corrective" rape of lesbians can be an example). However, power, resources, and awareness are yet to be given to many women in developing countries so that they can make their own choices. This calls for a change in policy at the international level. However, discussing reproductive rights and health can not be considered without discussing reproductive technologies. As Marwah and Sarojini N (2011) state, Assisted Reproductive Technologies (ARTS) is commodifying reproduction in India and promoting medical tourism for surgery, thus objectifying the female body. However, it had to be studied in the light of the taboo placed on infertile women. They also bring forth the differences between the rich and the poor while accessing reproductive healthcare, and the expensive ARTS. However, they raise a question: ARTS gives rise to casteism, sexism, and ableism, but so does right to abort. So, does the right to abort in India necessarily mean progress? When we discuss women not having children, we tend to ignore certain things. As Steinbock (1994) points out, is it okay to conduct involuntary sterilisation on mentally ill women? Do they have right to reproduce, although they cannot rear a child? Although she says that it is completely ethical and perhaps better to make them permanently sterile than to restrict those patients capable of giving consent to sex but incapable of child rearing from having sexual relationships, it raises a question about effective birth control and population control methods. As pointed out by Harper (1995) contraceptive methods can be racist and imperialist, and even potentially harmful. Although Harper argues that women should have the right to abort, as pointed earlier, and supported by Patel (2007), it can give rise to sex selective abortion, ableism, etc in developing countries in India, which Patel discusses in her discussion about NRTs. Although prevention of NRT and abortion may give rise to the number of girls born, it does nothing to stop infanticide and domestic violence on the mother. Previously, all studies mentioned above only provided a birds' eye view of the problem. However, for the first time Sen and Snow (1994), Patel and Turmen (2000), discuss in depth, the cultural context of the issue. In

an era when doctors and midwives are influencing the patients to “choose” to medicalise their births, as pointed out by Johanson, Newburn and MacFarlane (2000), it is important that we study the context and effect of the abortion laws in India in the current scenario and devise a way to provide choice-based and safer motherhood.

Indian laws on abortion

The Medical Termination of Pregnancy Act (1971) states that:

“Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,-

(a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is,

or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are of opinion, formed in good faith, that,-

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury physical or mental health ;

or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1.-Where any, pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.-Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.
(b) Save as otherwise provided in C1.(a), no pregnancy shall be terminated except with the consent of the pregnant woman." However, it was amended in 2017 and stated that, "The Sub-section (2) of Section 3 of the Medical Termination of Pregnancy Act, 1971, allows the abortion of terminally ill foetuses upto twenty weeks pregnancy. During the intervening period after the Act was enforced, several genuine cases have come up where the fact of foetuses with serious risk of abnormalities with grave risk to physical and mental risk to mother had been noticed after twenty weeks. As a result, many women were forced to move the Supreme Court for permission to end pregnancy beyond twenty weeks, leading to lot of mental and financial hardship to such pregnant women. The Bill intends to extend the permissible period for abortion from twenty weeks to twenty four weeks if doctors believe the pregnancy involves a substantial risk to the mother or the child or if there are substantial fetal abnormalities. The Bill also intends to amend the provisions of sub-section (3) of section (6) relating to laying of rules before each House of Parliament and their notification etc. by the House."

Keeping these in mind, we can see the available literature on MTP. It has a few deficits. Some portions may be misconstrued to deny abortion without spousal consent, or to unmarried women, and doctors take advantage of it by asking for bribes/charging extra, or use their bias by insisting that they bring along their spouses/relatives. Private centres need more infrastructural capability than government ones, and hence are a more favourable choice than government ones. Private healthcare being low in rural areas, access to good quality abortion services in lower in rural areas, especially in the eastern states of India. MTP Act also comes in a tussle with DNTP Act. However, criminalising abortion is not a solution. A comparative study on laws of different countries shows that abortion being criminalised only increases the number of unwanted children, people with ill-health, and criminalises women who had no other choice or the money to access safe abortion under the guise of induced miscarriage, and the law can be used against women even in cases of genuine miscarriages. However legalising abortion and increasing knowledge about contraception brings down the number of abortion cases and we can have a healthier population. DNTP Act needs to be enforced more strictly. Unmarried women in India

are not being brought under family planning programmes and do not have the sufficient knowledge to detect pregnancy, and hence end up with late abortions that are more risky. Also, only allopathic doctors are licensed, but there is a need to license mid-level service providers as well. Also, the process of registration is complicated and lengthy. (Hirve et al, 2004).

In 2007, the Supreme Court, while hearing an appeal on the Ghosh vs Ghosh divorce case ruled that vasectomy, tubectomy, or abortion without the partner's consent amounts to mental cruelty. This ruling denied abortion the status of an absolute right and came in conflict with existing laws, giving rise to more confusion among service providers and abortion seekers alike (Rajalakshmi, 2007).

Most of the present literature does not discuss firsthand experiences of abortion in developing countries like India and itis important that we bring it forward in the current context, given that most data is fairly old.

Abortion as a choice

Main reasons for abortion in order are: contraceptive failure , though Gupte et al (1997) suggest that these are mostly cases of using no contraception, women only try to cover the matter by lying, delaying first birth due to career/educational reasons, incest/rape, abandonment by partner, pregnancy outside wedlock, family coercion (including outside wedlock, father not ready and sex selective abortion), survival strategy (mainly sex selective abortion). Many also face lack of family support in continuing with pregnancy, or attaining abortion.

Researchers have time and again felt the need of more research on maternity health, morbidity, and related issues, quality of care in all aspects of reproductive health, women's ability to exercise reproductive choices, and abortion and infertility. (Jeejeebhoy, 1999)

In most cases women are not aware of their reproductive rights, and it is more difficult to reach out to them because many are illiterate/have no access to reading material. Hence, male family members have to be targeted with pamphlets by health workers, which complicates the process. This also makes them a better target for duping and harassment. Women have a lack of

knowledge and sometimes even a fear about contraceptives, because of which they do not agree to access them in many cases (post abortion) and many change their mind even after initially accepting (Rao et al, 1977).

Infrastructural deficits and social taboos enhance women's problems by forcing them to make do with poor quality equipments and no painkillers (so that they do not become drowsy, and avoid attention). Although government promotes Manual Vacuum Aspiration, Dilation and Curettage is pretty common, giving rise to further complications. Women also in most cases try "home remedies" before coming to a clinic, which increases their risk of death. Their choice of clinic also depends on social taboos and family approval (unmarried women travel far, married women with family supported visit the closest one, or women from communities where abortion is a taboo go to clinics that provide fast and quality service within a few hours, etc) (Mishra, 2001).

Therefore, the question arises, how many women freely choose abortion equipped with information, agency and material resources, and can execute their free choice? It can be further discussed in the following sections.

Bias of service providers and its effect on the women's lives

Doctors have a strong bias against rural women, especially unmarried ones. Rural women hence avoid going to legal practitioners more than urban women. In the urban sector there is a similar bias against the poorer and lesser educated, which reflects in the attitude. Unmarried women in both cases are ostracised by both doctors and family. The younger the woman is, the lesser choice she has with respect to abortion. However, a few papers also suggest that most women make the choice themselves, and this point requires further study. However, legally, the doctor has the final say, which can sometimes be used to deny services to clients. (Ganatra et al, 2002). Many doctors do not believe that women should be given a choice regarding the procedure, because they might not make a choice suitable to their needs. However, most doctors surveyed insisted that they discussed the choices with the patients prior to deciding. (Visaria et al 2008)

A study was done in Vellore, India on women undergoing abortion and the role of service providers in it. It was found that most women used induced abortion as a family planning and

child spacing method, instead of contraceptives, due to the social stigma attached, and lack of accessible healthcare. 40% of the women were forced to undergo abortion by in laws or due to situational crisis like being abandoned by the husband. The study suggests that the regulations laid down by the MTP Act has further complicated the situation, by excluding local healthcare professionals and forcing the women to travel far to reach a licensed service provider who agreed to go through with the process. The author suggests that as the women preferred to go to local professionals who could do the job with limited amount of social stigma attached, it would be better to give these practitioners adequate training to help these women. Most women and local practitioners did not even know that induced abortion was legal in India upto a specific period of pregnancy, and suffered from unnecessary anxiety of doing something illegal. (Varkey et al, 2000)

The situation is not present in India alone. A study of abortion laws in Indonesia painted a similar picture. In Indonesia, women's health, reproductive health, and maternal health mean one and the same thing. There are also high notions of morality attached to the practices. It is legally forbidden to provide reproductive healthcare services to unwed women. Practitioners too have a moralistic attitude towards unwed women who seek reproductive healthcare, especially induced abortion. All doctors hold the view that abortions and related consequences for an unmarried woman is the consequence for the sin of having premarital sex. They add to the shame, humiliation, and difficulty in obtaining abortions for unwed women by taking advantage of the situation and charging exorbitant amounts for the procedure. The study also questions the credibility of these doctors, because one of the women had to get abortions twice in a month at the cost of 300000 rupiah that gave rise to a myriad of health problems for her. The doctor however held married women with children in a very high esteem, as they thought that for a married woman her family comes first before a new baby she might have, and those who sacrifice in order to maintain a balance in their small families are to be applauded. However, unmarried women do not really have the luxury of choice when they are abandoned by their partners or ostracised by the society. (Bennett, 2001).

In both countries, condoms or other contraceptives are believed to cause a myriad of health problems, and only to be worn by sex workers or in any relationship outside marriage where there is a possibility to get STDs. Therefore, women refrain from buying these products, and

depend solely on the will of the men to buy and use such products, making abortion the only way of avoiding pregnancies for them (Gupte et al, 1997).

Government regulations and their failure

In many cases government shows poor regulation in abortion service, and most laws do not come into practice. Sometimes the states put in unnecessary measures that limit rather than promote accessibility to abortion service. In some cases, doctors are forced to prescribe contraceptives against the woman's choice in order to achieve the population goal. (Pisal et al, 1997)

Medical abortion drugs are available over the counter, which should not be. Many drug store owners are recommending it to customers and even selling them without referring the customer to a licensed practitioner or being fully informed themselves, and women are falling prey to side effects. Doctors deny knowledge of this practice. Sometimes doctors prescribe drugs based on commission and effectiveness, rather than legal issues or complete well being of the patient. However, many doctors consider the patients' health, economic condition, etc before suggesting. Although surgical procedure is cheaper, many patients prefer medical abortion because it is less invasive.(Visaria et al, 2008)

A view of other countries

A study done in Zambia (Freeman et al, 2013) suggests that Termination of Pregnancy Act (1972) permits abortions in Zambia under a variety of circumstances. Both government and private practitioners offer safe abortions at registered centres across the country. However women are still forced to access unsafe methods, due to which abortion amounts to 30% of the country's maternal mortality rate and 50% of reproductive health related hospitalisation. This is mainly due to the role of important male figures in the pregnancy. Decisions regarding unsafe abortion are usually taken by women who faced partner abandonment, or being disowned by their fathers/other paternal figures. There were also women whose fertility and mobility were controlled by their husbands, that led them to hide the pregnancy and access unsafe abortion. On the other hand, women in non abusive relationships, or those who were financially secure could openly discuss with their partners or paternal figures, and access safe abortion with their positive influence. Although the researchers acknowledge that they did not interview the men directly or

did not discuss the issue with service providers, they feel that abortion policies should hold men in accountable positions, instead of just portraying it as a women's issue.

Steinfield (2015) discusses abortion laws in Israel. In Israel abortion is supposed to be highly available, but legally restricted to a great extent. A minor does not need parental consent, and abortion is legal upto gestation. The state pays for a large number of legal abortions, but 40000 illegal abortions are performed every year. She states that in order to get an abortion, a woman has to qualify for either of the following: i) Age below 18 or over 40, ii) Pregnancy caused by rape, incest, or relationship outside marriage, iii) the mother or the child have risks of developing physical or mental defect, iv) The pregnancy might endanger the life of the mother. Even if the woman meets the criteria, she will have to be approved by a board of two doctors and one social worker, one of whom has to be a woman. She discusses the historicity of the law. Israel started its journey as an independent country with the British era law (Penal Code of 1936) that permitted only medically necessary abortion. Although activists time and again suggested relaxation of rules, popular state policy was to consider people's health (lower rate of childbirth) and maternal health (that included increased rate of infertility after abortion). This approach came from 3 main reasons: the religious urge to fulfill the biblical commandment to be "fruitful and multiply", to replace the Jews killed in Holocaust, and to maintain a Jewish majority in a country that saw a boom in birth rate of Muslims over that of Jews, scaring political leaders because they would not be a Jewish majority state anymore. This became a both pro natalist and anti natalist approach, where fetuses with disabilities were encouraged to be aborted to promote a stronger Jewish population, and all other pregnancies were encouraged. Many leaders suggested that there should be a specific minimum number of offsprings stipulated by the state for every fertile couple, failure to meet which should result in moral condemnation, for failing the Jewish community. The leaders called for execution of all doctors who practised abortion. However, recently, there have been talks of making abortion laws more inclusive, and making women's bodies less policed by the state.

In Australia (Ackland, Evans, 2005-2015) abortion is legal since the 1970s, although various provinces have different provisions, giving rise to discrepancies. A study on the web activity showed the social trends among Australians, based on internet activity. In 2005, before abortion

related drugs were legalised, abortion remained a social and policy level issue, with equal prominence of pro-life and pro-choice groups. With gradual commercialisation and introduction of regulated drugs, abortion became a more pharmaceutical and commercial topic of discussion, and pro-life groups are on the decline, whereas pro choice groups are on the rise.

Debates on abortion

When we look at the abortion laws around the globe, we can detect several debates (Oomman, Ganatra, 2002): i)Abortion being believed to be equivalent to murder and being a sin vs abortion as an essential reproductive and family planning right of women, ii)Rights of the father vs right over one's own body, iii) Abortion being ableist and sexist because of the prevalence of disabled and female foeticide. The debates are unanswerable at the moment because of the different aspects it has. While many argue that once a life is formed, it should be considered a valid human being, others say that an embryo or a foetus is a parasitic structure that depends on the fully developed human body of the mother for nutrition, therefore, the mother has a right to life with dignity more than the right of the foetus to life, which will begin only at birth. Men too, cannot force another human being to carry his child to term if it has the potential to damage her quality of life. Therefore, women, however sexist or ableist it might sound, should have the right to end a pregnancy on the basis of abilities or sex of the child, if it can put her own quality of life at risk. Studies show that banning abortions has never been able to stop malpractices such as sex selection, women are often tortured when they give birth to girls or disabled children, due to the inaccessibility of such services. Instead, the author suggests that structural inequalities in the society should be done away with, so that mothers of girls or disabled children can access all resources in an equitable manner, that will eliminate the reason for her to terminate pregnancy totally.

Situation in West Bengal

West Bengal ranks quite low with respect to reproductive health, however little or no research has been done in this area, especially with regards to abortion. Although several authors think that it is necessary to study eastern states, only Jharkhand has been studied to a great extent, and Bihar comes quite close (other states massively studied are Tamil Nadu, Maharashtra, Rajasthan, Punjab, Haryana, Mizoram, etc). Only Jharkhand's medical service providers and clients have

been studied in both objective and subjective manners, something that needs to be done in West Bengal. (Times of India Nov. 1, 2015, Kolkata, Jha et al, 2010).

Doctor patient relationship

Buetow et al (2001) argues power is an element in all kinds of relationship, and a doctor patient relationship is no different. A doctor needs power to provide information to patients and carry out procedures for their betterment. No patient would like a doctor that is powerless. Doctor patient relationships can often become paternalistic (parent-infant or parent adolescent) or doctor as agents to carry out patient's preferences (adult-adult relationship with patients as the consumer). In a paternalistic relationship, a patient is supposed to either obey a doctor or cooperate with the doctor. The doctor is supposed to be responsible for the patient, unlike in an adult-adult relationship where the doctor is responsible to the patient. Sometimes a doctor is entrusted with dual responsibility of prioritising the patient's health along with the community health. This becomes a problem during mass public health programmes such as vaccination, whereas the doctor does not do anything for an individual patient, but for the community as a whole. However, doctors are not trained to form bonds with their patients outside the time for medical procedures, which makes them out of touch with the patient's reality. Each patient's experience of a certain physical condition is different, but doctors treat everybody the same way, expecting similar cooperation from anybody, without enquiring about the patients' lifestyles (Santos, 2014). A study done in UK (Nimmon et al, 2016) suggests that due to this inability to relate to the patients, doctors, most of whom are aware of the power they hold, misdirect it into a moralistic and paternalistic relationship without knowing what else to do. The researchers suggest that doctors should be given proper training in order to channelise this. However, doctor-patient relationship is evolving, and patient-centred care is taking over paternalistic relationships in the medical world (Kaba et al, 2007). However, that is only in the case of not so sensitive medical issues in the western world. When it comes to sensitive issues like HIV/AIDS, a study done in the USA (Sullivan et al, 2000) shows that patients are more comfortable with doctors of the same sex, and patients' perception of empathy in the doctor directly related to satisfaction with the quality of care. However, researchers admit that there was no study of the power relation between doctors and patients, or a scale to judge patients' satisfaction other than their own words, which can be problematic, because the concept of satisfaction is very subjective. A

study of leprosy patients in Brazil (Teasdale et al, 2015) shows that majority of leprosy patients were underinformed by the doctors, due to which they did not feel comfortable asking the doctors further questions regarding prevention, cure, or the whole treatment in general, which resulted in a poor quality of care. Doctors in this case used their power and moral standards to withhold information from the patients that led to poor quality of the patients' lives. There has not been much writing with relation to doctor patient relationship on abortion except in the USA (Wood et al, 1978) which is also too old to be applicable in present day India. The paper suggests that abortion laws in the country in 1978 gave too much power to doctors to control the process of abortion, and not enough to the parents of the foetus. The laws were doctor centric, it harmed not only the parents, but also the children who were not aborted on the doctors' discretion. The authors suggested more emphasis to be given on doctors' medical knowledge and patients' decision making, rather than giving the sole power of decision making to the doctors, as was the ground reality, despite the court claiming that doctors took decision by consulting with the patients. This hampered women's bodily autonomy as well. No literature of a similar nature, i.e. relating to doctor-patient relationship around abortion in India can be found. However, as doctors hold complete power over patients in such a sensitive issue, it is really important to study doctors' perception of abortion in present day India.

Chapter 3: Methodology

Rationale

As can be seen from the literature review, a doctor's point of view is the most powerful factor in the process of abortion. The doctor's knowledge, experiences and biases shape the whole experience of abortion and influences the choice of the women seeking intervention. In many cases, the doctors are powerful enough to use the legal system and its loopholes to wield power over women's bodies, like influencing or denying abortions, or in the choice of methods. As mentioned above, West Bengal ranks as one of the worst states in terms of reproductive healthcare. With debates arising all over the globe, it is necessary to study the rapidly urbanising areas of the state that has not been studied before, to understand how the present scenario is playing out for women undergoing abortions. Therefore, it is necessary to study the voices of doctors in such areas.

Framework

According to the United Nations, reproductive rights for a woman entitles her to decide whether or not to reproduce, how many children to give birth to, spacing between children, and access to safe and consensual abortion. However, in a country like India, in spite of the presence of MTP Act passed in 1972, women may still be unable to access safe abortion as a right, as doctors hold most of the power in the whole process. According to the MTP Act, a woman needs the consent of one registered doctor upto 12 weeks, and then of two registered doctors upto 20 weeks of the pregnancy in order to get an abortion, in a government approved registered clinic. Being denied abortion in a safe environment can lead the women to unregistered professionals, that threatens their quality of life. Other than this, social taboo also prevents women from accessing abortion, even though they are legally entitled to it. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1981) was the first international treaty to eliminate all forms of discrimination against women. Therefore denying women medical procedures like the medical termination of pregnancy is an infringement of their rights as it is denying her quality of life and healthcare services simply for being a woman.It is considered a human right violation (Braam et al, 2004).

Research objectives

1. To look at different experiences, challenges, and ethical concerns that doctors face when performing abortions.
2. To understand how a doctor can influence the procedure of abortion.
3. To look at ways in which the current scenario around abortion can improve in terms of accessibility and quality of care.

Research questions

1. What is the personal stand of service providers regarding the issue?
2. How does the personal stand influence the practice?
3. To what extent are doctors aware of legal requirements?
4. To what extent are women allowed the agency to choose required medical procedures?
5. What kind of challenges do doctors face while performing abortions?
6. What can be done about said challenges?

Research design

This research is a qualitative study. A qualitative study focuses on having an in depth understanding of a social phenomenon and studies experiences of human beings as individuals holding agency over their lives. It is exploratory because this particular area has not been studied earlier. Therefore this research aims to develop priorities and a functional research design as well. The research was revolves around describing the characteristics of the phenomenon of abortion, and hence can be termed as descriptive research.

Sampling method

Snowball sampling method was used in this study. It is a sampling method where participants in a research study recruit other participants in the same study. This method is employed when there are difficulties in finding participants. As evident from the literature review, many clinics still do not have proper registration due to legal problems and the “red tape”. Hence it will be easier to reach out to service providers through snowball sampling.

Unit of analysis

The sampling units are doctors performing abortions from Howrah, Hooghly, North 24 Parganas, South 24 Parganas, and Kolkata districts of West Bengal.

Sample size

Through snowball sampling, one doctor from rural sector, one from peri-urban, and one doctor from urban sector from each district were selected for the study (except for Kolkata, from where only one doctor was selected). One doctor, from South 24 Parganas urban area, participated in the study by sharing experiences, but refused a full in depth interview. Therefore, the sample size is 14.

Area of data collection

The region selected forms the early jute mill belt of the state, and are neighbouring districts. The region is very close to Bangladesh and some areas visited are border areas. The registered service providers approached in this region practised in different types of set ups. Urban areas were populated with large scale multispeciality private hospitals (mainly accessible by the upper class only), private small scale nursing homes accessible by the lower middle class, government hospitals mainly accessed by working class individuals, and charity hospitals that are also visited mainly by working class individuals. Peri urban areas have small scale private nursing homes, charity hospitals and government hospitals. Rural areas have only charity and government hospitals. Other than this, in urban areas, there are personal private clinics run by doctors themselves or by larger hospital chains. Some of the personal clinics are unregistered.

Tools

The tool, an in depth interview was designed to include the variety of setups mentioned, and the services (along with cost) offered by them. The interview guide also aimed to address the diversity in standpoints that may arise due to age, sex or religious orientation of a practitioner.

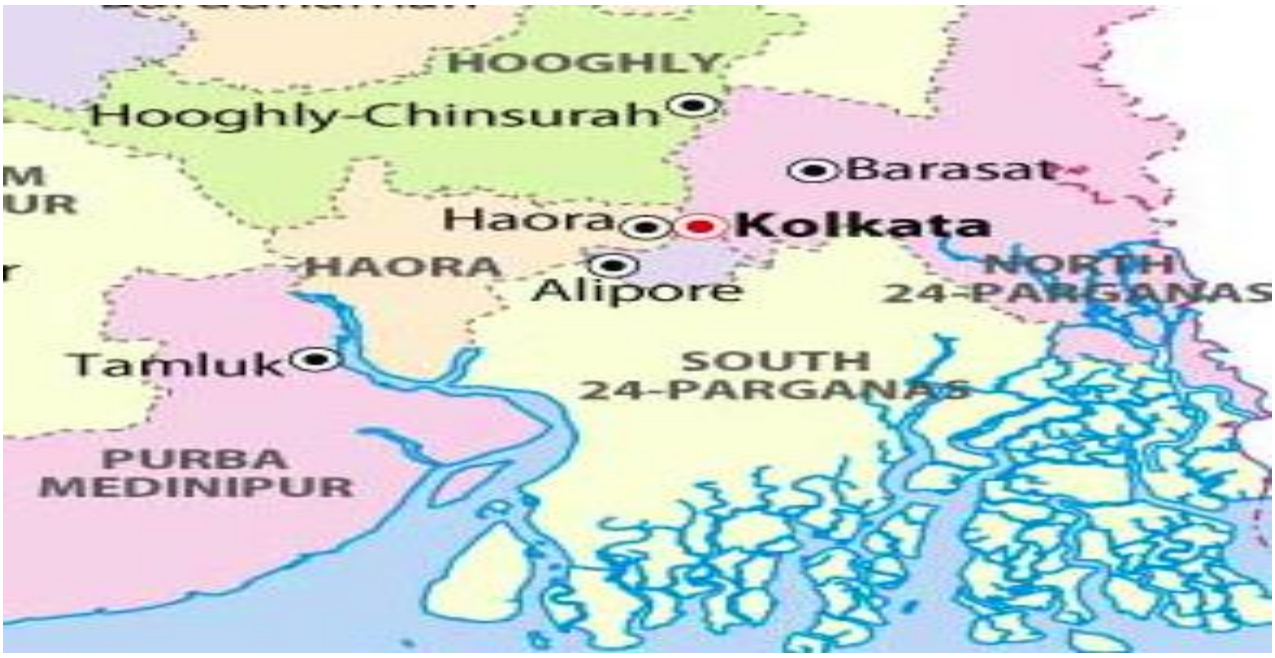

Image 1: A map of Kolkata, Howrah, Hooghly, North 24 Parganas, South 24 Parganas

Ethical concerns

1. The researcher conducted the research with informed consent from the respondents, and will maintain confidentiality.
2. The researcher did not indulge in acts of plagiarism, and proper references have been mentioned.
3. The researcher respected personal boundaries and did not create pressure for obtaining information. All data collected were from voluntary responses only.

Limitations and challenges

The study was conducted in five districts, therefore a considerable time had to be spent locating respondents and travelling, giving rise to time constraints. Some clinics were not registered, therefore many doctors gave telephonic interviews, or refused to talk altogether. One doctor backed out in the middle of an interview, and two doctors sent written responses. Abortion being a sensitive topic, some information was withheld by some doctors. All these resulted in difficulty in data collection.

Chapter 4: Findings, Analysis, Discussion

4.1: Power Structures Operating Behind Abortion Services

According to the literature review there are various power structures at play behind the situation around abortion in India. They are as follows:

Patriarchy

Patriarchy is combination of practices, beliefs, cultures, and institutions (legal or otherwise) that violates and discriminates against anything feminine or related to women. Understanding patriarchal power lies at the core of understanding abortion. Masculinity is seen as the norm and the world is shaped by men's definitions and experiences. Therefore women specific social or other needs are considered secondary. The development process often omits women specific services like reproductive healthcare because it is not vital in men's lives. Therefore, by extension, women's need to access safe abortion care is not considered a priority, or as important as traditional development needs such as illiteracy or poverty. Abortion is also labelled morally wrong by religious texts primarily composed by men. Abortion is also seen as a sensitive issue as it challenges women's traditional role in childbearing and child rearing. Therefore, the issue is often ignored by policy makers as well, as its full significance is not comprehended.

Gender discrimination in public life

Women are discriminated against through wage gap, inadequate policies, religious customs, etc. Policies do not address unwanted pregnancies through coercion or rape, or a woman's inability to provide for an unwanted child. Policy makers use abortion as a vote bank tactic and treat it as a volatile subject. Therefore, women's human rights are neglected.

Legal systems

Legal systems are an extremely important power structure in legitimising access to safe abortion. Indian laws allow abortion in certain cases (contraceptive failure, health risk for the mother or the child, etc) upto 12 weeks with the consent of one doctor and upto 20 weeks with the consent of 2 doctors. Sex determination and sex selective abortion is banned. Although it gives female foetuses right to life, the law gives others (i.e. doctors) complete control over women's bodies.

Therefore, the abortion laws are restrictive. Abortion without spousal consent also amounts to mental cruelty, according to the Supreme Court ruling of 2007. Therefore, abortion is not an absolute right in India. Marital rape not being criminal, married women sometimes end up with unwanted pregnancies. The legal systems also make it difficult to register a service clinic, so many abortions are carried out illegally.

Doctor patient relationship

The doctor patient relationship in India is a patriarchal relationship where the doctor has complete control over the patient's body. The doctor patient relationship is similar to a parent child relationship where the doctor makes all the decisions and the patients comply. The doctors being a part of the same social fabric, they judge the process of abortion in a similarly patriarchal fashion as another common person, and this view affects women's lives by denying them access to safe abortion, since, according to law, doctors are the ultimate decision makers in the matter.

Religion and culture

Most institutionalised religions in the region (Islam and various sects of Hinduism) are highly patriarchal. Abortion or contraception goes against religious dictums of married women being mothers and unmarried women being virgins. Culture also plays an important role, where a woman is shamed for buying contraceptives on her own. Men assume no responsibility for their actions, and have unprotected sex at their will, which women cannot report. Premarital pregnancy is a taboo and inevitably results in abortion. The culture has son preference, therefore sex selective abortion goes on behind closed doors.

Infrastructure

Women often have to travel long distances to avoid taboo, or access quality care. Cheaper hospitals are overrun with patients and have no space or time for one on one quality care. Doctors are overworked. Private hospitals are very expensive and are present only in urban areas. Therefore, it is out of reach for many women.

The Market for Abortificants

Often unregulated medicines for abortions are available over the counter without prescriptions. Many women, when turned away by doctors, or when trying to hide the pregnancy, access these medicines. These can cause severe damages. Government regulations are not stringent enough to control it. The media platforms also advertise them as good quality solutions. These abortificants can cause incomplete abortion, heavy bleeding, infertility, or even death.

4.2: Demographics of Setup

Profile of respondents:

Table 1: Details about the respondents- their location (urban, rural or peri urban), age, sex, religion and caste, and set up of practice.

Serial no.	Region	Age	Sex	Religion	Set up
1	Urban	45	Female	Hindu general	Upscale private hospital (accessed by upper class patients)
2	Urban	27	Female	Hindu general	Government hospital
3	Peri urban	40	Female	Muslim Sunni	Own clinic, private hospital
4	Urban	39	Male	Hindu Brahmin	Private nursing home
5	Urban	62	Female	Hindu Brahmin	Low scale private nursing home (accessed by middle and working class patients)

6	Peri urban	30	Male	Hindu SC	Low scale private hospital (accessed by middle and working class patients)
7	Urban	58	Male	Hindu Brahmin	Clinic of an upscale private hospital chain
8	Rural	50	Male	Hindu Brahmin	Charity Hospital
9	Rural	46	Male	Hindu general	Charity Hospital
10	Peri urban	75	Male	Hindu general	Own clinic
11	Peri urban	42	Male	Hindu SC	Charity Hospital
12	Rural	47	Female	Hindu Brahmin	Own clinic
13	Rural	35	Female	Hindu general	Government Hospital
14	Urban	67	Female	Hindu Brahmin	Clinics at private nursing home and residence

The various setups visited included government hospitals in urban and rural areas that had various facilities like ICU, ITU, etc. Rural areas also had charity hospitals. One of the charity hospitals receives patients from Bangladesh as well, but did not have proper maternity care systems due to infrastructural difficulties. Charity hospitals are mainly run by trustees and are known for providing treatment in poorer localities for very less charge. Urban and peri urban areas have large scale private hospitals accessed by upper class patients only. These are multi speciality hospitals providing best quality care for ministers, industrialists and the like. There

were also small scale private nursing homes accessible by middle class patients. Some doctors had their own clinics (some of which are unregistered), some had clinics run by bigger private hospital chains. These doctors had to refer patients to other setups for invasive procedures.

4.3: Findings

Services offered by set ups vary according to the region. Whereas urban regions are populated by private nursing homes, government and private hospitals, and clinics with proper facilities such as OT, ICU, ITU, etc, peri urban and rural hospitals, mainly government and charity ones, lack proper infrastructure and have to refer patients to other areas for better treatment. One of the hospitals visited even received women coming from Bangladesh. Therefore, women in these areas cannot access abortion service at ease and have to spend extra or depend on somebody else for travelling. This hampers her right to safe abortion and right to bodily integrity as she cannot choose the procedure by herself anymore, and has to consider other factors such as travelling cost and companion, along with compatibility with her lifestyle before going for the procedure.

The cost incurred vary from Rs. 2 to Rs. 11 (additional cost for medicine) at government or charity hospitals. In private nursing homes or more expensive hospitals the charge may go upto Rs. 10000. However, government and charity hospitals having poor quality infrastructure and patient overload, poor women are often deprived of quality healthcare services, including abortion service at these hospitals. For any health complication, they have to be referred to more expensive places which they cannot afford. Doctors may sometimes lower their fees or not accept it altogether, but hospitals do not give any discount on their bills. Therefore good quality healthcare services fall outside the accessible healthcare services for poor women. Therefore, it again hampers their right to quality life and access to safe abortion.

The follow up procedure is also very methodical in urban areas with weekly or monthly follow ups that are usually strictly adhered to, rural areas do not have such mechanisms because patients do not adhere to it. This is mainly due to the fact that abortion is a taboo topic and women do not want to draw attention through longer absences at home, or their lifestyle as daily wage earners or farm labourers do not permit long absences very often. These women cannot exercise their

right to post abortion care. This again leads to violation of right to quality life and right to accessible healthcare.

Abortion is never a safe procedure. One doctor says:

There is nothing called safe abortion.

The most preferred methods of abortion were dilation and curettage, and use of orally consumed medicines. From the literature review it is evident that Manual Vacuum Aspiration is the safest method of abortion. Dilation and curettage or abortificants can cause excessive bleeding or damage uterine walls enough to cause infertility. The patients had little to no say in the selection of the procedure. As one of the doctors says

I am not taking suggestions from patients. Why should I have to? I just explain whatever I do to them.

Therefore, along with abortion being a dangerous procedure, patients who undergo abortion are practically at the doctors' mercy with respect to how it is carried out. Having no say in what is done to their bodies also violates women's right to bodily integrity.

Consent forms are a key factor in the abortion process. Whereas in rural areas doctors rely solely on the women's consent, in urban areas doctors usually take consent from the women's husbands or parents in some cases, in order to avoid legal trouble. One doctor says:

We always get the husband's consent after I faced some legal issues earlier. Other than that, all are according to law. It is bad thing, I know. But I can't help it. The law states otherwise, but I think I heard a ruling that if you abort a child without the husband's consent and the husband goes to court, your marriage can stand annulled. So we always stay on the safer side. Otherwise there is no problem.

Although the current laws state that an adult woman with no intellectual disability should be able to access abortion services on her consent alone, the Supreme Court ruling on the Ghosh vs Ghosh divorce case states that abortion without spousal consent amounts to mental cruelty and can be reason for divorce. This ruling takes away the right women previously had to access safe abortion on their own terms, and again hampers bodily integrity by conferring others (spouses and doctors) with power over her own body and this is an infringement of the women's right to consent to procedures.

Reasons for abortion include mainly failure of contraception and health issues. However, one doctor says:

There may be cases of forced abortions too, but the patients lie upfront, so we do not get the history correctly. They never accept that there is a pressure on them or somebody told them to seek abortion. Maximum patients are Muslim, and they do not opt for abortion without health complications. Do you understand? Many such women may also come and lie to us, and we have to accept that as the truth. We cannot go door to door to check out for ourselves!

Women may undergo marital rape without access to contraceptives and have to lie in the hospital because in Indian law marital rape is not a criminal offence, which violates married women's right to bodily integrity. They can access abortion only by saying it is contraceptive failure, because MTP Act has certain stipulated conditions when abortion might be accessed, and the list does not include unwanted pregnancies under coercion by husband. Many women are again under pressure by parents or in laws to terminate a pregnancy due to various reasons such as protecting "family honour" (in case of an unwed mother), husband not being ready, etc. These women also undergo violation of their bodily integrity, that does not fall under the purview of any law.

A few doctors also spoke about sex selective abortion. One doctor says:

Many doctors use their own machines and different terminologies to tell patients the sex of the child... Most abortions in our country are happening due to son preference, on whether male

child or female child is born. We should keep this in mind. The PNDT Act should be regularised more and very strictly on every clinic and every doctor so that they are bound to obey. Then abortions will vanish from India.

Sex selective abortion and son preference is one of the most horrific truths of the country. This practice comes from a deeply patriarchal culture that devalues women so much that even giving birth to a girl child is met with mourning. The practice has boomed since the time this culture accessed scientific advancements that made sex determination of a foetus and abortion procedures more accessible and accurate. Women are the ones who lose out in the whole process. On one hand women are not allowed to be born, giving rise to a society with a skewed child sex ratio and practices of bride buying, on the other hand, women who give birth to girl children are met with violence. The PNDT Act made it illegal for vulnerable mothers to determine the sex of the child and abort if necessary, in order to avoid domestic violence. Therefore, PNDT Act comes in conflict with the MTP Act and denies women right to abortion when they are at risk of physical and mental endangerment. Both Acts, in this case, violates the right to quality of life of one woman in order to protect the life of the other. Many women are also forced to go through sex selective abortion against their will, which is again a violation of their right to bodily integrity.

Challenges faced by doctors include assault or lawsuits by patients, that can be a result of the prevalent power structure, or lack of awareness among women, that can be a result of social taboo around sex education and contraception. Doctors in government and charity hospitals are also overworked, which impacts the quality of their work.

Women rejected for any reason whatsoever, go for unsafe abortion procedures by taking over the counter medicines, or visiting untrained service providers. These cause grievous physical injury or even death of the women. In spite of so many government rulings on safe abortion, medicine sale, etc, a large number of the country's abortions are unsafe. 80% of Indian women do not know that abortion is legal in the country, and access unsafe abortion methods, which is the third highest leading cause of maternal death (India Today, July 26, 2018). Only formulating laws is not the answer. Implementation of these laws is not possible due to the taboo around topics of

reproduction, especially abortion. Unsafe abortions are also popular because women can access them at their discretion when registered professionals refuse them due to moral or legal reasons. However, most doctors interviewed do not accept any moral responsibility if the women end up suffering physical or mental damage through the procedure.

4.4: Stand of Service Providers

The service providers interviewed were doctors who practised medical termination of pregnancy in the districts of Kolkata, Howrah, Hooghly, North 24 Parganas, and South 24 Parganas, and their demographics are given above. They assume a variety of standpoints, which do not necessarily correlate with their set up, sex, age, or religious/caste background. We can take a look at some of the responses for a better understanding.

A 45 year old female doctor from a Hindu general caste background practising in a high profile urban hospital said:

We provide abortions to those who ask, given it is legally permissible. However, I see girls going for abortion on a daily basis. They misuse their rights. You can have abortion does not mean you should. We had a seventeen year old the other day. She is a widow from some remote village. Her husband died when she was 7 months pregnant. Her family wanted to marry her off again, so they forcefully took her to a quack. She came here bleeding profusely. Died within three days. Her family spent a lot of money for her. What did they get? Now these are the type of people I wish to help. Just the other day a girl came. She was around your age. She said, "do it quickly, I have to go watch a movie. I'm leaving for Bangalore tomorrow, so don't want to waste the evening." We performed abortion on her but I was so angry. She misuses her rights. Do you think it is child's play? You are destroying a life! Take some responsibility! You want to have fun then use protection! These people are despicable.

A 27 year old female doctor practising in a government hospital in an urban setting said:

But I believe a woman has rights over her body and should decide what to do with it. It depends only on her mentality and family and health condition, provided she is below 24 weeks. After that

medical practitioners cannot help with a live foetus. But I believe she has 100% right… But what happens is in illiterate families parents almost discard their daughters in the hands of a man. In that case, even if they desire something, they cannot express it due to social conditions… Due to illiteracy they are dependent on their husbands and especially mothers in law, who are very rigid in their wrong beliefs. Even if the woman knows the mother in law is wrong, they cannot say anything. It is very difficult for them… Maximum patients are Muslim, and they do not opt for abortion without health complications. Do you understand? Many such women may also come and lie to us, and we have to accept that as the truth. We cannot go door to door to check out for ourselves!

The above statements come from doctors who perform medical termination of pregnancy when a pregnant woman wants it, and it is legally feasible. But it is noteworthy that these doctors have very different standpoints and show a class bias in different ways. The first doctor takes a stand against abortion by clarifying that it is good only when a woman is a "victim" from a lower class and not someone who has control over their life and sexuality or belong to an upper class educated background. The second doctor on the other hand, stood up for abortion rights, with a similar argument. Whereas she spoke for the "victims" from lower class or Muslim households, she appreciated women taking control of their sexuality. It is a reflection of the general bias against lower class or Muslim families that the society hold. The women of such families are gullible and in the need of rescuing, whereas their families are harmful and torturous. Educated women from upper classes are again generalised as necessarily empowered women who have access to resources to make choices, whether that be seen in a positive or negative light.

Some doctors took moral stands against abortion. A 40 year old female Sunni Muslim doctor said:

We are very against abortion. Sometimes people come, they get pregnant after having fun, then they come and say, "perform abortion on me". Or, they conceive too soon after their wedding, we are not doing these, we straightaway tell them that we won't do it. You can go anywhere if you want. First we try to convince them to keep the baby, then we let them go. If there is a legitimate health concern like bloated ovum, we do it. Otherwise we don't. Sometimes girls from

high status families come. They are unmarried. Sometimes we have to perform abortions on them. Otherwise we are very against it… As for example the daughter of an advocate came that day, very well known. We had to save their reputation… They mindlessly kill babies. Accidents happen to young unmarried girls once or twice. But for those who are married and have 16 year old kids, they come only for the kicks. How else do you justify 6 abortions? It is not like they don't know anything. They know everything.

The doctor seems to take a stand based on patriarchal standards of the society. She seems to believe in the concept of compulsory motherhood for every married woman, or in saving the "reputation" of unmarried women, only when they came from an upper class background. This statement shows how little a woman's personhood and right over her own body is valued against what is considered right in the society, what portrays her family as a "reputable" one, and what controls her sexuality.

A 58 year old male brahmin doctor practising in an urban upscale clinic says:

Abortions should only happen during health concerns, not in any other case… I have also worked in villages, they have such hygienic troubles that people form wrong ideas about. The media and the government are saying so many things about sanitary napkins, but in villages people will unhygienic methods or not go to many places during periods. This happens only in villages and uneducated areas like in slums, mainly in Muslim, or rather downtrodden people who are dependent on others for knowledge, in places like Sonarpur or Baruipur.

This statement brings reflects both the class bias and issues of moral constraints as shown in the above statements.

A 30 years old male doctor from a peri urban scheduled caste background gets very upfront with his statement:

I usually treat miscarriages or when there are health problems. I do not abort healthy foetuses.

He, although speaking against abortions, does not hold his patients to a moral or ethical standard according to their socio-economic standing. His practice, however limited, follows a gender and class blind blanket rule. This can be problematic because experiences of abortion vary according to the social location of the woman undergoing the procedure.

However, there were a few doctors who provided abortions. A Hindu Brahmin male doctor (39) practising in an urban area says:

Abortion is a social necessity. Most of my patients come due to social necessity. Therefore, I have to offer them my services according to law. If anyone is rejected and uses unsafe methods, they do not come back to me. I do not usually take up such cases.

A 62 year old female brahmin doctor practising in an urban low scale nursing home says:

I do not really like rejecting patients. However, I do not like doing above 12 weeks.

A 46 year old male doctor practising in a charity hospital in a rural area says:

I always do abortions as long as it is legally feasible. Those who say they don't do abortions are speaking utter bullshit. It is a part of our practice and very much ethical… What do I say to helpless mothers who have small children? They are my patients. I can't say, "go away!" Where will they go? To more dangerous doctors? Those who appear holier than thou also do it. Nobody turns away their own patients.

A 75 year old male doctor practising in a peri urban area says:

All my colleagues and I always try to offer the patient what they want, if it is feasible. There may be doctors who do not, but I do not know any such doctor… When a married couple comes with the first issue, I refuse it. It can cause lifelong infertility in the woman, and there is no shame in the pregnancy too. I refuse it. That does not mean they can't do it. They will go to somebody else.

If we look at all the quotes above, we can see that most doctors interviewed are taking up a protectionist approach. They either talk about protecting the fertility, the life of the foetus, or the health of the woman. As mentioned in the literature review, the power structure assumes a guardian-infant or parent-adolescent relationship instead of an adult-adult relationship structure between the doctor and the patient. This can be further substantiated by their views on choosing procedures. As one doctor says:

Their literacy rate is very low. So they do not even know what is good for them. They can never suggest anything to the doctors. They must accept the doctors' suggestions.

Another doctor says:

I am not taking suggestions from patients. Why should I have to? I just explain whatever I do to them.

There is little to no connection between the doctor and patient outside of the procedural interactions, which, according to the literature review, disconnects doctors and patients, and affects the quality of service. The patients place a blind faith in the doctors who then hold absolute power over the procedure. The doctor then plays God, and is expected to take absolute responsibility. This can result in negative outcomes both for the doctor and the patient. Whereas the patient has to submit not knowing what she will be subjected to, the doctors also have to deal with violence from the patient's companions in case anything goes wrong, and has to take absolute responsibility in case of any of glitch. As one of the doctors says:

Sometimes they even assault the doctor blaming him for the miscarriage. These happen very often. They say the doctor killed the child. They never disclose that they cannot feel the foetal movement themselves. Doctors are helpless in this case. They cannot go inside the belly.

Another doctor says:

After a few months, due to some reason, the boy expired. Then they filed a case of medical negligence against me, saying I could not diagnose.

Sadly, this mindset is ingrained in West Bengal, and there are lots of cases of assault on doctors performing abortions or any other surgical procedures.

However, the whole discussion brings to question what social skills doctors learn in medical school that they can use in their practice. The doctors interviewed, in most cases, had very limited understanding of reproductive rights. To them, reproductive rights, in most cases were the rights of a married woman to have a child, or care for a child already born, and not to be used in any other way by anybody else. This view is centred around notions of the "good" and the "bad" pregnancy. A pregnancy within marriage, with no other child or may be one other child was a "good" pregnancy that the doctors wanted to keep. Newly married women pregnant with their first child are told to prioritise the child over her other goals or comforts, in fear that she might not become pregnant again. This pushes the idea of compulsory motherhood within marriage on everyone. The doctors are also unaware of legal bindings. One of the doctors approached for an interview said, "Abortions are illegal in India", and some doctors interviewed did not perform abortion above the range of 10-12 weeks, as they considered it to be the legal requirement. Other than this, none of the doctors interviewed had a sociological understanding of the doctor patient power structure as explained above. Whereas they maintained that they be given absolute decision making power over the patients, they refused to accept the responsibility that comes with it. They blamed the lack of knowledge in patients when assaulted or accused of medical negligence, but used the same as an excuse to withhold decision making abilities from the patients. It is extremely important to impart these skills and knowledge in medical school in order to make the practice more transparent and have an adult-adult relationship in the doctor patient power structure.

4.5: Malpractice, Violence, and Awareness

There has been mentions of malpractices in abortion service by most doctors interviewed. As one of the doctors said:

Her husband died when she was 7 months pregnant. Her family wanted to marry her off again, so they forcefully took her to a quack. She came here bleeding profusely. Died within three days.

Such encounters with under trained service providers are not rare. Many women, who may not be able to reach even such service providers usually take over the counter medicines directly from the shop owners, without a prescription. As stated in the literature review, the practice is quite prevalent in the country. One doctor says:

They sometimes also visit their neighbours for advice. They take the medicine, and only when there is bleeding, will they come to the hospital, seeing no way out. Many lie, many tell the truth.

This leads to further complications. As another doctor says:

They will just take over the counter medicines, that might sometimes cause complications. They have incomplete abortions and come to us. We do USG, and have to treat them accordingly.

This practice is prevalent in areas where women are frequently denied service due to little availability of registered doctors, clinics, or being rejected by a doctor. Especially in rural areas, where unregistered and undertrained service providers and traditional midwives provide the service on demand. There rejected women definitely end up accessing pills or other harmless methods. As one doctor says:

In rural areas, the patient's choice is the only choice. I do not think we can impose any dictum by the state or by orthodox cultures.

But how does the practice of taking over the counter pills get justified in educated sections of the society? One doctor says:

Media also plays a role. They do propaganda. They show contraceptives as IMA approved. But IMA is not an authority. WHO is the authority, IMC is the authority. Not IMA. It is just an organisation. Therefore, doctors should always prescribe medications approved by WHO or IMC, even when pressured by patients to prescribe other kinds of contraceptives.

The communities the interviewed doctors work with mostly comprised of working class women with no access to proper information, so they relied heavily on what is portrayed in the TV or what is common knowledge in the community. As a doctor points out:

So the women take tablets. Now there is a rule by the government that after the deliveries you have to put in copper-T. And mostly, after a few months they come to us wanting to remove it. They complain that it causes pain in the abdomen and repeated bleeding, but it is due to prefixed ideas like it causes cancer. Copper-T is a very good contraceptive advice. They also like using tablets like OC pills, but Muslim women don't usually take those. Many women here hide from the husbands and take injectable contraceptives, although it makes their cycle irregular, which is usually unacceptable to women. Many others can never be convinced that no period equals no pregnancy. Some women accept it, but many women refuse contraceptives pushed by the government. We try to convince them that it is a government rule that we must follow. Many educated women however come to me to get copper-T because you can use the same one for 5-10 years. Public awareness is required. Abortion is risky.

All doctors have spoken on a similar note. It might be because reproduction and abortion are such taboo subjects in the society that women rarely seek out information openly. They go through abortion as a last resort. With no discussion of contraception and family planning, women fall victim to husbands who do not care about safe sex, or the pleasure of the woman. As a doctor points out:

Sometimes the husband forces the women to keep the baby. It happens mostly in Muslim communities. So the women take tablets.

Many a times, all this stems from women's lack of knowledge about their own sexuality and sexual health. Whereas men have some idea to at least serve their own interests, women are not given enough information to enjoy a healthy sex life. As a long time practitioner says:

Do you know how many couples stay with the husband's parents and go through sexual dissatisfaction for both the girl and the boy?... If you ask a married girl, "Do you orgasm?" She will stare at you blankly. Because they do not understand what is orgasm. Most of my patients are like this. I see that the husbands are not doing any kind of foreplay... This is a huge complaint from most of my patients. If there was a system of pre marital counselling, it could have been avoided. It should be explained... Although some boys are taught, girls are never even taught that they can have pleasure too. I ask them, "Haven't you ever considered this?" They say, "No, nobody taught me." There was once a woman who was around 35 or 40. She said her vagina gives her burning sensations during intercourse. This is a common problem... Then I said, "Do you enjoy sex?" She said, "No". I said, "Why?" You should also see how many times they have sex. For newly weds, for upto 2-3 years, at least 2-3 times a week should be normal. Many say once a week or even missing entire weeks. And this problem is very traditional. If there is satisfaction, it will drive them to have more sex. Anyway, back to the lady I was talking about... She said, "What do I do? My husband has a girlfriend. He goes there only. He comes to me once in one or two months. But he never tries to do any foreplay. I never get excited." There are many problems like this. This lady said only because I asked. Otherwise nobody discloses such things. These cases are many.

The cases will sometimes escalate to physical domestic violence. One doctor says:

Women are coming after fathers in law are torturing them. You must be getting many such cases in the field of your work. Educated women. Matron in PG hospital. Used to beat her daughter in law like anything. Where will the girl go? She did not have anybody else. She had fertility issues as well. She really wanted a baby. After a few days she stopped coming to me. I really don't know what happened to her. She was also educated. What is the meaning of such education if you do not have freedom? Even if I refer her to other services, she won't go. It is really important to look into such matters

This is a result of internalisation of patriarchy, that stops women from taking steps against abusive family members. The violence begins before birth with sex selective abortion and son preference. As a doctor says:

There is sex selection everywhere. Even I have an only child, a girl. Even educated people ask me why I did not have a son. I am very happy with my daughter. Even I wanted to try again at a point of time, but could not due to professional responsibilities. People also poke their nose into everything. Thankfully my brother in law has a son, so nobody asks me to carry on my father in law's name. But it is very normal.

Another doctor recommends:

Most abortions in our country are happening due to son preference, on whether male child or female child is born. We should keep this in mind. The PNDT Act should be regularised more and very strictly on every clinic and every doctor so that they are bound to obey. Then abortions will vanish from India.

It continues with discrimination at home and deprivation of economic independence. A respondent says:

In our country nothing will happen as long as women are not educated. Along with it they also need financial help. However small, if you can earn a small livelihood, you might be able to afford your children. More often than not mothers take the children. Even in animals. Boys don't take any responsibility. Nothing will happen without financial freedom. Mann ki baat and Swachchh Bharat stops nothing. There are many cases of domestic violence. I am seeing many qualified and well earning women being beaten up by their husbands. They can't say anything. They beat, and gift a new saree the next day. Husband can also violate the woman sexually. It is not always done by an intruder. I get a huge number of cases like that. Many women are aborting due to abortion and bleeding. When I ask why they are having perennial intercourse in such a manner, the woman looks at the husband. Do not think it is specific to a certain

community. It is everywhere. Many women have 5-6 kids, and can't do anything because they have to pleasure their husbands.

There is also prevalence of child marriage in migrant worker communities. As a doctor practising in such a region says:

Therefore I would suggest that all couples should go for pre marital counselling, and the government should do something about the rampant child marriage in the area.

From the above discussion, we can very much understand how a discussion around abortion essentially revolves around the oppression of women in various ways. The discussion brings to light how patriarchy affects the healthcare system. It all becomes a tale of controlling a woman's existence, whether it be right to life, right to education, right to livelihood, right to healthcare, sexual rights, or even reproductive rights. The way the present legal system and the social mindset gives absolute power to doctors, who are also a product of the same society, it takes away women's autonomy to choose. The quality of care and accessibility to not only abortion services, but services of any kind, then depends solely on her family, and the service providers involved.

4.6: The Overall Picture

Women in the region come from a culture that taboos any talk about sexual or reproductive health. Although there are laws present to make abortion and contraceptive services accessible to women, the women find it difficult to disobey the patriarchal cultural fabric. The general purview of women is very protectionist. The present laws also play a paternalistic role in aiming to protect women from unsafe or sex selective abortions. However, the present laws also make it harder for a woman to access legal and safe abortion by making the process of clinic registration too complicated. Therefore, women from some remote areas are having to travel long distances to access quality services. The registered practitioners who conduct abortions are also a product of the same social fabric as the women, and have similar taboos around abortion that come from patriarchal and religious ideals of "morality". Doctors who find the process immoral refuse

women who urgently require abortion due to the various forms of violence or deprivation they experience, like economic difficulty, rape, domestic violence, social taboo, coercion, son preference related abuse, etc. These women, in a state of desperation, seek illegal unsafe methods of abortion like unregulated medicines or surgeries by untrained service providers, which can severely damage their health, and may even lead to death. None of the doctors who refused these services assumed moral responsibility for the outcome. The doctors who do provide abortion, provide services that vary from setup to setup. Structured setups like nursing homes and hospitals have various facilities like OT, ICU, etc, whereas doctors treating patients in clinics or other setups not up to date had to refer patients to distant places for invasive procedures. The cost varied according to setups. Some setups, that were not very up to the mark with respect to quality of service due to patient overload, charged upto Rs. 11. However, fees in better quality setups go upto Rs. 10000, which the patients are not able to access. The doctor patient power dynamic is that of a parent and child, where the doctor is the all powerful decision making figure, and the patient has to obey all advice by doctors. The laws also enforce such a notion by giving doctors complete power over the procedure. However, doctors are not always aware of the legal requirements and can deny patients at an earlier stage than legally required. This power structure also poses a threat to doctors who then become responsible for the patients instead of responsible to the patients. Therefore, in case of any negative impact on the patients' health, the doctors face the danger of lawsuits or even physical assault, that makes providing service even more difficult. Doctors also have a protectionist approach towards patients, which hinders interaction between equals. They play a role in pushing the state's protective policies like forced contraception after childbirth or abortion, even without the consent of the patient. Women in this case, lose rights over their own body and reproductive systems, which is a violation of their reproductive rights. However, with a very limited understanding of reproductive rights, doctors do not recognise this. They show unconcealed bias against illiterate women or women coming from Muslim households, and view them in the light of victims who never know what is right for them. Therefore, very few women can access safe abortion services in a registered clinic. Many more abortions go unregistered. Women who do access legal and safe abortion services, are often denied a choice on the procedure. Many cannot keep up with the follow up schedule due to their lifestyle or social structure.

Doctors recommend better regulation of over the counter medicines, and awareness camps on sex education and contraceptive use. Pre marital counselling is also recommended in many areas. Doctors also recommend making the PNDT Act more stringent. The researcher recommends educational programmes for doctors that will focus on doctor patient relationships, human rights, laws, and a medical approach free of moral boundaries.

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Annexure - I: An Interview Guide for Doctors Practising Medical Termination of Pregnancy

A. Introduction and General Setting

1. Name and gender
2. How long have you been practising?
3. How long have you been practising in the current setting?
4. Could you give a general idea about the setting like the date of establishment, services offered, etc.?

B. Personal Stand

1. What do you think about abortion and about the women seeking abortion?
2. What are the paperwork and documents required for seeking abortion in this clinic?

C. Quality of Care

1. What are the systems in place to carry on smooth functioning of the whole process/procedure and ensure quick and effective intervention?
2. Since when have these systems been made available? Or, how did these systems come into practice?
3. Were these there from the beginning? What influenced the addition/evolution/rejection of the systems in practice?
4. Could you give an idea about the cost incurred?
5. From where do the patients obtain required medicine and other items pre and post abortion?
6. What are the procedures you prefer?
7. How do you choose the procedure?
8. What are the systems in place to ensure proper healthcare post abortion?
9. Do you think women approach other settings or undergo unsafe abortions if rejected here?

D. Demographics and Accessibility

1. What are the main reasons for which women seek abortions?
2. Could you give an idea about the marital status and family income levels of the women who come here and get abortions?
3. What are the main reasons women are rejected from accessing this procedure?
4. Can you give an idea about the target geographical area of this clinic?

E. Challenges

1. Do you find anything morally or ethically wrong in the setting or the practice?
2. Do you think your clients face any challenge themselves or pose challenges for you?
3. Is there any other legal or social challenge you face?
4. What do you think can solve these issues?