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Perceptions Regarding Induced Abortion Among Marginalized Communities in India

A Qualitative Exploration

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Reproductive health advocates argue that as a fundamental human right every individual should have access to sexual and reproductive health services, including safe abortion. However, the fact remains that in many parts of the world, abortion seekers face serious and sometimes insurmountable barriers in obtaining these services, with stark consequences for their health and well-being. In India, the Medical Termination of Pregnancy Act legalised certain induced abortions in 1971.[1] However, access to it continues to be disproportionate for several abortion seekers. It has been reported that approximately 50% of abortions in India are estimated to be unsafe and unsafe abortions result in almost 20% of all maternal deaths.[2] This represents huge lacunae in access, which is quite comparable to settings where abortion is illegal. Several legal and practical barriers are known to restrict abortion seekers' access which manifests as denial or delay in care, forcing them to continue with the pregnancy posing serious risks to physical, mental, and social health, or seeking the services in unsafe, clandestine, and/or expensive avenues.

Research studies and surveys conducted in India frequently overlook the demographic of never married and/or single women, not only underestimating the measurement of prevalence rates of induced abortion but also rendering them invisible from the discussion regarding safe abortion. [3] Community-based surveys which collect information pertaining to abortion directly from the abortion seeker may not provide reliable data, because abortion seekers typically underreport abortions to evade the stigma associated with pregnancy termination, which will be particularly pronounced if they believe abortion to be illegal. [4] In addition to the poor awareness among both abortion seekers and health care providers about the legal status of abortion, studies have also revealed the existence of stigma and negative perceptions against abortion in India. The prevalent social and cultural norms, particularly regarding female sexuality and motherhood, have contributed to the generation of widely held constructions about abortion. [3] The scenario is further worsened by the notions that medical terminations will lead to greater sex-selective abortions profoundly contributing to the abortion stigma. The existence of stigma also leads to underreporting and consequent underestimation of the incidence of abortion. [5]

However, despite such acknowledgment in the literature that negative perceptions and stigma against abortion exist in India, both in the general community and among health care providers, potentially posing barriers to accessing safe abortion services and the quality of care, empirical research into the nature of stigma and its operation among individuals, communities, and institutions, is scarce.[6] This exploratory study has been a step towards addressing this gap. The study was set

to explore the perceptions of induced abortion in two marginalized communities of India, tea plantation workers from Assam and traditional fisher-folk from Kerala, with the following objectives:

- How do the stakeholders perceive the knowledge/awareness of the community regarding the legality, acceptability, availability, safety, and consequences of induced abortion?
- What are the major sources of information for the community members, especially young people, regarding these aspects?
- What are the major barriers, especially for young potential abortion seekers from the community in accessing induced abortion services?
- How do the stakeholders perceive the stigma around abortion and how does it operate in the communities?

In-depth interviews were conducted telephonically among young people and community stakeholders living within and outside the study setting from June-August 2021. Some of the social issues affecting potential abortion seekers and their right to access to healthcare can be traced as follows:

- With the onset of economic decline because of the impact of COVID-19 and natural calamities witnessed by both the study setting, the access to healthcare has severely been impacted, especially with respect to sexual and reproductive health services.
- Underage pregnancies, premarital sex, or pregnancies as expressions of uncontrolled sexuality of young women have been pointed out as a grave rising concern in both the communities. The prevalence of early marriages, controlled female sexuality, and mobility were highlighted.
- Dominant voices from both the communities expressed that all the crucial decisions regarding birth control and family planning were finally taken by the men of the household.
- Young people from the community shared the lack of space to freely express their concerns or platforms to access knowledge on sexuality and contraceptives. This has neglected and impacted young people, especially adolescents in accessing sexual and reproductive health and abortion services.
- Unmet needs for contraceptives were highlighted in both communities. Tubectomy is a definitive form of birth control for women from the coastal community, while women from Assam rely on modern contraceptives such as oral pills. However, both the communities

shared relying on the withdrawal method and witnessed the lack of poor spacing between pregnancies affecting women's mental and physical health.

- The only available government facility for accessing abortion is the District Medical Hospital for Assam tea plantation workers. Several challenges, including financial, social, and distance, push them to opt for local midwives and unsafe methods of abortion. Adolescents' desperation and vulnerability in opting for such unsafe methods came out from Assam's study setting.
- Respondents from Kerala expressed the lack of privacy in OP wards and the judgemental attitude of healthcare professionals pushing them for expensive private healthcare or continuing with the pregnancies.
- The dominant voices from both settings understand abortion as illegal and morally unacceptable. Many social activists and ASHA workers endorsed the illegality of abortion and demanded spousal consent. Many respondents, including health professionals, harboured misconceptions surrounding abortion, including abortion leading to infertility and death.
- Voices from both communities argued that there is a definite demand for induced abortion among women from various age groups. The reasons varied from poor usage/access to birth control measures to sexual violence and lack of reproductive agencies. Many women continued with the unplanted pregnancies only due to poor access to abortion services, societal and familial pressure, fear for their own health and fear of social judgment, and denial of abortion services, especially to unmarried women and adolescents.
- There were two dominant voices concerning the moral agreeability of induced abortion. The first, that abortion is morally disagreeable under all circumstances and that it can be chosen only and only as a last resort. The second dominant voice said that induced abortion may be necessary under certain circumstances – if the life of the pregnant person is at risk, if the pregnancy is a result of rape or incest, or if the foetus has anomalies.
- Conscientious objection of providers and health workers and their personal values interfering with the provision of abortion care is one of the barriers. Poor conditioning of providers and health care workers to understand marginalization and consequent vulnerabilities led to negative attitudes and stereotyping of communities.

Based on the findings, the report suggests the following policy interventions:

- Reorient sexual and reproductive health to centralize a rights perspective - incorporating rights framework in the construction of sexual and reproductive health in both settings.
- Government health facilities at all levels have to be responsive to the specific needs and vulnerabilities of women. This includes privacy in interactions with the health care providers and assured confidentiality protecting the identity of the abortion seeker. Increase in availability and affordability of abortion services to address the risk of abortion seekers opting for unsafe and expensive private services.
- Need to disseminate accurate and complete information about contraception and induced abortion, since the fear of abortion in the community was linked to rampant misinformation about its legality, safety, availability, and the methods of induced abortion. Local self-governments and local health systems need to take greater initiative to organize campaigns and develop platforms in collaboration with the civil society organizations.
- Need for community-based campaigns and initiatives with a renewed focus on socio-economic marginalization and patriarchy. Women experience serious social issues such as domestic violence, marital rape, financial distress, frequent and multiple pregnancies and childbirths, and unintended pregnancies. Interventions can be taken up by civil society organizations and youth-based organizations in tandem with local self-governing bodies to address these issues.

BACKGROUND

Introduction

Induced abortion is being identified globally as an indispensable health service necessary to ensure the rights, health, and well-being of women. Abortion is restricted by laws, cultural and religious traditions, and the scarcity of resources, especially in developing countries. According to the U.N. Population Fund, in 2020, an estimated 218 million women from the developing world who wanted to delay or avoid pregnancy could not access modern, reliable forms of contraception, placing them at risk for unintended pregnancies. [6] It is estimated that roughly 121 million unintended pregnancies occurred each year between 2015 and 2019. About 61% of these ended in abortions, amounting to about 73 million abortions per year. The estimated unintended pregnancy rate of Central and Southern Asia is 64 (per 1000 women aged between 15-49 years; 59-70 at 80% uncertainty level) and the abortion rate is 46 (per 1000 women aged 15-49 years; 42-51 at 80% uncertainty level). [7] A study that estimated the national incidence of abortions and unintended pregnancies reported that, in 2015, 15.6 million abortions (14.1 million–17.3 million) occurred in India. In the age range of 15-49 years, the abortion rate was 47 (42.2-52.1) per 1000 women and an overwhelming majority were medical abortions done outside of the medical facilities (73%). [8]

Despite the persistence of abortion as a health care need and a relatively common gynaecological experience among women across geographical regions (81 women experience abortion every minute), negative social perceptions and stigma have remained critical contributors to its legal, social, and medical marginalisation. In addition to denial of the service, poor quality care, and unsafe procedures, stigma around abortion has also significantly contributed to the violation of several fundamental human rights of women, including the right to health and freedom from discrimination. As with other forms of stigma, the social and political processes which have led to the origins, perpetuation, and normalisation of abortion stigma, rely on power disparities across population groups. [6]

Induced Abortion: The Indian Scenario

India, as a signatory to the International Conference on Population and Development (1994), has committed itself to uphold ethical and professional standards in family planning services, including the right to personal reproductive autonomy and collective gender equality.[9] Indian policies and laws so far seem to reflect this understanding, at least on paper. The National Population Policy (2000) affirms the right to voluntary and informed choice in matters related to contraception.[10] Induced

abortion has been legal in India for the past five decades through the Medical Termination of Pregnancy Act (1971). [1, 8] According to the Act, a pregnancy may be terminated up to 12 weeks based on the opinion of one doctor, and up to 20 weeks based on the opinion of two doctors. Termination is permitted only when the continuance of the pregnancy would involve a risk to the life of the pregnant woman, cause grave injury to her mental or physical health - including rape and failure of birth control measures - or in the case of foetal anomalies. It is also allowed at any point in the pregnancy if there is a need to save the pregnant person's life immediately. [1] The recent Medical Termination of Pregnancy (Amendment) Act, 2021 amends the 1971 Act to increase the upper limit for termination from 20 to 24 weeks for survivors of sexual assault, rape or incest, minors, mentally ill women, those whose marital status changes during pregnancy (widowhood and divorce) and those with physical disabilities. The other conditions include the case of foetal anomalies that have a substantial risk of being incompatible with life for the women and the child in humanitarian settings or disaster or emergency situations as declared by the Government. [11, 12] The amendment removes this upper limit in the case of substantial foetal anomalies and constitutes Medical Boards at the state level. [11]

Despite the Act, access to safe, legal abortion services continues to be inadequate, with women approaching pharmacists, chemists, and informal vendors for services, often receiving no information or inaccurate information on safe abortion. [8] The data from the fourth round of the National Family Health Survey (2015-2016) shows a significant difference in proportion between those who accessed the service in the public health sector (20.2%) and those who accessed it in the private health sector (52.4%). This difference was observed in both urban and rural areas. A significant proportion of women underwent an abortion at home (27%) and in a high proportion, the procedure was performed by either the woman herself or by a family member/relative/friend. Nearly a fifth of women who underwent abortions experienced complications and the majority of them had accessed care for complications in the private health sector (73.6%). The low utilisation of public health sector facilities and a significant proportion of women who did not have a qualified professional performing the procedure are indicative of persisting difficulties in accessing the services. [13]

The results of a recent survey conducted among six Indian states show that, except for the state of Madhya Pradesh, fewer than half of the facilities in the other five states offered safe abortion services. None of the facilities which provided abortion had the necessary equipment and trained personnel required to provide the service safely. Fewer than half of the facilities offered the WHO-recommended Manual Vacuum Aspiration (MVA) method. Only a small proportion of facilities across the states (6-26%) sought the woman's consent alone (and not the consent of the husband or the partner) for providing abortion and only about 8-26% of facilities across the states also required that

women adopt some method of contraception before receiving an abortion. The majority of the facilities offered dilation and curettage (D&C) or dilation and evacuation (D&E). D&C, which is invasive and requires more resources and trained staff carries a higher risk of complications, is not a WHO-recommended procedure. [14] A study conducted in Jharkhand found that while government facilities and certified private practitioners had the required facilities and infrastructure to provide the services, such as a well-equipped labour room, operation theatre, and indoor services, the majority of the uncertified private general practitioners and unqualified practitioners had a single room with a curtained off area. The services of such unqualified practitioners were higher among the clients from the remote tribal block as compared to both urban and rural areas. Perceptions of quality of abortion care among clients prioritised the affordability of services over other attributes such as technical competence, skilled and trained staff, confidentiality in client-provider interaction, and other facility-level factors such as proximity to residence. [15]

A critical review conducted by the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, of selected studies on maternal health and abortion in India between 2002 and 2014, found that only a few studies were conducted from a gender and human rights point of view to explore society's knowledge and perceptions about abortion. The available literature suggested that the knowledge, perceptions, and cultural notions attached to motherhood and pregnancies, including that of health care providers, acted as potential barriers to access to both the service and information pertaining to the service. These could also manifest as delay in seeking services, lack of autonomy for women, and reflect in other choices like the type of facilities or providers, all of which have a significant role in determining the safety of induced abortion. [3] Another study conducted in abortion facilities from two districts of Maharashtra indicated that the providers' perceptions were significantly influenced by their attitudes towards women and their health care, especially abortion care. The attribution of responsibility of abortion to individuals, mainly the women or their spouses, the strong disapproval of pre-marital sex, the assumptions that widows, separated or unmarried women need abortion because they are the "sexually indulging type" are all reflections of such attitudes. These attitudes in turn influence women's access to services and the quality of services. [16] A report based on this study also found that the quality of abortion care offered to women was substandard and that the compliance of medical professionals with the existing laws was very low. The implementation of laws and regulations intended to maintain the quality of abortion care was also found to be poor. [17]

LOCATION

This study was conducted in two geographically distant and socio-politically diverse marginalized communities - tea plantation workers from Assam and traditional fisher-folk from Kerala – and discussed the existence of barriers that restrict them from accessing safe abortion. Although the states are starkly different in the health indicators and in terms of the infrastructure, available facilities, and resources invested in their health systems, the available literature suggests the relatively low priority accorded to abortion services and the need for greater supply-side interventions. Another similarity of the settings is the social and economic marginalization experienced by the two chosen communities and the central role played by the major occupation as an axis of marginalization.

The 2012-2013 Annual Health Survey estimated that the proportion of pregnancies ending in abortion was about 7% in Assam. [18] A more recent study (2015) found that an estimated 5,80,100 abortions are performed in Assam every year. These include abortions taking place both in health facilities and in other settings. The state's abortion rate was found to be 66 terminations per 1,000 women in the reproductive age group. Though a majority of women in Assam live in rural areas, merely 45% of the facilities offering abortion-related services were located in these areas at the time of the study.[19]

The tea plantation industry is labour intensive and is predominantly driven by women. The Assam Human Development Report of 2014 acknowledges the backwardness of the tea plantation workers in economic, social, educational, and health parameters. [20] The inadequate healthcare facilities in approximately 800 tea estates across Assam have been flagged repeatedly by labour unions, NGOs, and other grassroots organizations, especially on the issues pertaining to lack of doctors, nurses, medicine, ambulances, and medical equipment. The health indicators of the state have been poor in the districts which have a high concentration of tea estates and tea plantation workers. Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR), malnutrition among children and women, and anaemia in adolescent girls, pregnant women, and young mothers is reportedly high among tea plantation workers.[21]

A community-based cross-sectional survey among eight randomly selected tea gardens of Dibrugarh district of Assam found that there was a high prevalence of malnutrition among children and thinning among adults. Worm infestation, anaemia, skin problems, respiratory issues including tuberculosis and filariasis were also major issues. Non-communicable diseases like hypertension, stroke were emerging in the community and there was a high prevalence of tobacco and alcohol use. [22] In another study, it was also reported that a significant proportion of workers and their families

had died in the past five years due to tuberculosis, high blood pressure, and inadequate health care. Child mortality was also high among the group.[23]

A more recent study conducted qualitatively among women plantation workers from the Jorhat district of Assam found that determinants at a structural, intermediary, and individual level were associated with health. Poor housing and sanitation and inadequate diet and nutrition affected their health. Poverty and poor working conditions along with the lower social position attributed to women in the community prevented their ability to improve their situation. Lack of social support and poor standard of health services compounded the problems of the women. Thus, in addition to health concerns and poor access to health services, a high level of psychosocial stress also was a vexing problem for women workers from the tea plantation industry of Assam. Although there are few systematic studies enquiring the access of women workers to sexual and reproductive health services, there is a significant body of non-academic literature which points to poor access to services. Lack of awareness and access to sexual and reproductive health services among these women enhances their risk of unintended pregnancies.[24]

Kerala, the southernmost state in India, has recorded significantly better health indicators like MMR (61; national average is 167) and IMR (10, national average is 34) compared to the rest of India, and its consistent health achievements and strong public health system have been widely discussed. However, the relatively poorer health of marginalized communities has remained a concern for several decades. The fishing community has remained neglected and excluded from the larger development experience of the state and this has reflected as an overall social and economic backwardness of this community.[25]

Among an estimated 5.4 million people engaged in various fishing-related economic activities in India, about 1.6 million are women and more than a million of them are from the 222 fishing villages of Kerala. The effects of globalization and mechanization in fisheries, repeated anthropogenic and natural hazards, pollution, and climate change causing depletion of fish stock have significantly affected their livelihoods. Unsanitary and overcrowded living conditions, lack of access to basic services like piped water supply and electricity, poorer health outcomes among both men and women, higher infant mortality rates, lower sex ratio, and poor access to health facilities have been reported from this community, clearly underscoring their marginalization.[26]

Among all the three prominent religious' denominations (Hindu, Christian, and Muslim), fisherfolk are known to have strong belief systems related to the fertility of women, follow specific rituals and appease higher influences in order to ensure the fish catch and the safety of men at sea. They reverently refer to the sea as "Kadalamma" (Kadal – sea, and Amma – mother), equating the fertility and nurturing role of a woman to the fish yield provided by the sea.[27] Women were the worst affected

by the changes in the fisheries sector of the state since the 1960s, characterized by modernization and mechanization of the fishing sector driven by an export-oriented approach, emergence of big fishing corporations, international subsidies, stringent conditions of global trade, and the consequent rise in competition. The fall in fish stock and rise in competition meant loss of income for traditional fishing households and decline in productive activity pushed men from the community into alcoholism and gambling. This naturally had consequences for women, in the form of rising in domestic abuse, desertions, and sexual harassment.

Women were also facing other difficulties such as denial of entry into public transportation citing the odour of the baskets with fish, causing them to walk long distances with heavy head load for sale of fish. All of these concerns led to the rise of women's collectives in the fishing community of the state during the 1970s and 80s, which marked the resistance of the communities.[27]

There is a severe paucity of studies among the fishing community of the state regarding their reproductive health concerns and/or access to reproductive health services including abortion. This presents a clear need to prioritize this as a research agenda. A qualitative study that examined the attitudes and barriers of fisherwomen from Kerala regarding reproductive tract infections, identified a "culture of silence" around the issue.[28] The major barriers which prevented women from taking timely action against the infections included the socio-cultural environment which conditioned an underrating of self among the women, issues of economic accessibility, and institutional constraints that made seeking primary health care tiring and time-consuming process due to the unavailability of physically accessible medical clinics. The study found that the powerful perceptions shaped by socio-cultural conditioning led to a loss of the concept of "self" and pushed them into silent submission to decisions taken by others regarding healthcare-seeking. The inconvenience and cost of follow-up visits, negative attitude of health professionals towards the members of the Scheduled Caste group, lack of adequate facilities in government health care centers, unaffordable private health facilities, and lack of knowledge regarding subsidized health services discouraged the women from seeking curative services. The poor educational background of the women prevents the permeation of knowledge and the absence of the minimum amount of information required for decision-making restricts them from breaking the socio-cultural conditioning. Apprehensions about social exclusion, associated with diseases of the reproductive system and attributable misgivings about the potential ways through which the infections are contracted were other major barriers. [28]

CONCEPTUAL FRAMEWORK

We have used the five-level ecological model to explain the negative social perceptions and stigma around abortion.

Negative social perceptions against abortion and stigma around it

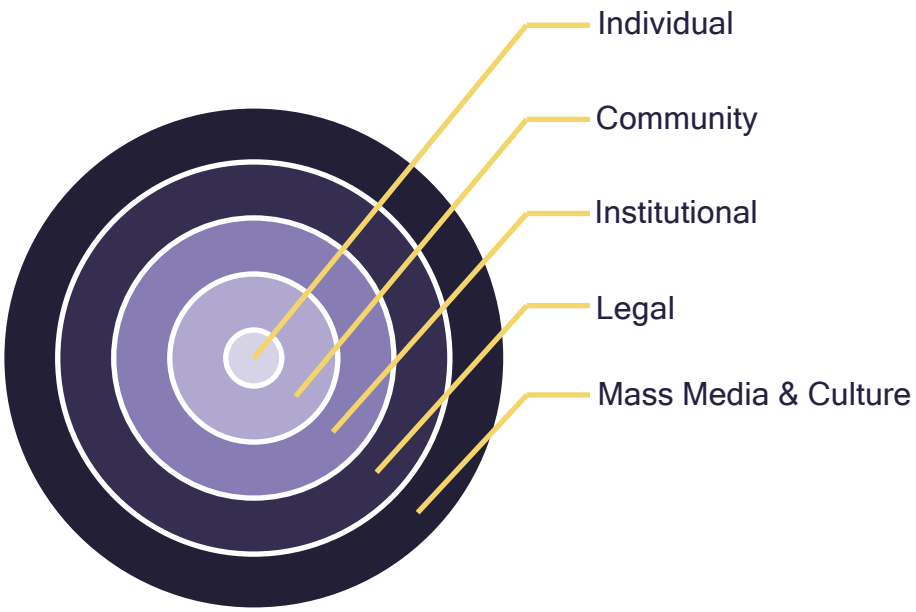
One of the widely accepted definitions of stigma was put forth by Goffman in 1963, as a deeply discrediting attribute that negatively impacts the identity of an individual as inferior, tainted or discounted. [4] This conceptualization has been applied to enhance our understanding of stigma across several conditions like mental illnesses, HIV/AIDS and tuberculosis. Stigma could also be 'contagious'. That is, the act or the condition that brought about stigma could also be attributed to the larger group that the individual or individuals belong to.

Drawing from these general conceptions of stigma and applying it specifically to the context of abortion, Kumar, Hessini and Mitchell in 2009, proposed that abortion stigma is, a negative characteristic attributed to women who seek to terminate a pregnancy by labelling them as inferior to the ideals of womanhood. Cockrill et al in 2013 added that this shared understanding that abortion is morally wrong and socially unacceptable influences abortion providers, systems of care, law and policy environment, community and the media. At the root of stigma are the prevalent social perceptions about reproductive physiology (when does life begin, is the foetus viable, can the foetus feel pain), normative sexuality, the legal status of abortion, the policy environment in the nation, women's sexual agency, their reproductive autonomy (who takes decisions regarding women's bodies), cultural and social norms, demographic trends and family dynamics.[4, 29] Thus, it is critical to factor in the social perceptions about abortions and the social processes leading to its production and reproduction before engaging with the stigma.

The role of social processes in producing and reproducing stigma has been conceptualized by Link and Phelan in 2001 in a four-component model – labelling, stereotyping, separation and discrimination. Shellenberg et al., has applied this conceptualization to further the understanding of abortion stigma. [6, 29]

Labelling *Characterization of an act/condition as abnormal*	• Women undergoing abortion/ providers offering the services are labelled as abnormal/deviant • Over-simplified arguments vilifying pregnancy termination will be used to further this process
Stereotyping *Linking of individuals/groups associated with the stigmatized act or condition with negative traits*	• Women undergoing abortion will be consistently associated with negative traits like promiscuity, carelessness, selfishness and lack of compassion • Providers who offer the services will be stereotyped as cold, unfeeling people who are greedy and prioritize money making over values
Separating *Moving the individuals/groups into a separate category creating a false 'us' versus 'them' dichotomy*	• Women who undergo abortion and providers who offer these services are categorized as separate from the women who do not undergo abortion and the providers who do not offer these services respectively • Purpose is to shame those who are stigmatized; propagate the fear of exclusion and silence perpetuating the separation
Discrimination *The social process of stigma could continue to result in overt discrimination or loss of status*	• Those stigmatized due to abortion - women and providers - could be overtly discriminated and could end up losing their social status and position

Abortion stigma can manifest at multiple levels and the ecological model has been developed based on an understanding of how stigma operates in other fields, such as HIV and AIDS and mental health. [6, 29]



Source: LeTourneau, K. (2016). Abortion stigma around the world: A synthesis of the qualitative literature. A technical report for members of The International Network for the Reduction of Abortion Discrimination and Stigma (inroads). Chapel Hill, NC: inroads.

Ecological model of abortion stigma: social perceptions and processes at different levels

Individual *Internalized, perceived, or enacted stigma by individuals*	• Women who underwent abortion • People who support these women • Providers who give abortion services
Community *Norms, attitudes, and behaviours at the community level*	• Social and cultural norms, attitudes and behaviours which exist at the community level towards women who seek or undergo abortion, people who support these women and/or abortion care providers
Institutional *The way policies and practices within institutions*	• Health facilities, professional societies, and medical education institutions • Its effect in marginalizing abortion and on the people who undergo, support, or provide abortion
Legal *Barriers to abortion in laws and policy environment*	• The manner in which the laws are written which end up marginalizing abortion and the women needing abortion care • How policy makers and institutions interpret these laws and how these interpretations can impact stigma
Mass Media & Culture *The manner in which abortion is portrayed in mass media and dominant discourse*	• How are women who seek abortion and those who provide abortion portrayed in popular media and dominant discourse? • The impact this has on the visiblization or invisibilization of abortion in popular culture.

Source: LeTourneau, K. (2016). Abortion stigma around the world: A synthesis of the qualitative literature. A technical report for members of The International Network for the Reduction of Abortion Discrimination and Stigma (inroads). Chapel Hill, NC: inroads.

Interplay of different levels of stigma

Stigma at each of these multiple levels does not act independently. Stigma at one level usually has an inextricable influence on stigma at one or more levels and will have an impact on how it manifests. [29] For instance, in settings where abortion is illegal and is often provided extra-legally by providers, legal reforms may not always be acceptable to providers, since this could restrict their provision. Regardless of the legal status, the attitudes of the providers can have a major impact on the access and quality of care that women receive. In many settings, due to the legal ambiguity, there are hardly any records or documentation concerning abortion. It also has an impact on how abortion providers characterize their own work within the system. [29]

In settings where community norms around motherhood and sexuality stigmatize abortion, there is a considerable negative impact on access to abortion care. This impacts the attitudes of providers and health staff and also encourages women to value privacy over safety, forcing them to choose clandestine venues over registered facilities. Thus, the concept of "safety" in the context of abortion means different things for the women in need of the service and the system. The experiences that women face in facilities situated in communities that hold anti-abortion stigma and hostility may reinforce in them the community notions that abortion is indeed "unsafe". [29]

Role of marginalized identities in enhancing the experience of abortion stigma

The impact of abortion stigma is known to be exacerbated in those communities who are marginalized due to other identities, which may also already be associated with stigma for other reasons. Two communities where this has been clearly demonstrated are the young people and HIV-positive women. [29] Sexual activity among young unmarried women is penalized in many cultural settings. Criminalizing sexual activity under 16 and the mandate of parental consent not only encourage shame and silence but also force them to access poor quality abortion services from clandestine avenues to maintain the secrecy. The social stigma around unplanned pregnancies among young women, rooted in community norms around female sexual agency, leads to coerced abortions and delay in seeking abortion services. So, in this situation, the abortion stigma was compounded by the stigma around sexual activity outside the institute of marriage among young women. Similarly, studies conducted among HIV-positive pregnant women considering abortion from South Africa found that they experienced social disapproval at two levels – if their pregnancy status is known along with their HIV-positive status and for their desire to access abortion. [29]

Higher rates of unintended pregnancies are reported among women from marginalized sections, indicating that social and economic marginalization could further restrict sexual autonomy and reproductive freedom. A study that explored the incidence of unintended pregnancies in the United States reported clear disparities in rates according to age, race, ethnicity, and class. Young African American, Latino, and poor women reported a significantly higher rate of unintended pregnancies. Similar disparities have also been reported in the case of access to abortion, where non-poor women were found to have greater access to abortion compared to poor women. [30]

Role of local contexts in the social production of abortion stigma

Research on stigma suggests that, although it has emerged in a multitude of diverse social and cultural settings across the world, its actual production is profoundly local. The role of social relationships and cultural constructs set in "local worlds" is of great significance to not only understanding its production but also its impact. [29] In the case of abortion stigma, we have limited understanding about how it is produced and shaped in specific communities, its impact, and how it can be countered. However, available literature in this area and mass media accounts clearly indicate that despite common denominators and shared outcomes across cultural settings, the production of abortion stigma is local. The meanings of abortion can change across settings and over time, necessitating an in-depth understanding of the social relationships, cultural constructs, and norms of the local communities where stigma operates, and its impact on individual perceptions and on institutions where such services are delivered.[6] The impact of stigma on access to services and quality of care also needs to be explored in specific contexts.

OBJECTIVES AND CONCEPTUAL STUDY PLAN

The study has the following objectives:

- To explore how informed the young people associated with two specific marginalized communities are about the legality, safety, and availability of induced abortion and to identify the sources of this information.
- To identify the barriers faced by young people associated with the marginalized communities in accessing safe abortion services.
- To explore the perceptions of young people associated with the marginalized communities regarding the acceptability and social consequences of abortion.
- To explore the socio-cultural construction of abortion and the stigma associated with it, from the perceptions of the gatekeepers of the marginalized communities and representatives from the institutions functioning within these communities.

Through this exploratory study, we intended to examine abortion stigma at three levels namely individual, community, and institutional.

INDIVIDUAL

- Information pertaining to legality, safety, availability among young people
- Barriers to access information & services among young people
- Perceptions regarding the acceptability and social consequences of abortion among young people

COMMUNITY

- Socio-cultural construction of abortion in the community - norms
- Information pertaining to legality, safety, availability among the gate keepers
- Perceptions of gate keepers regarding the acceptability and social consequences

INSTITUTIONAL

- Construction of abortion among the representatives of institutions functioning in these communities
- Information pertaining to legality, safety, availability among the stakeholders
- Perceptions of stakeholders regarding the acceptability and social consequences

METHODOLOGY

Data Sources and Methods

In-depth interviews among young people and key informants from the community and local institutions were the primary method of data collection. Documentary information in the form of relevant administrative documents, formal studies, or news clippings regarding access to abortion, barriers to access, and/or abortion stigma were used when appropriate. This also helped us explore the context and to identify sources of the perceptions among the community members.

Sampling

The respondents were selected using theoretical sampling from three major categories conceptualized as the following:

A. **Young people** (with a reported age between 18 and 24 years of age) who either belonged to the coastal and the tea plantation communities or those who did not belong to these communities, but who were either residing in the study setting or associated socially with young people from the community (attending same educational institutions, part of the same socio-cultural and/or political organizations and so on).

B. **Key informants from the community** occupy powerful positions in the community by virtue of their educational background, social and/or political position. Leaders of workers' collectives, women's collectives, trade unions, political, social, or cultural organizations, and other prominent community members were included.

C. **Key informants from local institutions** such as the members of the current local self government and health care providers from both private and public health facilities, public health professionals (Health Inspectors and Public Health Nurses) and community health workers (ASHAs) associated with the local health system, anganwadi staff and representatives from self-help groups like Kudumbashree.

From each of the above groups, the first round of respondents (two people each) were selected, interviewed and the interviews were analysed. Based on the emerging themes, we decided as to what areas to explore further and the kind of respondents to be interviewed.

Data Collection

The data collection was conducted virtually whenever possible to reduce direct physical interactions considering the pandemic situation. When direct face-to-face interviews were required, all precautions were taken in terms of an appropriate venue, maintenance of safe distance and all personal protective equipment for the safe conduct of the research. IDI schedules were prepared in English and translated and culturally adapted to Malayalam and Assamese for Kerala and Assam respectively. The interviews were conducted from the period of June 2021 - August 2021.

Data Analysis

The IDIs were audio-recorded, transcribed, and translated to English simultaneously, with utmost care to preserve the cultural nuances of the conversations. The documentary evidence and the transcripts were coded, guided by the conceptual framework. The codes were then thematically analysed using the method of constant comparison.

Ethical Considerations

The detailed research proposal incorporating the potential risks and benefits was cleared by the Ethics Review Board at The YP Foundation following due process. Verbal informed consent was sought from every respondent after explaining to them the research objectives, methods, and potential risks.

FINDINGS & ANALYSIS

Overall Context of the Study Setting

In this section we discuss the characteristics of the respondents, the overall social and economic context of the study settings, and the major social issues faced by potential abortion seekers from both the communities studied in Assam and Kerala.

Characteristics of the respondents

A total of sixteen in-depth interviews were conducted from the indigenous tea plantation community residing in Jorhat district, Assam, and twenty in-depth interviews from the traditional fisherfolk community of coastal Gram Panchayat, Thiruvananthapuram, Kerala. The following tables, Table 1.1 to Table 1.4, describe the characteristics of study respondents from the tea plantation community, whereas Table 2.1 to Table 2.4 describe the characteristics of study respondents from the coastal community.

Table 1.1 Young people belonging to the tea plantation community

#	Gender	Age	Caste/ Religion	Marital Status	Children	Educational Background	Employment Status
1	Woman	18	Adivasi	Married	0	Completed 5th standard	Tea plantation worker
2	Woman	20	Hindu, OBC	Unmarried	0	Completed 9th standard	Unemployed
3	Woman	18	Adivasi	Unmarried	0	Pursuing10th standard	Student
4	Man	24	Adivasi	Unmarried	0	Graduate	NGO worker

Table 1.2 Young people who do not belong to the tea plantation community but reside in and/or socially associate with young people from the community

#	Gender	Age	Caste/ Religion	Marital Status	Children	Educational Background	Employment Status
1	Woman	22	Hindu, OBC	Unmarried	0	Completed 12th standard	NGO worker
2	Woman	22	Hindu, OBC	Unmarried	0	Pursuing Master's	Student
3	Man	23	Hindu, General	Unmarried	0	Pursuing Master's	Student

Table 1.3 Community key informants from the tea plantation community

#	Gender	Age	Caste/ Religion	Marital Status	Children	Educational Background	Role in Community
1	Woman	25	Hindu, OBC	Unmarried	0	Graduate	NGO worker
2	Woman	26	Hindu, ST	Married	0	Graduate	NGO worker
3	Woman	37	Adivasi	Widow	2	Completed 10th standard	Member of Adivasi Women's Association, Former ASHA worker
4	Woman	25	Adivasi	Married	1	Respondent cannot recall	Tea plantation worker
5	Woman	29	Adivasi	Unmarried	0	Completed 12th standard	NGO worker

Table 1.4 Institutional key informants from the tea plantation community

#	Gender	Age	Caste	Marital Status	Educational Background	Role in Community
1	Woman	38	Hindu, OBC	Married	Completed 10th standard	Auxiliary nurse midwife
2	Woman	40	Muslim, ST	Married	Respondent cannot recall	ASHA worker
3	Woman	38	Hindu, OBC	Married	Respondent cannot recall	Anganwadi worker
4	Man	28	Christian, OBC	Married	Completed 12th standard	Oversees clinical charts in the dispensary

Table 2.1 Young people belonging to the coastal community

#	Gender	Marital Status	Children	Educational Background	Employment Status
1	Woman	Married	2	Completed 12th standard	Homemaker
2	Woman	Married	2	Completed nursing	Employed as nurse in a private hospital
3	Woman	Unmarried	0	Did course on Business Process Outsourcing	Employed in techno park
4	Man	Married	1	Graduate	Unemployed. Earlier employed in the Middle East pre-pandemic.
5	Man	Unmarried	0	Completed 12th standard	Plumber, welder, painter
6	Woman	Unmarried	0	Pursuing B. Comm	Student

Table 2.2 Young people who do not belong to the coastal community but reside in and/or socially associate with young people from the community

#	Gender	Marital Status	Children	Educational Background	Employment Status
1	Woman	Unmarried	0	Pursuing Nursing	Student
2	Woman	Unmarried	0	Graduate	Previously employed; in between jobs at the time of the interview
3	Woman	Unmarried	0	Graduate	Unemployed

Table 2.3 Community key informants from the coastal community

#	Gender	Marital Status	Children	Educational Background	Role in Community
1	Woman	Married and separated from husband	2	Graduate	Social activist with experience in public health associated with multiple NGOs
2	Woman	Married	3	Completed 10th standard	Fish seller and independent social worker
3	Woman	Married	2	Completed 10th standard	Tailor and ASHA worker
4	Woman	Married and separated from husband	1	Completed 12th standard	Runs a small shop, Social worker and formerly actively involved in fisher women's collectives. Former ASHA worker.
5	Woman	Married	2	Completed 10th standard	MNREGA overseer at the gram panchayat. Former social worker involved in activities related to women's health.

Table: 2.4 Institutional key informants from the coastal community

#	Gender	Educational Background	Institution	Role in Community
1	Woman	MBBS	Local government health facility	Medical officer for the past three years
2	Man	Completed 10th standard	Gram Panchayat	Ward member
3	Woman	MD	State health services	Medical officer and former reproductive child health officer
4	Woman	B Sc Nursing	Local government health facility	Lady health inspector
5	Woman	Graduate	Gram Panchayat	Panchayat president
6	Woman	Completed 12th standard	Gram Panchayat	Chair of standing committee on health

Social and economic context of the communities

Jorhat is an administrative district of Assam, located in the central part of Bhramaputra Valley, spreading over 2851 sq. km, with a population of 1,092,256 and a density of 383 persons sq. km. The population comprises SC and ST communities of 7.61% and 12.09% respectively of the total population and has a sex ratio of 962 females per 1000 males. Jorhat is known for its cultural and historical heritage and is a commercially valuable district of Assam for its extensive tea-plantations gardens. The tea plantations not only contribute to the economy of the district but also to the state.[31]

The study setting chosen for the study is one of the tea gardens out of the over 135 tea gardens spread across the district. The participants interviewed for the study lived around the tea garden, either engaged in working as labourers, or engaged with the community via other institutional engagement. The community at large consists of religious, ethnic, and caste minorities. The tea garden workers historically were indentured labourers brought in the 1860s from present-day Jharkhand, Orissa, West Bengal, and Andhra Pradesh. They prefer calling themselves 'Adivasi' instead of the 'Tea-tribe' community.[20] This is an act of political assertion of their tribal identity to be recognized through the 'Scheduled Tribe' status, and a larger part of their collective demand for indigenous rights.

The Adivasi community predominantly follows Christianity as their religion. The community acknowledges the role of Christian Missionary schools and their positive impact on the life of tea workers through literacy. The women interviewed largely belonged to the Hindu OBC and Adivasi community and are predominantly employed as labourers in the tea plantation estate or work in local NGOs that engage with the community. The community at large has a low educational rate. The educational qualifications of the respondents ranged from primary school to graduation, however, most women had only completed the primary level of education. The community also witnesses early marriages and adolescent pregnancies.

The labourers at the tea plantations work for 10-12 hours a day, leaving their homes at 6.00 am in the morning to work at the *Bagaan* (tea garden) till 6.30 pm in the evening. They work long and hard for low wages which impacts their overall physical and mental health. As shared by most of the respondents, they develop work-related health issues, such as skin diseases, malnutrition, anaemia, and diarrhoea.

> *"Most of the people in our area are so busy with work, they don't have enough time to eat properly and timely. Due to financial constraints, they cannot take the necessary vitamins and are ultimately deprived of adequate nutrition."*
>
> *~ Young woman from the tea plantation community*

Owing to the impact of the COVID 19 pandemic, economic conditions have worsened for the tea-plantation workers. Several tea estates were closed during the nationwide lockdown that resulted in job scarcity and financial constraints. Adding to the lockdown, the community also underwent severe social and economic deprivation during the annual torrential rains and floods from May to July 2020. The rise in COVID cases has brought out the starkly inadequate health infrastructure for tea-plantation workers.[32] Respondents observed that the congested dwellings, lack of isolation facilities, and the abandoned hospitals in the tea gardens, have aggravated the health conditions of the workers.

> *"Despite the Swacch Bharat Abhiyan, we still don't have toilets in many homes. It hasn't been 100% successful. The drinking water that is provided to the tea garden workers isn't clean. The workers don't have access to any facilities, be it toilets, clean water for menstruating women. I feel this is also a reason that contributes to the overall poor health of the workers"*
>
> *~ Young woman from the coastal community*

The health indicators of the tea-plantation workers such as IMR and MMR have been consistently poorer than the rest of the state.[20] Anemia, iron skin diseases, tuberculosis, and malnutrition are also commonly reported, especially among women and children of the community.[22, 23] According to Census 2011, the prevalence of access to safe drinking water in rural households of Assam was found to be 68.3%. [33] Based on a study conducted by the Department of Community Medicine of Jorhat Medical College in 2018, it was found that 64.1% of study respondents belonging to the tea-garden population practice open-air defecation.[34] The ration cards that allow economically marginalized communities to access subsidized rice and wheat under the PDS system have not yet been availed to the tea plantation labourers. According to the Plantation Act, the subsidized ration is part of their wages. However, in the absence of ration cards, the provision of subsidized rations by the estates is not efficient and transparent and this has resulted in many protests and petitions filed by the labour unions since 2003. [35]

Even though every tea garden has local dispensaries that the community heavily depends on, access to it is disproportionate. The beneficiaries of health covers that are accorded by the Plantation Labour Act of 1951, which mandates tea-managements to provide free health services are only limited to the 'permanent employees' and theiir dependents. However, this excludes a major chunk of the population, as tea-plantation labourers are mostly hired as 'casual workers'. This makes them more susceptible to exploitative working conditions. The community largely opts to consult local and traditional healers or resort to home remedies to cope with this situation. Women who are the predominant workforce in the tea industry continue to face increased discrimination. They are

often denied the maternity and related benefits that are covered under the Plantation Act, denying them adequate rest during pregnancy and post-partum.

The community is dependent on the Panchayat meetings, Anganwadi, and ASHA workers for information related to government policies and schemes. However, the extent to which these channels are effective in providing the necessary health-related information to the communities is called into question, when we encountered workers who had not heard of the Covid-19 pandemic. The topographical location of hilly terrains, distant health facilities, lack of infrastructure and not having access to timely information puts the community at risk and creates several barriers to accessing healthcare and facilities.

The **traditional fisherfolk community of Kerala** has undergone a major economic decline over the past two decades. Repeated climatic disasters starting from the Indian Ocean earthquake and the consequent Tsunami along the Kerala coast (2004), the more recent Ockhi cyclone (2017), and the devastating floods (2018 & 2019) have wreaked havoc on the lives of the fishing community of the state.[36] In addition to the climatic changes which affected the behaviour of the ocean, the regulations imposed by the state on fishing as part of the disaster reduction strategies, the steady depletion of marine resources attributed to climate change, rising ocean temperature, and the dumping of plastics and other toxic waste into it are some of the factors mentioned by the respondents as the potential reasons that contributed to the economic decline. Some of the respondents have also raised the role of the Vizhinjam International Deepwater Seaport project in sea erosion and sea advancements, in addition to effectively reducing the areas where they can fish, contributing to their existing woes. The pandemic and the restrictions imposed as part of the state's measures to manage it have further worsened the situation, significantly compromising the livelihoods of thousands of families whose lives have been entirely dependent on the resources from the sea.

The respondents perceived that the recent ecological and political changes have pushed their community further behind economically, and consequently reduced their standard of living. Due to the failing fishing sector and the absence of other jobs which earn them a steady income, those traditionally engaged in fishing have been facing severe financial distress for over a decade. Many of these families have been able to tide over the crisis to an extent when young men started migrating to Gulf for jobs. However, the pandemic has forced a significant proportion of them to return home and are now left without jobs.

The coastal Panchayath in South Kerala where the study was undertaken is one of the most densely populated in the state. [37] The poor sanitation and consequent contamination of water sources made the community vulnerable to the easy transmission of water-borne diseases like cholera and acute diarrhoeal diseases in the past. [38] In 2020, several wards in the Panchayath reported positive cases

of Covid-19 through local transmission as the high population density practically excluded the strategy of social distancing. [39] The respondents opined that the financial distress experienced by the families has affected the quantity and quality of their diet. In the past, the community considered themselves to be healthy and highly immune to diseases since they consumed a significant amount of good fish. However, due to the depletion of marine resources, they sell whatever fish they manage to catch and this omission of fish from their diet which had been a staple component until about a decade ago, has affected their health in a major way. The social workers who have worked for decades in the community felt that the families tried to compensate for the absence of fish by increasing the amount of rice because it was available free of cost through the Public Distribution System. This compounded by the poor use of vegetables and other sources of protein in the diet has in effect increased their risk of developing non-communicable diseases. Many also attributed the poor disease immunity to the use of "contaminated" vegetables imported from other states, which were not organically cultivated. In addition, the loss of traditional healing practices of the community, especially those related to post-delivery care among women, were also reported to have long-reaching consequences on the immune system of the community members through their impact on the quantity and quality of breast milk.

One of the sectors that have marked a positive transformation in the community since the nineties has been that of women's education. There are many women graduates and postgraduates from the community and due to the early dropout of men from schools, this has also led to the creation of a gap in the educational status between men and women. The rise in consumerism in the globalized era, the availability of credit from several sources including the Panchayath and women's self-help groups like the Kudumbashree and the Gulf remittances have led the community to build attractive houses and purchase other amenities even in the midst of continuing financial distress. Consumerism has also been reflected in competition among families regarding the size of the houses, the number of household amenities, and the amount of money spent in the wedding ceremonies of daughters, leading them to owe money in the form of debts and loans.

The community acknowledged that the government, especially the local governance, has been periodically undertaking several measures to help the community cope with the financial distress. However, they also felt that certain measures like distributing fishing nets and catamarans every year, although well-intentioned, do not acknowledge the factors contributing to the failing sector and economic decline. They felt that the solutions constituted a "quick fix" without attempting to delve deeper and address the fundamental realities of the community. The key informants observed that this may be one of the reasons for a certain amount of mistrust that the community feels towards the system. However, they also felt that, despite the initial hesitation and mistrust, people do listen and

co-operate to the plans of the government, when they are promptly communicated to them, as indicated by the success of the Covid-19 vaccination drive.

Social issues faced by women of the communities

The women from the community join the plantation work from a young age. They are assigned for plucking tea leaves that involve vigorous physical activities such as standing, walking, ascending, and descending hills, for long durations under intense heat. Lack of mobility and financial agency often restrict women from exercising their bodily and reproductive autonomy. Poor access to education also plays a role in how they exercise this right. While the community largely depends on ASHA and Anganwadi workers for information on public schemes and policies, a small proportion of educated women rely on the internet for information regarding sexual and reproductive health. The respondents observed that the school enrolment of children, especially girls, is lower among the workers of the tea garden community. Children from the community are often the first-generation learners, their parents being either illiterate or with low educational qualifications. It has been reported before that the girls from the community are not encouraged to study beyond the primary level.[40] The economic backwardness, poor emphasis on girls' education, early marriages, and unavailability of appropriate learning avenues contribute to low literacy among women workers. Women respondents pointed out that they have no opportunities or platforms to discuss their sexual and reproductive health concerns either within or outside their families. In the absence of healthy spaces to freely talk about these concerns, the privacy and freedom provided by mobile phones, which have become a major source of health-related information, constitute a liberating experience for women. However, many of the respondents pointed out that the "overuse" of mobile phones by women constitutes a significant social change with potentially negative consequences for their family life.

> "*Most women here are uneducated. Young girls have to drop out of school around 5th-6th standard. Hence, they earn very low incomes. Their parents also cannot afford to continue their education. These girls have to join the workforce at a very young age"*
>
> *~ Middle-aged anganwadi worker serving the tea plantation community*

Child marriage is another social issue that has been identified by the community. Adolescent girls are married off as soon as they hit puberty, and this burdens them with household work in addition to the work on the tea plantation. Early pregnancies are also reported from the community deepening the vulnerability of young women. The respondents observed that the use of modern contraceptives among the tea garden labour community is low. The respondents opined that multiple, frequent childbirths with poor spacing were responsible for high maternal deaths in their community. In the absence of adequate support from their partners and financial insecurities, the women workers were

left with the responsibility to support and feed their children. This compelled them to continue work even during ill health and advanced pregnancies and consequently, spontaneous abortions have been reported among women while at work. Similarly, they do not have the choice to take adequate rest after deliveries too with long-term consequences for their health. Thus, being overworked and underpaid have significant effects on the reproductive health of women workers from the community. Recently the state government increased the daily wages of tea garden workers by 50 INR making it to a total of 217 INR. The workers had demanded a raise in daily wages to 350 INR for a long. However, the respondents observed that even if they had been given the demanded wages, it would have been impossible for the workers to live a dignified, healthy, and safe life.

> *"Such cases (spontaneous abortion) especially come because of excessive work-related cases. In the case of the first child, there needs to be a rest for four months but they cannot take that rest, they go to work in the gardens and exert themselves."*
>
> *~ Auxiliary nurse midwife serving the tea plantation community*

A lowering age at marriage has been observed among the women from the coastal community, and the respondents from all three categories namely, young people, community key informants, and institutional representatives opined that many young women got married between 18 and 20 years of age and this was considered an issue which required serious consideration. Although many observed that, getting girls married off in their adolescence was a common practice in most of the communities until the latter half of the twentieth century, and compared to that, things are definitely better now. However, many felt that the current pattern of lowering marital age was mostly related to growing consumerism and the resultant competition amongst families as to "who gets their girls married off first" and "how grand the ceremonies are". Another perspective was that early marriage of women was the community's response to young women going astray under the influence of social media bringing "disgrace" to families. Marriage was used as a way to control them. This has to be read in tandem with the issue of underage pregnancies and the demand for induced abortion highlighted by the Medical Officer at the local government health facility. Another theme that emerged from many of the key informants and institutional key informants was that the community accorded a lower value to women, which in turn reflected in the life of women within families. The families considered young women a "burden", who could bring them no returns except humiliation and shame if not married off at the right age. The young women who got married at such young ages get into the institution without much idea about the expectations from them, responsibilities associated with it, and information regarding sexuality, reproduction, and child-rearing. However, there was also an observation that overt exposure to "social media" made girls mature earlier than required, and hence they are indeed ready to be wives and mothers. The fact that many of these women get pregnant within the first few months or even weeks of marriage was pointed out by the

respondents from the health system, raising questions about their sexual agency, reproductive autonomy, knowledge about birth control, and power to negotiate birth control within marriages.

> *"Yes, it is true that in coastal area lots of early marriages are happening because if a parent is having a girl child, they are very much disturbed and worried about their child. When this child finally get married, they feel very relaxed. I think… having a girl child for them is like a liability because they are very much scared if this girl will fall in love with someone unsuitable and then create a bad name for the family. That happens a lot in these areas. Girls elope with men from other religions or men who are not capable to run a family and so, due to these reasons, they arrange a marriage for girls at the age of 18 or 19. I think this is a more recent trend."*
>
> *~ An elected representative from the coastal community*

The idea that the internet and social media brought more harm than good to families was almost unanimous among the respondents. Overuse of mobile phones was found to reduce family time, quality of communication, and emotional bonding within families. Women were found to be the ones who bore the greatest brunt of this poor emotional bonding and lack of family support. Many observed that married women, especially young women, felt lonely and isolated within families, which in turn forced them to seek happiness and company outside marriage, which was again made possible through social media. The dominant voice amongst the respondents was that women were mostly trampled or neglected within their own homes, denied rights, and conditioned to accept their situation without complaints.

This lack of partnership and support experienced by the women is enhanced by the gendered roles and responsibilities. Alcoholism among men added to their concerns and was frequently the reason for domestic conflicts and violence. In many of the families, men were considered the "providers and breadwinners", but were not actually accountable for running the families. It also worsened the financial insecurities of families, as men spent whatever little they earned on liquor leaving the women to fend for themselves and their children. The women were ultimately accountable for running the establishment by saving money, raising loans and investments through Kudumbashree and micro-financing schemes, building homes, finding resources to educate children, getting them health care when required, and marrying the daughters off. Many of them were engaged in selling fish at the major markets of the city. Women constituted the majority of the labourers in the region since men were not willing to work for the wages offered for manual labour. They were also the breadwinners for those families where men could not generate adequate income through fishing and other local jobs. There were also families run by single women who were widowed, separated from

or deserted by their husbands. Many of the women belonging to families traditionally engaged in fishing were overworked, underpaid, and suffered a significant amount of psycho-social stress.

The respondents observed that there has been a shrinking of social spaces for women to come together and share their issues. One of the reasons for this is the eroding shorelines brought about by the torrential rains and the consequent loss of beach spaces. Another reason has also been the decline of civil society engagements and social and cultural activities involving women over the past decade. Such activities were very common during the nineties and the first decade of the millennia and organizations like Sakhi had worked actively among women and youth of the community focussing on promoting their health and education. Many social activists observed that the absence of platforms for health promotion and for women to discuss their issues openly have significantly affected their physical and mental health. They concluded that society demanded too much out of the women from the community, leaving them stressed and vulnerable, and empowerment was still a distant dream for them.

Sexual and Reproductive Health and Rights among Women from the Study Settings

In this section we discuss some of the prevailing patriarchal notions in both the study settings on sexuality and reproduction, the major health concerns of women especially those related to sexual and reproductive health, and rights among the women from the communities, their opportunities to be informed of sexual and reproductive health, the sources of information available to them, the status of health services available to the community members and the perceptions of the community members and institutional key informants on family planning in both the communities.

Patriarchal notions prevailing in the communities on sexuality and reproduction

Prior to exploring the status of sexual and reproductive health and rights in the community, it is critical that we examine the prevailing notions and norms guided by patriarchy. Sex outside marriage is considered immoral and shameful by the tea plantation as well as the coastal community. Underage pregnancies, premarital sex or pregnancies as expressions of uncontrolled sexuality of young women have been pointed out as a grave rising concern in both the communities. In Kerala, specifically, this has been considered a side effect of unrestricted modernity. Although the communities endorse the need for sex education, there was a dominant voice expressed that that too much information about sexuality could do more harm than good to young people, especially

women. Premarital sex and pregnancies are considered extremely humiliating incidents not just for the concerned families but also for the community as a whole. The communities are extremely conscious of their social image and the families do not tolerate such indiscretions by young women. The taboo around sex outside marriage and the aggressive stance of the elders restrict any opportunities in the community for conversations around sex. Adolescent girls have no opportunities to have healthy conversations about sex within families. Young women responded that many of them did not have any platforms to discuss their concerns or clarify their doubts when they were adolescents. If a girl was found to have engaged in premarital sex or if she is found pregnant and if she is legally an adult, the quickest solution would be to locate the man that she has been involved with and get them married off. In certain other situations, respondents from Kerala shared that the parents may not even attempt to find the man involved for fear of embarrassment and would take the girl for induced abortion. Older men and women from the tea plantation community also felt that unmarried women will resort to abortion in secrecy in order to protect her 'honour'. There have been several cases in the tea plantation community where young couples have eloped fearing societal consequences for premarital relationships and sex.

> *"Society is progressing. But at the same time, there are also side effects to this progress. When we talk to schools and so on, we understand that young girls are closely interacting with auto drivers and people like that. Once we had to interact with a doctor in medical college as a part of a Sakhi campaign and he told us that in the few months prior to that conversation close to 40 or 50 girls these areas have been brought there by the parents for abortions."*
>
> *~ Middle-aged woman from the coastal community (social activist and former ASHA worker)*

Both the communities had strong views on the centrality of motherhood. The dominant voice regarding the roles of men and women clearly differentiated between them and stated that while fatherhood is not the primary role of a man, motherhood is the definitive defining trait of a woman. A woman is the primary parent of a child and is ultimately accountable for them even if they are yet unborn. Thus, despite talks of equality, the community members endorsed the view that men and women have different roles within families. Hence, they considered the refusal of a pregnant woman to induce an abortion and willingness to continue the pregnancy as ideal traits. Such views glorifying maternity were also raised by the health system key informants. Some of the respondents from the coastal community said that adolescent girls and young women should be cared for and groomed to ensure that they will be good mothers in the future.

Although the dominant views in both the study settings had quite clearly expressed that all the crucial decisions regarding birth control and family planning were finally taken by the men, denying women any choice over their own body and health, they still held on to the view such decisions cannot be

and should not be taken by women alone. They believed that these decisions should be discussed as a couple and should be taken jointly. They also believed that if women attempt to independently take such decisions, then that would lead to conflicts in families. The respondents from the tea plantation community felt that adolescents and young women would be more susceptible and pushed to consult local healers and *dhais* (midwives) instead of accessing public healthcare in case of unintended pregnancy.

The notions of masculinity have been captured well from the coastal community. The whole concept of a man from a coastal community can be encapsulated in one sentence, *"He is like the sea itself. They get hot and cold like the sea. When they are hot they are burning. When they are cold they are freezing."* The community key informants reminisced that earlier, the men from the community were more masculine and had greater stamina, although this meant that they were more aggressive and insensitive to women. The younger men, on the other hand, were perceived to have much lesser machismo and were much more sensitive in their interactions with women. The response of such aggressive masculinity to any kind of crisis is also self-destructive and violent, potentially leading to the rise in alcoholism, substance abuse, and domestic violence as a response to the financial distress. Women from the tea plantation community have shared their concerns of rise in domestic violence as well. Many respondents shared that a critical reason for the women from the community to continue with an unintended pregnancy was the fear of spousal violence, as the mere suggestion of termination could aggravate the husbands. Women from both communities opined that they did not have a say in decision-making related to pregnancies or abortions. In the tea plantation community, the decision-makers were husbands, in-laws, guardians, or partners. However, regardless of poor agency and autonomy, the social onus of pregnancy or abortion and the accountability towards the consequences of these decisions rested on women regardless of their marital status. For instance, the responsibility to rear the children born out of their pregnancies or the social labelling of "the one who underwent abortion" had to be borne by the women. The married women from the tea plantations also underwent considerable pressure to undergo repeated childbirths until a "male" child is born.

> *"In our society, the family often expects a grandchild right after a year of marriage. The husband also desires to fulfill his parents' wishes and feels that he needs to have his own progeny. All of this together influences the woman a lot. Thus, before the woman can get properly adjusted to her new family, she gets pregnant. There are instances where the woman gets pregnant just 2-3 months after marriage. Moreover, there is also a fear of second marriage in case the women cannot bear children. We do get to hear such cases. So, I think the pressure is more from the family and husband's side."*
>
> *~ Young woman from the tea plantation community*

"The men in the coastal community are like the sea. They get hot and cold like the sea. When they are hot they are burning. When they are cold they are freezing. They don't understand the problems or situations of women. That is their physical nature. They won't bother if their wife is healthy or is she having her periods now. They don't bother about any of this when they approach them physically. Their position is when they approach them, these women should be ready for them and welcome them. If that doesn't happen, in those houses... (Laughs)."

~ Middle-aged woman social activist from the coastal community

Sexual and reproductive health and rights of women

There was a general consensus among the respondents from both the communities that there was a decline in the overall health of women in the community with tiredness, fatigue, and anaemia caused by under nutrition, change in dietary patterns and decline in physical activity that have led to the rise in chronic non-communicable disease and chronic pain. The key informant from the health system also pointed out the rise in hypothyroidism and polycystic ovarian disease among the women from the coastal community. In addition to these, there are issues of recurrent urinary tract infections and white vaginal discharge. This is especially among women who are engaged in selling fish, the primary reason being reduced water intake to avoid frequent urination since they don't have access to clean toilets in the marketplaces where they spend long hours. The respondents from the tea plantation community shared young people experiencing issues like Dhat Syndrome and white vaginal discharge. Most of them are unable to consult the local dispensaries because of the stigma around sexual and reproductive health. Miscarriages and infertility are also observed to be on the rise in both communities. Dysmenorrhea in the form of severe pain, muscular cramps, and vomiting was reported as a significant issue faced by young and adolescent women. Social workers observed that unhygienic menstrual practices were very common among the women from the coastal community until a decade ago. Various interventions to address this were undertaken by civil society organizations and also the government health system through the invaluable work of the Public Health Nurses and consequently things have definitely improved significantly over the past decades. However, adolescents and young women still need guidance in these aspects. While in Assam, women shared that menstrual health issue continues to be taboo subject. The lack of toilet spaces, also makes it difficult for menstruating women working on the tea plantation.

Lack of sexual agency among women is one of the most reported concerns. Many respondents from the coastal community commented about the situation where women had to be ready for sexual intercourse whenever men expressed a desire to do so, regardless of her mental or emotional status and/or willingness. This was expected from a woman even if she was menstruating or physically

unwell. Many women from the coastal community expressed that they were leading unhappy, unhealthy sexual lives, where sexual intercourse was often non-consensual and women were forced to engage in sexual acts that they were not comfortable with. Some of them even reported having contracted sexually transmitted infections from their husbands. Sexual incompatibility had become a common cause of conflict among young families and when younger women resisted sexual advances from their husbands, that led to issues in families which escalated into instances of domestic violence. Alcoholism and substance abuse among men frequently accentuated such conflicts leading to sexual violence and breakdown of family planning. Respondents from the tea plantation community repeatedly shared narratives of child sexual abuse reported in the community, often leading to adolescent pregnancy.

The respondents observed that poor reproductive autonomy was another major concern faced by the women from both communities. While unwanted, unplanned pregnancies have always remained an issue for women, the lockdown introduced as part of pandemic management enhanced the risk of unwanted pregnancies for several reasons. In addition to the fact that men spent more time within houses, the lockdown also added to their financial distress, which worsened the conflicts within households. Such conflicts in the coastal community could also be due to the gap in educational status between genders among the youth, with many women being more highly educated than men. The unavailability of liquor due to the closing down of liquor shops had the advantage that men did not have access to alcohol, however, it was a major disadvantage to those women whose husbands were addicted to alcohol, as they grew particularly aggressive as part of withdrawal. Thus, the lockdown increased the risk of sexual violence and unplanned pregnancies among women.

> *"Women don't have that freedom at all. Women cannot think and decide that these are my preferences, this is the situation of my health, I need to have children only after say two years or say five years. The husbands are not willing for that kind of negotiation. When young women try to negotiate and say I am tired or I don't want to have children now or I don't want to have sex, then in such families, there are too many conflicts and arguments. At the same time, nurses or the ASHA workers who work under them, they do come and tell the women after a delivery that considering the situation of your health now, let us insert Copper T or Nirodh for say three years or five years. Are you willing? Suppose due to ill luck if the husband comes to know about this conversation, then these people will be driven away."*
>
> *~ Middle-aged woman social activist from the coastal community*

The interviews with community key informants and young women revealed that there were a multitude of reasons why women wanted to avoid or delay pregnancies. Financial difficulties and concern for one's own health were among the major reasons. The respondents agreed almost

unanimously that ideally, pregnancy required planning and preparation and that it could not be imposed upon women. Women moving into their husbands' households after marriage itself constituted a huge adjustment. An unplanned pregnancy would add to their pressure and would be difficult to come to terms with. However, even educated women did not have the freedom and space within families to negotiate reproductive choices. In reality, men almost completely dominated all decisions related to sexual relationship and reproduction in most families in both communities. As a consequence of this, instances of unplanned pregnancies do occur, affecting women's plans for their future such as education and careers and their physical and mental well-being. More often than not, they continue with the pregnancies under familial and societal pressure. The respondents opined that younger, educated women found it difficult to come to terms with unplanned pregnancies compared to women from the previous generations and that it could affect the emotional bonding between the mother and the infant leading to lesser breast milk production. In effect, this amounts to blaming young mothers for what may be the result of a combination of factors such as poor health and anxiety among many other factors.

> *"When there is less money, men will go more into drinks and once they are drunk, they will behave badly to the women at home and this will create a lot of issues within families. Then, of course, men will spend more time within homes which means family planning will stop. That means, in many situations, the second child will be born even before the first one reaches one year of age. These are all issues."*
>
> *~ Young married woman from the coastal community*

Awareness on sexual and reproductive health and the sources of information available to the community

The women from the tea plantation community opined that they do not actively reach out to ASHA workers for information on sexual and reproductive health, as ASHAs are considered to predominantly work on maternal health and cater to pregnant women. So, the provision of information and services related to sexual and reproductive health concerns such as contraception and abortion are not considered to be the responsibilities of ASHAs.

> *"There are monthly awareness campaigns that are conducted by ASHA workers in Anganwadi centers. In these campaigns, haemoglobin levels of pregnant women are tested by government doctors. In case any health problem is detected, they are directly referred to Titabor Medical Hospital or Jorhat Medical Hospital. These women are also provided with iron tablets. However, sometimes these necessary injections and tablets for women and workers are prescribed by a doctor and are asked to buy them themselves. Since not all of them have*

the capacity to do it, they remain deprived of the necessary medication. Those who are a little more knowledgeable than the rest, try to get access to these medications through ASHA workers. The nearest sub-center is almost three kilometers away. Titabor Medical Hospital is almost 6-7 km away. Most of them don't have the money to be able to afford transportation. Moreover, they also have to rent the ASHA worker. The tea garden management has a provision to provide transportation to permanent workers. However, it will be only provided once or twice, which is not enough. Not only that, the fee is deducted from their wage for availing of the provision. Some take loans to be able to access necessary healthcare during pregnancy. Sometimes we try to offer help to a few of them, although we cannot help everyone. We also don't have enough funds but we try our best."

~ Middle-aged woman (former ASHA worker and member of Adivasi Women's Association)

The tea plantation community relies on ASHA, Anganwadi workers, Panchayat meetings, local dispensaries, government facilities, and local non-governmental organizations to access information on healthcare schemes and services. However, they fail to reach the vulnerable communities of women and children, especially on issues related to sexual and reproductive health rights. Adolescents and educated women rely on mobile phones and the internet for information. The ANM, ASHA, Anganwadi Worker, and Community Health Worker did not have adequate information on contraception and induced abortion.

The most common sources of knowledge related to sexual and reproductive health for the coastal community included the health workers, particularly the ASHA workers, the local government enhanced primary health care facility, internet and social media, friends or relatives with or without a background related to health, parents - particularly mothers for young women, the Catholic church, organizations like Kerala Catholic youth movement, magazines, television, and schools. Most young women reported that they had received sex education in schools, during higher secondary class. These classes were either given exclusively to girls or conducted separately for boys and girls. Adolescent girls reported on receiving classes limited to menstrual health and hygiene in schools. However, the young women respondents who reported to have attended such classes in schools acknowledged that because of the nature of these classes which were mostly conducted in large groups with little opportunities to freely interact or raise queries, they did not learn much. Except those with a nursing background, all the other young women respondents, regardless of their marital status, were not sure about the common birth control measures, legal status, methods, and safety of induced abortion. Another major source of information to women from the coastal community, especially the social activists and health workers, were seminars or workshops conducted by experts from the health system or other eminent personalities. Although the respondents who got the

opportunities to attend such sessions were far surer about the information they had, such classes were neither frequently conducted nor were these open to everyone interested. Yet another source of information that was accessible to everyone aged above 18 years was the premarital classes conducted by the Catholic church. Almost all the married respondents had attended these sessions and according to them, the sessions covered healthy sexual relationships and natural methods of birth control like the withdrawal method. However, the content of these classes revealed a strong negative stance against modern methods of contraception and induced abortion. A major source of information to young people was the internet, however, many of the respondents had serious reservations about the accuracy of the information that they received.

There was unanimous agreement among both the communities that young people did not have adequate awareness of sexuality and family planning. Since sex education was offered mostly during higher secondary schooling, completion of schooling up to this level was a prerequisite for young people to be introduced to this information. Since a good number of children dropped out of schools to join the workforce, especially boys in the coastal community, many respondents believed that young men had fewer opportunities to learn accurate information about sex compared to young women. This gap in educational status and consequent incongruence in exposure to information between men and women become significant in the context of sexual incompatibility, reproductive decision-making, and conflicts between young couples. Although young women of the present day, particularly the educated ones are better exposed than those from the previous generations to the ideas of sexual and reproductive health and rights, they are still not privy to accurate and comprehensive information about it before entering into relationships and/or marriage. The community key informants from the coastal community, particularly the older women insisted that it was necessary that the young people were made aware of natural methods of birth control like withdrawal, as it was both effective and suitable for the Christian way of life. The community health workers from the tea plantation community did not support the idea of educating young people on sexual and reproductive health and rights, they believed that this would create more instances of premarital sex, adolescent pregnancies, and abortions in the community.

> *“I also think in general use of family planning services is very less in this area. Madam, there are pills, condoms, Copper T etc. But in this coastal region, people don't have a lot of ideas about these things. When we go to the hospital for vaccination of the baby, the nurse will ask us, that if you have not stopped the delivery (tubectomy), then it is better to use condoms or pills or insert Copper T. But people who don't know about this may not take it in the right sense. They will think, "O these people say this all the time, let us not bother", and they will return home. Because they don't know in detail about the actual use of these methods.”*
>
> *~ Young married woman from the coastal community*

Another aspect which was uniformly agreed upon by the respondents of both the communities was the fact that there were fewer platforms in the community now than before for young people to discuss issues related to sexual and reproductive health and rights, clarify their concerns and acquire knowledge.

> *"When I started working around 4-5 years ago, I was not willing to talk about anything related to abortion. Even when it came up in a conversation, I would avoid it. I considered it a women's issue and thought I shouldn't bother about it as a young girl. When I started working with the community, with time I got to know about the various issues the women face. The more I engage with the community, the more I become aware of the problems the people face that they don't talk about very openly. There are young girls who don't have any knowledge about these things because these subjects are still taboo. There isn't much awareness about topics such as this among girls."*
>
> *~ Young woman social worker from tea plantation community*

Status of health services available: preventive, promotive, and curative

Every tea garden estate has a local dispensary that the community heavily depends on. The dispensary lacks regular assistance from a doctor or necessary amenities. In the unavailability of a doctor, the compounder and nurses provide all necessary medical assistance. In case of serious health issues, people have to travel 6-15 km to the district medical hospital of Jorhat. Even though the roads within the tea garden estates are slowly improving over the years, most roads are not that efficient for traveling and it becomes a deterrent while accessing such healthcare services. Respondents shared that there have been cases where patients were unable to reach the hospitals on time, resulting in their untimely demise. There is no local ambulance facility, but a small van owned by the tea garden can transport patients from the tea garden to the civil hospital. However, the availability of the van is hardly reliable and this poses a problem, especially during an emergency. People from neighbouring districts also access Jorhat Medical Hospital for treatment making it a challenge to accommodate patients more than its capacity.

Women hesitate to share their concerns in such hospital spaces owing to a lack of space and privacy and are unable to freely discuss their sexual and reproductive health needs. This has also denied them timely access to early diagnosis and care. They also shared their preference for a female gynaecologist, as thier visiting a male gynaecologist might displease their husband and result in rumours. The sub-centers and hospitals available to the tea plantation workers only have male doctors appointed currently. Women also fear judgment from medical professionals and are hesitant to freely discuss their reproductive concerns with a male doctor. So, they share their concerns with the female nurses and ASHA workers who accompany them. Many key informants observed that

the poor access to health services and its association with the social constitution of the tea plantation workers, Other Backward Castes, Dalits, and Adivasis, is indicative of systemic discrimination from the public health care system and consequent denial of health services.

The sub-centres refer the patients demanding or requiring induced abortion to the Jorhat Medical Hospital. The ANM shared that they hesitate offering services to unmarried women and demand consent from the women's family or from the husband in the case of a married woman. Nurses also discourage abortion in cases of first pregnancies since they are afraid that abortions could lead to infertility as a consequence. This pushes the community, especially unmarried young women to opt for local traditional healers, and *dhais* (midwives) for abortion service. Women also need a person to accompany them for abortion, otherwise, they are treated with suspicion and are not given due care in the hospitals. ASHAs are the point of contact for many women for accessing healthcare. However, ASHAs' overt focus on maternal health, their understanding of abortion as an illegal and immoral procedure prevents abortion seekers, especially unmarried and adolescent girls from reaching out to them. Women from the tea plantation community observed that sometimes they have to also 'rent' ASHA workers to assist them with health care procedures at the government hospitals, which amounts to added expenses. They also mentioned that ASHAs sometimes charge for sanitary pads and condoms.

The coastal community from south Kerala is mostly dependent on the local government-enhanced primary health care facility for their basic health needs. This facility caters to patients with five coastal village Panchayaths located under the same Block Panchayath. Due to the pandemic and the worsening of the financial distress, now they almost totally resort to the government facility for their health care needs, despite the fact that they have several reservations against the facility.

The facility singlehandedly caters to a large population and is extremely crowded. The small cabins for Out-Patient (OP) care and the inadequate number of doctors result in long queues and waiting time. The respondents believed that this affected the quality of care available to them as the doctor hardly got any time to listen to their problems or reassure them. They quickly prescribe medicines and move on to the next patient and the primary intention of the doctors is to dissipate the crowd at the earliest. Many of the medicines prescribed by the doctors are unavailable at the facility forcing them to purchase from pharmacies. This applies to many of the diagnostic procedures too. Although the facility is meant to offer services 24X7, doctors may not be there at night forcing them to rush to far-off government facilities or private facilities for emergency concerns. There may not be a female doctor all the time and this creates an issue for many women who have trouble discussing their intimate health concerns, especially related to menstrual health or sexual and reproductive health to male doctors. The lack of specialists like gynaecologists and paediatricians in the facility have also been raised by the community members as something that reduces its utility to the community. This

meant that hardly any procedures are undertaken at the facility, not even under emergency situations. This was pointed out by the community members as a concerning issue because they remembered that even deliveries had been conducted there until a decade back as compared to the present day when all that happens is prescription of medicines and referral.

However, the major concern faced by patients, particularly women from the community, is the almost complete absence of privacy in the Out-Patient wing, while they share their issues with the doctor. The small OP cabin is usually crowded with patients, many of them men, who are awaiting their turn and get restless if one patient takes a long time with the doctor. The closely packed households in the communities make it is very difficult for the individuals and families to keep their family affairs within the family and the line between public and private is already blurred for the community. Due to this very reason, privacy is something they value the most and the women would not disclose their intimate health issues with the doctor, however, grave they may be, if they don't feel that the setting is private and comfortable. Some of them would visit private health care facilities if they can afford it and if the issue is serious enough. Some others may completely forego health care leading to worsening of the situation. In fact, some of the community key informants attributed this lack of privacy in government settings to why many women are diagnosed with cancers in advanced stages. Thus, the opportunity of early diagnosis and prompt intervention of health conditions is denied to the women due to the lack of privacy in the local government health facility, inadvertently pushing them into advanced stages of diseases, with potentially fatal consequences.

The respondents observed that the needs of women do not seem to be prioritized by the system despite the fact that women are the greatest beneficiaries of this government health facility. The facility is not equipped to offer greater privacy and despite the fact that all the institutional key informants from both the local governance and the health system agreed that lack of privacy is an issue, no action had been taken in this regard yet. The issue had been raised several times before the Panchayath and no action has been taken towards this. The lady doctor at the facility quite openly expressed her skepticism regarding whether this is as huge an issue to the women from the community as it was made out to be, considering the fact that she found the women from the community "uninhibited and less shy" compared to other women. She also felt that any intervention in this regard, such as having a separate cabin for women and children or separate OP days or OP times for them, neither looks necessary nor feasible, considering their already busy schedule.

Most of the members depended on the nearest Government Medical College and/or the nearest Women and Children's hospital for secondary and tertiary care. The community members acknowledged that the introduction of government run-health insurance schemes is a positive step that has tremendously enhanced the health care access of the poorer sections. However, many of them pointed out that the way the government facilities and the schemes actually worked, rendered

the patients helpless and forlorn in many situations. Many of them had negative experiences related to health care visits where they were made to wait and wander around in government facilities, emphasizing the point that none of the schemes would be completely useful until the facilities prioritize the patients and respond appropriately to them.

Many respondents believed that they were “treated better” at private health facilities. There was less crowd, privacy, better behaviour from the staff and the doctors gave more time and care at private hospitals. However, it was unanimously agreed that private health care was unaffordable to the majority of the members of the community. But due to the overall dissatisfaction with the experience of health care in the government facilities and the barriers in accessing prompt care, the community was compelled to depend on private health facilities which incurred expenses beyond their means and which required them to borrow money. The fear of the pandemic has also increased the utilization of private health facilities, since the government facility is too crowded and maintaining social distancing was practically impossible there.

The efforts of the state health system in improving the health care infrastructure and the advancements made in reducing maternal and infant deaths were acknowledged by the respondents as they reminisced how powerless the community had been about the outcomes of pregnancy or childbirth until about three decades back and how things have drastically improved over the years. They acknowledged that the state has now practically taken the responsibility for pregnant women, ensures that they are safe during pregnancy, during and after childbirth along with the health and safety of children. While this is definitely laudable and has brought some great dividends, other aspects of women’s health like their general health, their sexual health, and the health of adolescents and elderly women were being neglected in the process. The role of health workers, particularly the ASHA workers in ensuring the health of the community was particularly acknowledged. The community also noted that the Public Health Nurses had done a tremendous job in improving the health-related knowledge of the community during the nineteen nineties and that the ASHA workers were not able to effectively replace the invaluable work done by the nurses. Some of the respondents observed that the ASHAs were overworked, overtly focussed on the needs of pregnant women and that they were too busy all the time.

The decline in community-based health promotional activities and outreach activities like medical camps was raised as a major drawback of the current functioning of the state health system. In the past, such health promotional classes and medical camps were routinely organized by the state health system, civil society organizations and charitable institutions and women had greatly benefitted from these activities. Women, especially due to the added stress of financial distress, do not have the time, money, or opportunity for regular health check-ups. The lack of privacy in the government facility OP wing and the unaffordability of private health care make matters worse.

Hence they would greatly benefit from screening camps and other outreach programmes. The key informants observed that despite the professed focus on women's health, it is not really a priority for the health system, since the system does not function in a manner that is cognizant of the realities of women, especially from marginalized settings. Adolescent health was another area that they found that the focus of the system was deficient. The Anganwadis were not adequately focussing on adolescent health, their nutrition, awareness about sexual and reproductive health, and specifically on menstrual health and hygiene. Although food supplements were being delivered by the Anganwadis, not all beneficiaries received them due to limited supply. The respondents emphasised the need for Anganwadis to be more proactive and actively work among adolescent women and support them, at a time of their lives when they were going through major bodily changes.

Perceptions of the community members and institutional key informants on contraceptive use

The unmet need for contraception in the **tea plantation community** emerged as a clear theme. Contraceptive options are not widely available in the community. The prevalence of usage of condoms, birth control pills, or Copper T is low due to widely spread misconceptions and myths around them. Most men also refuse to use condoms, as a result, women are pushed to opt for oral pills, Antara Vaccines, and Mala D.

> *"People here believe that they should not be used, 'we will not use all these even if we have to give birth to children', 'if we use all this then, it will be sinful' – that kind of mindset people still have…… You mostly cannot convince the men to use condoms, so women mainly consume tablets."*
>
> *~ Young woman from the tea plantation community*

Women are fearful of using Copper-T as they believe it might move up to their stomach causing internal bleeding. As a result of such perceptions influenced by religion, gendered cultural norms, and lack of adequate health-related information, the couples resort to the withdrawal method for birth control. This less effective method not only gives greater control to the man making women vulnerable to unintended pregnancies but also does not protect the partners from sexually transmitted diseases. This higher risk of unintended pregnancies and the barriers to access induced abortion services to compel women to resort to over-the-counter abortion pills or to rely on quacks to terminate unwanted pregnancies. Many from the community pined that poor remuneration of ASHAs and inadequate supplies of contraceptives in the public health care system also deepen the women's vulnerabilities. Contraceptives are not only unaffordable for these daily wage earners, but

they are also hard to procure and usually require them to travel several kilometers to purchase them. Thus, women face poor spacing between pregnancies and multiple frequent childbirths over a short span with consequences for their health. Some of the respondents also pointed out that some women even fail to recognize that they are pregnant until the pregnancy has advanced.

> *"I remember a case where the woman got pregnant after just one month of delivering her baby. She gave birth to the second child exactly when her first child was 9 months old. However, only the second child survived as the first child died shortly after. After delivering her second child, the woman suffered from severe postpartum weakness which rendered her unable to walk. When I went to see her, I got sad. She wasn't aware when she got pregnant for the second time. She went for check-ups but nobody could figure out that she was pregnant, until it was too late."*
>
> *~ Anganwadi worker from the tea plantation community*

Men were hesitant to respond to questions on the contraceptives and the young men from within and outside the community were not aware of how and from where they could be accessed. External condoms are accessible through PHCs and ASHAs, however, they cater mostly to married couples. Many observed that the disproportionate focus of the health system on maternal health has led to the neglect of many other sexual and reproductive health concerns, especially family planning.

Respondents have shared instances of young women getting pregnant, and not being able to access health care services resulting in severe mental distress. Narratives of child sexual abuse and incest have further highlighted the vulnerabilities of young people and adolescents. However, ASHA and Anganwadi workers claimed that they do not observe many unintended pregnancies, especially among unmarried and adolescents, in the community and thus did not perceive the need for induced abortion.

The institutional key informants of the **coastal community** from both the local governance and the health system observed that this coastal community had a relatively higher average family size compared to the general pattern in the state. Although the average family size in the community has come down compared to what was the norm about three or four decades back, most families, even relatively young families, have about three or four children. The health system key informants and community key informants pointed out the low usage of modern contraceptives in the community and that poor spacing between pregnancies was an issue among young women in the community. They observed that while the use of spacing has considerably improved over time, it needs to be further improved for the health and well-being of the women. Many of the respondents observed that young women despite being educated, faced varying degrees of resistance from their families and partners regarding the use of modern contraceptives like Copper T and oral contraceptive pills.

While a small segment of the community did perceive the use of modern contraceptives for birth control as a sin influenced by the dominant religious beliefs, the majority of the community were reasonably aware and open to the idea of modern contraceptives. The respondents observed that the influence of religion on the community's perceptions and opinions about birth control were not as profound as it once was. Many of the young respondents had named condoms, Copper-T, and oral contraceptive pills as common contraceptive methods, while some of the older respondents spoke about the effectiveness of natural methods of birth control like withdrawal which places the men in charge.

> *"Yeah…you are right, many of the women in our area have at least 4 children and there is no gap between their pregnancies. A similar case was reported some days before and in that her baby is just 3 months old and she became pregnant again. They don't take any contraceptive measures."*
>
> *~ Woman Medical Officer, local government facility*

Despite the fact that many of the young married respondents, both men, and women, knew about modern contraceptives like condoms and oral contraceptive pills, no one actually used them. They did not have access to them and did not have any idea how to get hold of them or use them. The community members had considerable skepticism about the use of Copper T and the idea that Copper T caused tiredness, weight loss, and loss of vigour was quite established among several of the respondents. Many husbands, mothers, and mothers-in-law prevented young women from using contraceptives, and the health systems key informants mentioned that many women approached them for Copper T without the knowledge of their families. The resistance of families, men, and some women towards the use of modern contraceptives stemmed from incomplete knowledge and fears. Some of these include ideas such as the use of contraceptives like condoms reduced sexual pleasure, contraceptives reduced the chances of bearing a child later in life, and oral contraceptive pills posed serious side effects. Some of the community key informants observed that although the community, especially the young people were not totally averse to the idea of using modern contraceptives for spacing, they had many doubts and reservations and hence a nudge from the local governance and/or health system in the form of a community engagement campaign focusing on the benefits of modern contraceptives could make a difference. However, the key informants from the health system were far less optimistic regarding the possibility of the community opening up to modern contraceptives. They emphasized the reluctance that community members showed on various occasions to use modern contraceptives. The expression of this reluctance ranged between husbands and mother-in-laws prohibiting wives from going for Copper T insertion to angry husbands chasing away the ASHA workers from their houses for explaining to their wives about the need for birth control.

"Some girls do come and tell us we have come for Copper T insertion, but we don't want our husbands to know or some will bring their husbands and ask us to talk to them about contraceptive measures. So, then we will know that maybe these women are fearing some violence from their husbands or they won't be able to convince their husbands that we don't want another child. That conversation cannot be handled by them."

~ Woman Health Inspector, local government facility

The conversations with young women revealed that most of the families resorted to tubectomy as the definitive method of birth control. Once they complete their families and reached the desired number of children, the women underwent tubectomy. The health staff at the government facilities actively nudged the women to undergo tubectomy after the second or third delivery and this was accepted by men and other family members too. In certain situations where the women were suffering from other health concerns, some men from the community also agreed to vasectomy, although this is extremely rare.

The unmarried women shared similar concerns that of the tea plantation community, of failing to access contraceptives due to prevalent stigma leading to unintended pregnancies and distress.

Community Perceptions on the Legality, Safety, Availability, Social Acceptability, and Stigma Related to Induced Abortion and Barriers to Accessing Abortion Services

In this segment, we discuss the perceptions of the respondents regarding the legality, safety, acceptability, availability, and social stigma related to induced abortion. Under each of these sub-themes, there are both dominant and minority voices.

Legality of abortion

The dominant voice under this sub-theme was that induced abortion is illegal in the country. This view was voiced not only by the community key informants and young people but also by some of the institutional key informants. Many social activists and ASHA workers endorsed the illegality of abortion. Many of the respondents equated their own ideas of the immorality of abortion, with its illegality, the fundamental idea being, "it is wrong", so it must be "illegal". However, many of the respondents agreed that abortion was being done in society despite its illegality. According to respondents from the coastal community, this happened because people got the procedure done

illicitly using money and influence at facilities that were willing to break the law for more money. The respondents believed that there were also many providers who were willing to find loopholes to perform abortions illicitly to earn money. They believed that if the "crime" was uncovered these providers and facilities deserve greater punishment than those seeking abortions from them. However, respondents from the tea plantation were aware of the traditional healers, and midwives offering 'massages that induces abortion'. Many were however not aware of induced surgical abortions being offered at the hospitals. There was a general consensus among both the communities, that if abortion was ever made legal in the country, it will lead to blatant misuse of the law and the proportion of induced abortions will drastically increase.

There were also minority voices in the communities which endorsed two major ideas – abortion was legal in the country under specific circumstances and that abortion was illegal but allowed under certain specific circumstances. Both these voices agreed that the poor health of women and that of the foetus posed legally valid reasons for seeking an abortion. However, there was an absence of consensus regarding whether contraceptive failure posed a legally valid reason. While most of the respondents believed that abortion was not legally allowed for contraceptive failure, few voices did endorse contraceptive failure as a legally acceptable and valid reason for abortion, provided both the man and the woman were in agreement. Voices from the tea plantation community, especially health workers and ASHA workers expressed that abortion is a result of "recklessness", as there are contraceptive options available in the community, however, they fail to acknowledge the disproportionate accessibility to it.

Those who believed that abortion was legal also believed that the legally acceptable status of abortion was essential to uphold the rights, health, and well-being of women. There were also a minority of voices, particularly young women, who expressed that they were not aware if abortion was legal in the country or not.

Methods used and the perceived safety of abortion

The dominant voices in the community knew what constituted induced abortions and opined that there were two ways in which abortion can be induced – one under the supervision of a doctor, preferably a gynaecologist through a medical procedure, and the second, where the women themselves or others on behalf of them bought pills from pharmacies and got the procedure done themselves. However, they did not have much idea about the nature of the procedure or the mechanism of the pills. They believed that regardless of whether the procedure was done under medical supervision or not, it posed varying degrees of health consequences for women ranging from tiredness, bleeding, weight gain, weight loss, significant mental and emotional stress with impact on physical health and inability to conceive again. The idea that abortion was always "unsafe"

for women, regardless of how it is done, was quite prominent among the community key informants, young women, and even ASHA workers. The most serious and most commonly reported way in which abortion harmed women was by affecting their ability to conceive again. The fear of the inability to bear children was deep-rooted in society as many families even worried that regular use of contraceptives like pills and Copper T will reduce the chances to conceive later. It was also believed that multiple abortions endangered the lives of women, especially young women. According to many of the respondents, this fear of long-term health consequences prompts many women to continue with unplanned pregnancies. Such misconceptions have also resulted in the medical community taking unethical steps of offering sterilization without informing patients of other possible options for abortion.

> *"The government has directed us to sterilize the woman. A woman cannot give birth to a child again and again and she should not give birth to a lot of children also and women also should not abort repeatedly; we directly refer them for sterilization. When we get the information that this month laparoscopy will be conducted and that we should send our list of women who would like to have a laparoscopy done and that is how after two children we assist them with their sterilization process. That way the question of abortion does not come."*
>
> *~ASHA worker from tea plantation community*

There were a few voices among women, who could not differentiate between miscarriages and induced abortions and were totally unaware of the existence of service to terminate a pregnancy.

Demand for induced abortion

The perceptions about the demand for induced abortions in both the community were divided. While the health system key informants, especially the doctor from the local government facility of the coastal community observed that there was a demand for induced abortion in the community, especially among under-age girls and unmarried women, the dominant voice from the community emphasised that induced abortion was an uncommon occurrence for them. However, this was in contrast with the tea plantation community. While young women and ASHA workers narrated incidents of young women and adolescents opting for unsafe routes for abortion, the medical health providers- ANM and health worker at a dispensary - mentioned how they have never attended cases of abortion in their community. They believed that abortion is illegal, and such cases do not happen within their community. Many of the social workers from both communities lamented the rise in premarital sex among young women and extramarital affairs among married women as an adverse effect of the rise of avenues like social media. The voices from the coastal community largely diverged from the doctor's point of view that there was a notable demand for induced abortion in the

community regardless of the age of the women. The doctor and the Lady Health Inspector from the coastal community observed that some young married women who had recently delivered a child and became pregnant again also approached them seeking an abortion, although the proportion of these women is relatively lesser than the proportion of under-age girls and unmarried women. However, the dominant voice in the coastal community maintained that married women from the community seriously considering induced abortion was extremely unlikely. However, there were a minority of voices from both the communities who argued that there was a demand for induced abortion in the community among women from various age groups due to the overall poor usage of birth control measures and that they continued with the unplanted pregnancies only due to poor access to abortion services, societal and familial pressure, fear for their own health and fear of social judgement.

> *"Yes, there is demand for induced abortion in this community. Most of the time unmarried girls will come asking for an abortion. But many of the married or older women in this area are not ready for abortion because most of them are happy to be pregnant and they believe that having 4 or 5 children is some kind of credit for them."*
>
> *~ Woman Medical Officer, local government facility*

Availability of abortion services for the community

The dominant voice under this theme suggested that abortion services were not adequately available as many doctors and facilities were unwilling to provide abortion services. The institutional key informants from both the local governance and the health system of the coastal community clearly stated that the service was not provided at the local government facility and if patients persistently demanded the service, then they referred them to the nearest Taluk hospital to shift their responsibility, knowing clearly well that abortion service is not provided there also. This was the same for the tea plantation community. The ANM mentioned how the local dispensary does not attend abortion cases and refer them to District Medical Hospital. However, reaching the district hospital involves financial and transportation requirements. The women, therefore, rely on traditional healers, which makes them more susceptible to unsafe abortion services.

The health system key informants from the coastal community quite categorically stated that most of the lower-level facilities functioning under the decentralized system such as the Primary Health Centres, Community Health Centres, or even the Taluk hospitals do not provide abortion services most of the time. Providers in the government sector in general are known to be reluctant to provide the service and as a result, the service is either denied or limited in the sector. One of the reasons for their reluctance, especially for those working in lower-level facilities is the absence of the services of a gynaecologist and adequate facilities to manage any complications which arise during the

procedure. However, the positions of the health system key informants reflected that they had strong value judgements against induced abortions and had conscientious objection against providing the service. The health system key informants stated that it was simply not possible to provide the service to every woman who approaches even if they satisfy the legal conditions and they do evaluate the genuineness of every abortion seeker before deciding whether the service needs to be provided or not. For instance, a woman's unwillingness to be a mother would not be usually considered a valid reason to provide the service. Women are from the tea plantation community are fearful of the judgement and scrutiny posed by medical health providers and are afraid of risking their confidentiality in government hospitals, thereby resorting to expensive private facilities or unsafe alternatives.

> *"It's only while interacting with other women that we have come to know that doctors are often reluctant to provide abortion and ask for detailed reasons for the same, making the entire process difficult for the person who is seeking an abortion. The people who are seeking an abortion sometimes have to face verbal mistreatment. Their tone is very harsh and critical, indirectly suggesting that they shouldn't do an abortion. ASHA workers tell the same thing about doctors demanding detailed reasons for seeking an abortion, making the process difficult for both the person seeking abortion and ASHA workers seeking information."*
>
> *~ Community health worker from the tea plantation community*

The specific case of a married woman who had repeatedly sought abortion services at the local government facility and had been continually denied the service, was shared with us by the multiple respondents of the coastal community from both the community and the health system. She was a young mother of two children who were born just a year apart and the second baby was only a few months old. She became pregnant despite having Copper T inserted after the second delivery. The woman approached the local health facility with her husband when she was only a couple of weeks pregnant seeking an abortion. Her second child was sick and needed constant care, the husband was unemployed, the couple had the responsibility of a large family with dependent members and they were in financial distress. She could not afford to get the service from a private facility. The doctor repeatedly denied the service and advised her to continue with the pregnancy. They also advised her that the contraceptive failure that she experienced could be considered a divine intervention and the God had given her another chance to be the mother of a healthy baby to compensate for the ill health of the previous child. They asked her if she really wanted to reject such a blessing. The Lady Health inspector also advised the concerned ASHA worker from her ward to keep an eye on her to ensure that the woman does not make any effort to obtain the service from elsewhere. By then the pregnancy was advanced and she was left with few options but to continue with it. The minority voices from the community pointed out that this constituted a grave injustice to

the woman involved. They used the incident to highlight the fact that woman's health, rights, choices, and well-being were not considered or respected by the health system. The system valued the life of the unborn child over the rights of the living woman. The issue of health facilities denying abortion service to unaccompanied women was also raised as a violation of rights by a few of the respondents. The health workers of the coastal community observed that they used different strategies like religion, appealing to their judgement, and even instilling fear to dissuade women from seeking abortion unless the mother or the foetus had any health concerns that required pregnancy termination. Once the women return from the facility, the ASHAs constantly stay in touch to ensure that the women continue with the pregnancy.

> *"First and foremost, we are not doing abortions these days. We are not at all promoting abortions. To bring them to the line, we use their faith to convince them. This community is very serious about their faith in God. Which means that they believe in Jesus, church. We can say that people belonging to the Hindu community are not at all there in the coastal regions. Under these circumstances, when we mix some Godliness in our words, they will be okay. They will be convinced that, okay, no need. God has given this baby. So we will keep it and rear the child. They will come to that conclusion quickly… This case I was talking about the woman who wanted to abort the third child? …I told her, if you think that the other child is not very healthy, then that is why God is giving you this third child even after Copper T insertion. So that you can have a healthy child!... So this woman, I counselled her for over two hours the first day. So then she got convinced. After the scan, she came two more times asking for an abortion. Each time I spoke to her, counselled her and sent her back. When she returned home, the ASHA worker will tell me, "I think she is not convinced, she is still thinking about it". And I just dismiss her saying, no no I don't think so (laughs)."*
>
> *~ Woman Health Inspector, local government facility*

Women prefer privacy and confidentiality in matters related to abortion, and the crowd at the government facilities practically excludes the possibility of privacy. The wide network of ASHA workers who are closely engaged with both the system and the community threatens the confidentiality of those seeking an abortion. This is why people prefer private facilities or opt for traditional healers for induced abortion even when the care is unaffordable. Even married women who seek abortion with the complete support of their partner would not prefer government facilities located within or close to the community. On the other hand, remote government facilities like district hospitals or specialty hospitals or the nearest medical college could ensure privacy and confidentiality.

Social acceptability of abortion and the role of religion

There was consensus among all the respondents that the communities did not prefer or accept induced abortions and that it was a relatively unlikely occurrence, especially among married women. The general feeling was that abortion was unacceptable because it was wrong. The perceived immorality of abortion was considered more problematic than its legal status. There were two dominant voices concerning the moral agreeability of induced abortion. The first, that abortion is morally disagreeable under all circumstances and that it can be chosen only and only as a last resort. The second dominant voice said that induced abortion may be necessary under certain circumstances, some of which are morally agreeable situations, while some others are not. Both these positions viewed induced abortion as equivalent to ending a life and that the decision to choose it has to be taken with extreme discretion.

The proponents of the first idea believe that induced abortion is a sin and that humans have no right to induce abortions. They advocate the centrality of the unborn foetus as a separate living entity with rights. Children are precious and God-given and destroying them is unacceptable.

> *"Most people think that they have committed a sin by undergoing an abortion. However, according to me, even though we consider pregnancy as a gift from God, sometimes an abortion becomes the only way to avoid fatal conditions. Just like the anecdote of the young girl that I had shared, an abortion could have saved her life. So, even though I think that abortions are necessary, I can't seem to shake off the feeling that God might punish those who seek it."*
>
> *~ Former ASHA worker from the tea plantation community*

Some of the extreme situations where they consider abortion to be acceptable include situations where a woman's life has to be saved so that she can be there for her family, when the foetus has extreme physical or cognitive defects or when the family has to make an almost impossible choice between the life of the woman or the life of the foetus. Even reasons like rape, incest, women being unmarried or under-age are not acceptable reasons to opt for abortion. For instance, if an unmarried woman gets pregnant, then she could deliver the baby and raise it if there is support from her family or give up the child for adoption. A prominent idea put forth by this voice is that the advancements in medicine and technology have made induced abortions almost unnecessary due to advanced diagnostic and therapeutic procedures which can detect and correct even minor anamolies to the health of the mother and/or the foetus and save both their lives even in risky situations. They believe that "good" mothers will choose the life of their foetus over even their own lives and try to avoid abortions as far as possible.

"If this woman is married and she says she wants abortion, I will tell her we have now anyway got it. Whether you expected it, whether you planned it, you have got a baby. Now you protect it. That is what I will tell her. If a woman is unmarried also, I will perhaps tell her the same thing. Anyway, this has happened. This unmarried woman also would have had a sense of knowing that when certain steps are taken, pregnancy is a possibility. Even if she took all precautions and it failed, now that it has happened, I will tell her not to go for an abortion. We only have the right to give birth. We don't have the right to destroy. Pregnancy is a natural law. If you engage in certain activities, these things can happen and you should always expect that. Even if you take precautions and all of them fail, I would still say that you need to accept it as a reality and live with it. I think adult women who have the sense that engaging in certain activities can lead to pregnancy, those women should not be allowed to abort the child."

~ Middle-aged married woman social worker from the coastal community

The slightly more pragmatic second dominant voice, opined that although abortion is wrong, there were circumstances under which it would be necessary. These include: when a young woman is pregnant and is left widowed, when a woman's life is endangered by the pregnancy, when her health is at stake, when the foetus is not healthy, when the woman is mentally ill, when a contraceptive failure has occurred in a married couple's life and the woman is or both the partners are not prepared to take on parenthood. Contraceptive failure and a woman's unpreparedness to be a mother are acceptable circumstances provided the decision is taken jointly by both the husband and wife. The other circumstances where the community finds abortion necessary include: when both the partners feel that they don't have the financial circumstances to raise a child, pregnancies among under-age girls, when an unmarried girl gets pregnant and the man involved is not willing to take responsibility of the child or when the pregnancy is the result of a rape. They did argue that not all the reasons which make abortion necessary are morally agreeable. For instance, women opting for an abortion to pursue an opportunity in higher education or career, contraceptive failure among couples, women not willing or ready to be mothers, or poor financial circumstances of families are not morally agreeable reasons for choosing abortions.

Both voices agreed that the couples had to take accountability to avoid pregnancy if they are not ready for children and that seeking abortion once a pregnancy has happened is the wrong way out. The idea that induced abortion could lead to difficulty in conceiving again was prominent and so there was unanimous agreement that if a woman does not already have a child yet, then she should think carefully before deciding to choose abortion. There was also the idea that some women were "selfish" mothers who chose induced abortion for fickle reasons such as maintaining their physical beauty and hence it is important that the service not be available unconditionally and easily.

Although the second dominant voice talks about poor mental health, lack of readiness, willingness, and preparedness among women as circumstances where abortion is deemed necessary, they did not really consider these as morally acceptable reasons. However, there were minority voices that included educated young women, social workers with a background in feminist movements, men who are allies, who opined that women's mental health, readiness, willingness, and happiness are critical factors determining the decision to continue with a pregnancy or not regardless of how it happened. They believed that the pressure to carry on unwanted or unplanned pregnancies can not only affect a woman's prospects and future, but also her mental health and happiness. They observed that unhappy women cannot be expected to be caring, competent mothers. According to them the service of abortion is extremely important to ensure the health and well-being of women in the community and efforts should be made to enhance its availability.

The community members also had strong views about abortion providers. The dominant view regarding this was that a good doctor should discourage couples who approach them for abortion. That they will listen to their conscience and deny abortion services. Many of the community key informants strongly believed that the doctors and facilities which provided the service to those seeking abortion were more to blame than those who sought care. They believed that at least a few doctors in society were those who forgot their morals and performed abortions for money. Similarly, the facilities which provided abortion were also considered business enterprises with no social responsibility.

> *"But, I will blame the people who do it for people than those who are forced to undergo it. Isn't that more fair? See, the doctors know that it should not be done. It is not legal. But, still, they do it for these people. Did I not tell you that story? This happened right in front of my eyes within the past 1 or 1.5 years. A girl has undergone four abortions. As a doctor, she can advise the girl during the first time itself that it is not healthy. She should have insisted that she needs to talk to the girl's family. That boy also should have been warned. This is an illegal activity."*
>
> *~ Middle-aged woman social and public health activist from the coastal community*

Christianity is the prominent religion in the coastal community and an overwhelming majority of traditional fisher-folk are Latin Catholics. Abortion is considered a sin according to the Christian faith, which also takes a position against the use of artificial contraceptives. The dominant view was that religion no longer had the sole power in determining the community's perceptions about contraception and abortion and was not the major reason behind the community's views about sexuality, pregnancy, contraception, or abortion. However, it still played a very critical role. The majority no longer completely adhered to the teachings of the established faith, however, their views

are significantly shaped by them. But, there is a minority who strongly follows Christian beliefs. They believed that the Christian way of dealing with an unplanned pregnancy is to continue with it, give birth to the baby, and then give it up for adoption if you are not in a position to raise it on your own. Although the power of faith is not as strong as it used to be, the respondents believed that it significantly contributed to the fear of abortions. The fear is not only related to the perceptions on the potential health consequences of the procedure, but also in anticipation of the possibility of some divine retribution that could turn them infertile.

Stigma and negative social perceptions related to induced abortion

It was unanimously agreed that induced abortion was seen as something which brought considerable humiliation and shame to families regardless of whether it happened to under-age girls, unmarried women, or married women. Under-age pregnancies and abortions were considered as something which reflected poorly on not only the family of the concerned girl, but also her entire community. The health workers from the coastal community strongly believed that under-age pregnancies reflected the poor upbringing of girls and hence the parents deserved much of the blame. Both underage pregnancies and pregnancies among unmarried women were seen by the communities as the side effects of too much modernity which exerted a negative impact on the values of girls and women. The respondents from both communities agreed that women who underwent abortions were cruelly judged by the community and are constantly portrayed as wrong-doers and sinners in routine conversations among community members. If the information regarding abortion gets out, then the woman involved would become the center of baseless stories and malicious gossip and would not only accuse her but also isolate her. The community key informants and young people responded that if people come to know of a married woman who underwent abortion for any reason whatsoever, it would be assumed that she had an extramarital relationship and the husband was not the father of the foetus and hence abortion was the only way out.

There was overwhelming consensus among the respondents from both the community that the society blamed the women more than men for an induced abortion even when she is married and even if the decision to get an abortion was taken jointly by both the partners. There were two dominant voices under this theme explaining the negative social perceptions about women who undergo induced abortions. The first was that, it was unfair to blame women alone for a decision jointly taken by both partners. However, this group argued that it was natural that women were blamed more considering the more central role of women as mothers. Women are meant to be primary parents and hence they would be naturally blamed more. The second dominant voice was constituted by the perceptions of those who ardently argued that women deserved the greater blame for the decision to get an induced abortion. They argued that it is the woman's body that prepared for pregnancy and knowingly or unknowingly she has been instrumental for the creation of a new life

and hence she is inadvertently more accountable for the foetus, regardless of whether she wanted the pregnancy or not. One interesting observation made by a community gate-keeper was that, induced abortion was a very traumatic experience for a woman, almost comparable to a normal delivery, resulting in severe pain and blood loss. If a woman was willing to go through all that to abort a foetus, she could have delivered the infant and given it up for adoption. The minority voice under this theme argued that it was unfair and illogical to blame anybody for choosing induced abortion. They argued that women are predominantly blamed for abortion because it is easier to blame them. Men escaped blame simply by virtue of their position as men and this was expected in a patriarchal society.

> *"No. No one knew that she had an abortion. Not even her husband. So she could not tell anyone. Even when she was sick. As far as I know, in our community, if such a thing happens they can't share it with their families. They will have to share it with their friends or some friendly relatives, or someone like that. No one will dare to share it with the families first. They will hit her badly and the girls will be scared. The people at homes won't be able to tolerate such indiscretions. People here in the coastal regions are very proud. They value their social image very much. Once this happens their primary worry will be, how will we face the community now?"*
>
> *~ Young married woman from the coastal community*

Barriers to accessing abortion services

The respondents perceived that the women in the communities would be facing the following barriers in accessing abortion:

- Denial of the service in the local government facility along with lack of privacy and confidentiality
- Unaffordable care in private sector
- Lack of youth-friendly services for unmarried abortion seekers
- Lack of nearby public facilities offering abortion services for the tea plantation community
- Medical health providers seeking consent from husband or parent/guardian
- Fear propagated by religion and perceptions about the health consequences of abortions Fear of social judgement and need for secrecy
- Gender conditioning glorifying maternity

- Lack of adequate information regarding the legal status, methods and facilities where it can be accessed
- No avenues in the community to discuss the issues related to sexual and reproductive health and rights and to seek guidance
- Need for someone trustworthy to accompany abortion seeker before, during and after the procedure; unaccompanied women are denied the service even in private sector
- Unchanging, rigid views of families and societies who offer no support

DISCUSSION

Induced abortion has been legal in India for about five decades, however, several studies from different parts of the country indicate that the prevalent societal perceptions about sexuality, reproduction, have negatively affected its society. [41 - 43] Such perceptions also have implications for the access to abortion services and to the quality of care delivered. [16, 42] The ecological model of conceptualizing abortion stigma conceptualizes the construct as operating and interplaying at multiple levels including individual, community, and institutions, and identifies the potential exacerbation of abortion stigma in marginalized communities. The model identifies certain sections such as young women, as more vulnerable to abortion stigma compared to others, and highlights the role of local contexts, cultures, values, and norms in the construction and perpetuation of stigma.[29]

This qualitative exploration has been conceptualized on the assumption that, since societal perceptions are at the root of poor social acceptability and stigma around abortion, any efforts to enhance the accessibility, availability, and quality of induced abortion in a community should start with an in-depth exploration of the prevalent perceptions of the community members. Following the ecological model, we have explored the social perceptions and stigma around induced abortion through the perceptions of stakeholders from multiple levels – young people belonging to and/or residing in two marginalized communities of India, key informants from the communities, and from the local institutions. In this section, we attempt to coalesce the insights from the respondents regarding the legality, safety, availability, and social acceptability of induced abortion, use these insights to pare the socio-cultural construction of abortion stigma and to locate the major barriers to accessing safe abortion in two marginalized communities from India.

Legality, safety, and availability of induced abortion

Induced abortion is largely perceived as an illegal, unsafe and difficult to avail service by the respondents from both communities.

Legality

There were several respondents from both the settings who were almost completely unaware of the existence of an Act that legalizes abortions, its subsequent amendments, and the provisions. The absence of this vital piece of information was not limited to young people, but also key informants

from both the communities and institutions like the local self-governments and local health facilities. Many of the ground- level actors including social and public health activists and ASHA workers had identified abortion to be an illegal service. ASHAs play an extremely vital role as the bridge between the community and the health system in both the settings and their understanding of issues makes a significant difference to the community's perceptions. Despite reservations regarding their way of functioning, there was an implicit trust that the communities placed on the ASHAs, which makes it extremely relevant that the ASHAs have accurate information about the legal status of abortion in the country. The poor awareness regarding the legal status of abortion, especially among key institutional players also has considerable significance in the context of the more recent amendment (2021) to the MTP Act, which, through a slew of measures has attempted to enhance access to safe abortion services. [11] Several of the respondents branded abortion as "illegal" not because they had any information about the legal aspects of the service, but because they thought it should be "illegal" since they considered it to be inherently "immoral". It is important to note that topics like sexuality, contraception, or induced abortion are not discussed within families nor within community platforms like Grama Sabhas, and Panchayats. The almost complete silence that is observed around the topic and the secrecy that is mandated if any such discussion becomes necessary, reduces the chances of people receiving any information regarding abortion, regardless of its quality and accuracy. The social and public health activists also pointed out that neither the local self-government nor the local health system took any initiative to provide accurate information regarding sexual and reproductive health and rights including safe abortion to the community. They emphasised that enhancing the community's knowledge and awareness regarding these aspects did not seem a priority for the institutions

Safety

The concern of "unsafe" abortions did not emerge as a key theme from the respondents from both the communities. However, there was consensus between the key informants from the community and the institutions that the local health facilities did not encourage induced abortions, thus pushing women to either continue with the unintended pregnancy or resort to alternate options. Remote government medical facilities or expensive private health facilities were the primary alternate options for the women from the fishing community, while local and traditional healers, or resort to home remedies were the primary alternate options for the women from the tea plantation community. According to the Assam report of a national study on unintended pregnancy and abortions, ports that an estimated 580,100 abortions occurred in Assam in 2015, which included both safe and unsafe abortions, and those taking place both in health facilities and in other settings. The study concluded that more than half of the pregnancies in Assam in 2015 were unintended and three-fourths of them end in abortion. Only a fifth of the abortions took place in health facilities and the

majority were in government facilities. The majority of the primary health facilities (80%) in the state did not provide any abortion-related care and only 45% of the facilities which provided abortion-related care were located in rural areas. So, a significant proportion (74%) of these abortions took place outside medical facilities using medical methods of abortion, while a miniscule proportion (5%) took place outside facilities using non-medical methods, which is likely to include those performed by untrained providers, local healers or by the pregnant women themselves.[19] Thus, unsafe abortions constitute a major issue in Assam, which potentially poses an even greater issue for the poor women from marginalized communities like the tea plantation workers.

Fear of abortion constituted a significant reason for women not considering the option in both the communities and this fear is complex and triggered by three major components – religion, negative social consequences if the word gets out, and misinformation regarding the potential health consequences of abortion. The young women and community key informants observed that all abortions regardless of the method and/or medical supervision have health consequences for women ranging from tiredness and bleeding to inability to conceive again. An exploratory study conducted by SAHAJ and CommonHealth to explore the knowledge, attitude, and practices among urban poor women in Vadodara, Gujarat, reported that women believed that abortion adversely affected their bodies and caused several symptoms like weakness, anaemia, aches, and pains including pain in the pelvic and vaginal area, swelling/inflammation of uterus, ulcers or lumps in/on the uterus, irregular menstruation, and psychological problems. They also spoke about potential post-abortion complications such as bleeding, irregular menstruation, complicated subsequent pregnancies, or infertility.[41]

The following findings from the study indicate the potential role of the health system in allowing the unabated perpetuation of these fears:

- The ideas of adverse health consequences of abortion voiced by the community members were also reiterated by the ASHAs. ASHAS are the first point of contact of the communities with the health system, indicating their potential role in advancing and mitigating these fears.
- There are neither any systemic efforts from the local health facilities to impart accurate knowledge about sexual and reproductive health issues including abortion, nor any platforms to address the doubts and concerns of people, in both these communities.

Availability

Abortion services were not available in the local health facilities of both the communities. However, women did approach these facilities seeking the service and they were either referred to remote government facilities or counselled to continue with the pregnancy. The local dispensary in the tea plantation community and the government-enhanced primary care facility in the fisherfolk community were small centers with limited infrastructure and facilities. So, one reason why the service could not be provided at these facilities was because the providers feared that they could not manage any potential complications which may arise, especially if the pregnancy has advanced to the second trimester. However, the conscientious objection of the providers and the patriarchal structure of the health system were also significant contributors to their position. The key informants from the health system from both the communities observed that not all women seeking abortion were referred to other facilities, only the ones which were adjudged by them to be 'genuinely deserving with valid reasons'.

A qualitative study was conducted among women seeking abortion services in Jharkhand to explore the quality of care received. The most important component of quality of care identified by the respondents of the study was cost, that the care should be inexpensive and affordable to them. While they expected the provider to be competent, they also valued confidentiality/privacy in their interactions with the provider, preferred the services of a lady doctor, and the friendly behaviour/attitude of the staff. The respondents expected the facilities to be closer to their residence, well equipped with adequate stock of medicines, round-the-clock services, and cleanliness. In addition to these, the providers asking or not asking for spousal consent and the availability of contraceptive counselling and choice of methods were also quality considerations reported by women seeking abortion services. [15] The respondents from our study raised many issues with the kind of health care available to them from the local government facilities which was always the first option for the communities. Some of these concerns include long waiting time, unavailability of diagnostic tests and medicines at the facility, unavailability of doctors at all times especially at night, unavailability of a female doctor at all times, doctors being so busy that they don't even listen before prescribing medicines, the facilities do not manage even emergency conditions like minor wounds and the patients are always referred. It is important to acknowledge that even if abortion services were available in the local government facilities, the women from both the communities would have had serious hesitations availing them, the primary reason being lack of privacy in the settings and fear of loss of confidentiality. The local health facilities were crowded and under-staffed and the women routinely struggled to discuss their issues with the doctors privately. The women feared that the sensitive information regarding an unintended pregnancy may reach the community through the network of ASHAs which forms a bridge between the community and the health system. Several studies have identified that privacy during interaction with the provider and confidentiality and

secrecy with regard to the information shared with the provider are very important considerations for women seeking an abortion, in the absence of which they would even avoid seeking the service.[44]

Social acceptability of induced abortion and the socio-cultural construction of stigma

Induced abortion has been overwhelmingly defined as a "sinful act" in both communities. In the fisherfolk community from Kerala, the role of religion contributing to this fear appeared to be much more prominent than from the tea plantation community in Assam. A majority of the traditional fisherfolk community belongs to the Latin Catholic community and the Christian faith forms an integral part of their lives, both as individuals and communities. The Catholic faith has traditionally taken a negative stance against birth control and abortion, as both are considered to be against the "natural law" dictated and designed by a supreme creator. These not only turn sex into a non- marital act that is not solely aimed at procreation but also attempt to control or prevent the birth of another human being, both of which are meant to be the acts of God. Although the role of religion on the individuals and their choices are not as profound as once were, it still held a stronghold over the positions of the community. In the recent pandemic control activities undertaken in the coastal community, the Latin Catholic Diocese of various districts had taken initiative to ensure that the coastal communities stayed protected and forged pro-active partnerships with voluntary organizations to organize various essential services for the community members.[45] The role of religion in shaping the community's views on matters related to sexuality, reproduction, and abortion is complex. The ASHAs and key informants from the health system observed that young women from the community secretly choose to insert intrauterine devices for contraception, against the wishes of their families. While there was open skepticism about the direction that modern contraceptives were not to be used and that natural methods like withdrawal were preferable, there was more acceptance for the view that induced abortion is sinful and this contributed, at least partly to the fear and repulsion against abortion.

The other major source which contributes to the notions of the immorality of abortion and its poor social acceptability is patriarchy. This works quite powerfully in both the communities and guides their perceptions not only regarding induced abortion but also on female sexuality, sexual agency, reproductive autonomy, contraception, motherhood, and gendered roles and responsibilities. The idea that modernity and access to a corrupt and alien world through social media causes young women to become uncontrolled with regard to their sexuality was quite prominent among the key informants from both the communities and the institutions. Among the traditional fisherfolk

community, there were instances when the local police department advised the community leaders to monitor their young women closely and to exert greater control over them. The representatives from the health system cited the demand for induced abortions by under-age or young unmarried women as an indication of their uncontrolled sexuality. The community members also cited several instances which demonstrated that young women deviated from the "dignified" path expected from them and identified this as a social issue with implications for the health and well-being of families and the community as a whole. For instance, ASHAs from the fisherfolk community viewed adolescent pregnancies as a consequence of poor parenting and the lack of values among young women. What is even more important is that they did not associate this with the issues of poor access to and/or poor use of modern contraceptives. The ASHAs from the tea plantation community viewed the need for abortions among unmarried young women or adolescent women as a clear situation of unbridled female sexuality and a major social problem. The idea of premarital sex and pregnancies outside marriage was considered deviant and they were considered to be on the rise in the communities as a consequence of young women going morally astray.

The relations of power and control defining the experiences of sexuality and relationships among adolescent women who come of age in a patriarchal society have been described in feminist literature. The gender system in a patriarchal society is characterized by the experiences of women grounded in restrictions of economic dependence, sexism, gendered power relations, fear of violence, norms of acceptable physical appearance, norms related to specific roles and responsibilities, and appropriate behavior for women. It is during early adolescence that girls begin to experience these cultural expectations for the first time and demand a personality change among them to replace their assertiveness, confidence, and youthful androgyny with a more docile, submissive one and consequently a sexual-dualism which is firmly premised on the dual forces of patriarchy and capitalism. The need for such a transition is firmly impressed upon them by the commodification of female bodies and the cultural images of femininity propagated by the visual and mass media.[46] The impact of such expectations of patriarchy on young women is clearly demonstrated by the angst of both the communities regarding the behaviours and choices of young women.

The impact of such conditioning more often than not manifests as failure to access contraception and/or delays in seeking abortion care among young women. The lack of spaces for young women to discuss aspects related to their sexuality was a prominent theme in the interviews. The strong patriarchal notions of social image and pride among families meant that they were not spaces where girls could discuss these aspects or confide in due to fear of backlash. A qualitative study conducted among 34 unmarried abortion seekers aged between 10 and 24 years from a government tertiary care facility of Kerala indicated that fear of exposure, lack of any support system and scarcity of

resources were the major reasons for why they delayed seeking abortion services. The conflict between wanting to have sex and feeling guilty about it made these women undergo terrible distress. Another critical aspect is that only half of them knew about contraception and only two had used condoms.[47]

Scientific and unbiased information about sexual and reproductive health is mandatory for people to make informed choices. This was a major cause of concern among both the communities since they clearly lacked access to such information. The poor awareness among young people from the communities about matters concerning sexuality, sexual health, contraception, and reproduction, was stark, even among those who have received Comprehensive Sexuality Education (CSE) in schools. The poor access of young people from India to such information has been widely reported and this has been known to enhance their vulnerability to engage in unsafe sex and increases their risk of contracting Sexually Transmitted Infections (STIs).[48]

One of the six fundamental factors, which are sources of exploitation of women in any patriarchal society is sexuality, the other five being household, paid employment, state, male-on-female violence, and cultural institutions. In addition to accepting heteronormativity as the sole way of being, viewing other preferences as a violation of norms which is liable to punishment from the society. This view not only justifies the objectification of women as instruments for male gratification but also that of the male gaze, thereby eroding the sexual agency of women. [49] The lack of sexual agency among women, both within and outside the institution of marriage, was clearly put forth by the communities. While this was considered acceptable in the case of young, unmarried women, the lack of sexual agency among married women was raised as a concern and a potential reason for discord and violence within families. This could be considered a progressive position in a patriarchal society, as this implies that the community does not completely cater to the idea of the psychologically and institutionally dominated and conditioned, passive “traditional woman” who accepts such situations without resistance. It views a married woman as an individual having choices and preferences and the right to exert them. However, it should also be considered that these choices and preferences are largely limited to an existence where they are free from sexual violence, from uncomfortable or unpleasant sexual acts, sex during menstruation or illness, and the opportunity to choose to say ‘no’ to a demand for sex when they are exhausted or otherwise engaged. The primary reason for such a position on the sexual agency could then be due to the role of women from both the communities as workers and economic agents, rather than their empowerment or transformation as women. Neoliberal discourses have appropriated and transformed the notion of ‘agency’. Within this framework, the exercise of agency of women is sought in their survival strategies as individuals, rather than their empowerment or transformation as a collective. [50] Thus, this desire for ‘sexual agency’ cannot really be considered as a sign of resistance

or a real change in the patriarchal structure, rather an attempt to make their overworked, exhausted lives marginally better.

These views emphasizing the need for greater sexual agency among married women were more pronounced from the traditional fisher-folk community compared to the tea plantation community. One reason for this more vocal stand could be the history of organization and struggle of fisherfolk community through trade unions, with exclusive platforms for women workers such as the Theeradesha Mahila Vedi (TMV). These organizations have been hugely instrumental in resisting industrial aggression against small fishing communities and the seas to a significant extent. The transformation of the fishing sector since the latter half of the twentieth century, the mechanization, the transposition of production from communities to industries, the climate change and the ecological crisis depleting the marine resources have disadvantaged the women more and placed them under severe strain. However, the women have also consistently resisted these impositions and some of their successful struggles such as those for special buses for women fish sellers and recapturing of local fish markets are well documented. [51] The long history of decentralized planning and local governance in the state of Kerala, marked by platforms and processes for democratic engagement of citizens could also be a potential reason for the more vocal stand from the respondents.

A programmatic review conceptualises the desire for and ability of reproductive control among women as an interconnected continuum of three levels of factors and has identified the specific barriers at each of these levels.[52]

Levels	Barriers
Level 1: Desire to limit or space childbearing	Women derive their social and economic status in families and communities by conforming to the expectations of womanhood and motherhood dictated by the society
Level 2: Desire to exercise reproductive control	Women fear the potential consequences of using birth control measures or abortion – religious, social and health consequences
Level 3: Ability to effectively exercise reproductive control	Women are constrained by the power dynamics within families and societies which prevent them from effectively exercising reproductive control

The lack of reproductive autonomy in the communities is reflected by the low use of modern contraceptives, low awareness about contraception, resistance from men and families to women using intrauterine devices and poor spacing between pregnancies. Women are unable to negotiate sexual preferences or reproductive intentions within marriages and families, forcing them to experience unwanted pregnancies. The notion of abortion as a sinful, immoral act and the poor information available to the community about the methods involved in and safety of induced abortion have perpetuated a fear among women regarding abortions forcing them to continue with unwanted

pregnancies. The extent to which the cultural expectations of ideal womanhood and motherhood restrict the exercise of reproductive autonomy among women is clearly demonstrated by the perceptions of the community. While there was near complete consensus regarding the immorality of abortion and its role in "destroying" a life, thus validating the foetus as human life, there were a total silence about the potential physical, mental, social, and psychological consequences to be endured by a woman when she has to continue an unplanned, unintended pregnancy. Many young married women from the communities get pregnant within weeks or months of marriage, because they lack adequate information about contraceptive usage or due to lack of adequate space and opportunities within families to negotiate contraceptive use, or because they succumb to the social pressure of starting "families". Such social pressure is felt more by women as they spent more time interacting with close and extended families and feel pressured to validate themselves as women by embracing motherhood, the central defining characteristic of womanhood in patriarchal societies.

According to the respondents, tubectomy or female sterilization is the most commonly used birth control measure in both the communities, which was promoted and aggressively counselled for by ASHAs and doctors. According to National Family Health Survey (NFHS-5, 2019-20), 46.6% of currently married women from Kerala, aged between 15 and 49 years underwent tubectomy, almost the same proportion which was reported in NFHS-4 (2015-16). Female sterilization held the highest share in contraceptive methods in the state (86%) according to NFHS-4 and the share has only slightly decreased (77%) according to the NFHS-5 report, making it the most used form of contraception among married women in the state. According to the NFHS-5 report, the prevalence of modern contraceptive use among currently married women aged 15-49 years of age in Assam is 45%, which is higher than the prevalence reported in NFHS-4 (37%). But the prevalence of female sterilization in Assam is 9% according to NFHS-5, which is 1% lower than what was reported in NFHS-4. So, although, women from both communities vouched for tubectomy as the most common method of birth control, the available data suggests that there is a stark difference in its prevalence between both the states. In both states, the proportion of respondents who do not use any method of contraception is the same (39%). However, the lion share of contraceptive methods in Kerala is occupied by female sterilization, while in Assam the most common form of contraception used by women is pills (28%), followed by withdrawal (9%) and female sterilization (9%). The prevalence of male sterilization, which is reportedly more effective and less expensive, has remained steady across the last two rounds of NFHS at 1%, making women the overwhelming majority of the sterilized population in the state (NFHS-4 &NFHS-5). This indicates that the onus of birth control in the state rests squarely on the shoulders of the women.[53, 54]

A qualitative study conducted in Thiruvananthapuram district of Kerala, during 2014-15, among 30 postpartum women and 10 healthcare providers can shed some light on the situation in the state. The women respondents were literate and the majority had post-secondary education and were from households above the poverty line. Most of them had limited knowledge about modern contraceptives and relied on natural methods like withdrawal for spacing. The women did not have the freedom for contraceptive decision making and once the desired family size was achieved, then the responsibility of birth control rested entirely on the women's shoulders. The health concerns experienced by women during pregnancy, childbirth, and postpartum periods affect their use of postpartum contraception. [55, 56] In a community-based cross-sectional study, among 104 married Dalit women of the reproductive age group from Jorhat, Assam was conducted to assess the level of knowledge, attitude, and practice of different family planning methods. The majority of the women were unemployed and only a minority had attended college. Oral contraceptive pills were the most common form of contraception followed by condoms. The study found that almost 96% of the respondents had knowledge about any one method of contraception. However, the concept of planning parenthood was not very highly prevalent and there was a disparity between knowledge, attitude and practice.[57]

Kerala is a highly literate state whose declining fertility rate is often considered as an indicator of women's progress, due to potential temperance of the "traditional feminine" roles of childbearing and child-rearing. However, the high prevalence of tubectomy and the abysmally low use of other modern contraceptives in Kerala have led to several questions being raised about the real state of reproductive decision-making in the state, which is obscured by the below-replacement fertility figures. [58] The significant improvement in education among women from the traditional fisherfolk community over the past three decades was highlighted by the key informants. However, the perceptions of the women from both the communities and the findings from the aforementioned qualitative study indicate that the status of women's literacy and education does not really explain or predict the state of women, their sexual agency, contraceptive decision making, and reproductive autonomy in patriarchal societies. If that was the case, then there should have been stark differences in the perceptions favoring women's reproductive decision-making from the traditional fisherfolk community from Kerala compared to that of the tea plantation community in Assam.

Another critical aspect that we need to consider with regard to women's reproductive decision-making is the part played by gendered roles and responsibilities, especially regarding the responsibilities towards the family. Both the communities have been experiencing challenges to sustaining their primary source of livelihood (fishing and tea plantation work) due to multiple reasons and consequently experiencing economic distress for the past few decades, which have been affecting their standard of living. The respondents were vocal and clear about the implications of

their dire economic situation on their physical, mental and social health. The economic distress, challenges associated with the traditional occupation and dwindling employment have led to increased economic activity among women. Many studies from developed settings that have explored the association between the involvement of women in paid work and their husbands' task sharing in the household, have failed to find a significant relationship. Studies conducted in traditionally patriarchal societies have reported that gendered division of domestic labour continued even after women started taking up paid jobs, in effect enhancing their share of work.[59] Although men are considered the "traditional providers" in both the communities, the accountability of running the families and delivering responsibilities like educating the children, getting adequate health care for family members, maintaining savings, and taking and paying off debts for needs like building houses and getting girls married off, are either disproportionately borne by women or equally shared by men and women. In other words, the burden of larger families increases the financial and mental distress of the already overworked women. So, the need for smaller families is also sharply felt by women as opposed to men. However, studies indicate that the fertility preferences of male partners have a significant role in reproductive decision-making in patriarchal societies. A study from Madhya Pradesh, India which explored the role of women's fertility preferences and that of their husbands and in-laws' in decisions pertaining to induced abortion, it was found that, husbands' fertility preferences exerted a strong independent effect on the outcome. [60]

Several studies have indicated that men and women are socialized to cope with stress in different ways. [61] Men who find it difficult to cope with the responsibilities associated with the traditional male roles such as staying in control or success as a provider for the family, success at work, experiences Masculine Gender-Role Stress (MGRS). Masculinity is different from MGRS. Masculinity reflects the characteristics which are considered socially desirable for masculine people and these may vary according to the context. MGRS, on the other hand, refers to the appraisal of specific situations and behaviours as stressful or undesirable. On an average, men have been found to demonstrate more MGRS than women. MGRS has been related to negative psychosocial and somatic consequences, anger, anxiety, and risky health behaviours like cigarette smoking, greater alcohol intake, unsafe driving habits, and inconsistency in diet and exercise. [62] The findings from our study indicate that the men from both communities cope poorly with financial distress, resort to alcoholism and substance abuse and engage in violent behaviours. Our study found that women's refusal to engage in sexual activity was a source of conflict within families, leading to sexual violence and unintended pregnancies. The better educational status among young women from the traditional fisherfolk community and the consequent gap in the educational status between partners in young families meant that women attempted to negotiate for the more sexual agency, which ended up in conflicts and violence in many situations.

The acceptability of induced abortion in the communities needs to also consider the perceptions of the key informants from institutions such as local self-government and the health system. The notions of 'sin' related to abortion, its equation with 'destruction of life', and its relationship with the credibility of women were endorsed by the institutional key informants from both the communities. ASHAs, nurses, and doctors supported the notion that induced abortion had to be discouraged as far as possible. They also believed that the character of the women and/or the couple seeking abortion and their reasons for seeking an abortion need to be carefully evaluated and the choice of providing the service was to be based on the discretion of the provider regarding whether the situation was indeed valid. There seemed to be an agreement that a woman's lack of desire or intention to be a mother was not a good enough reason to seek the service.

A cross-sectional survey was carried out among 1996 medical interns in Maharashtra, India, to explore their attitudes toward abortion. While a quarter of the respondents considered abortion to be morally wrong, a fifth found abortions for unmarried women unacceptable. A quarter of the participants were under the erroneous impression that a woman needs her partner or spouse's approval to have an abortion. A majority of the respondents believed that unsafe abortion was an issue in India, yet negative stances against abortion and inaccurate or factually wrong information about its legality were common among the participants. [63] In an earlier study conducted in Maharashtra among 130 abortion providers from 115 health care facilities from two districts to explore the gender dimensions of abortion providers' perceptions of users.[16] The findings of our study regarding the perceptions of institutional key informants on the acceptability of abortion, closely aligned with the findings of this study on the following aspects:

- Institutional key informants held women to be primarily accountable for pregnancies and abortions regardless of her social, economic or political context or the circumstances which led to the pregnancy. Even those who perceived that women of the community did not have the freedom and autonomy to implement their reproductive intentions including the use of contraceptives, believed that, once pregnancy happens, then the survival of the foetus or the unborn child takes precedence over the woman's intentions or choice. The themes upholding motherhood as the central defining theme of womanhood such as *"the woman should have known or anticipated this before"*, *"now that she is already pregnant, she should just continue"*, *"it is the woman's body that prepares itself for a child, so she is the primary parent"*, *"a man is needed to create a child, but he is not primarily accountable for that child"*, were repeatedly raised by the key informants. These themes resonated with the powerful age-old patriarchal notions stressing that women's identity is primarily that of child-bearers. In both settings, an overwhelming majority of these key informants were women. It is also interesting to note that, the male respondents, in general, were less critical of women and their role in

abortion seeking. The male respondents raised the issue of “readiness” or “willingness” to embrace parenthood and the need to value a woman’s mental health as considerations before continuing or terminating a pregnancy.

- The key informants from the government local health facilities observed that they carefully considered the situation of every woman or couple seeking an abortion. For instance, the health of the woman and the foetus were unanimously accepted as situations that called for the decision to terminate the pregnancy. However, if the issue is that of contraceptive failure, then they try to talk to the couple and convince them to continue with the pregnancy even in situations of poor spacing. The marital status of the abortion seeker and her age were critical aspects in deciding the genuineness and validity of the situation. Although even married women were coerced or emotionally manipulated using different strategies such as appeal to their morality or use of religious faith to continue with the pregnancy, young unmarried or single women were quite blatantly judged. While there were themes that depicted the underage and/or the young unmarried pregnant girls as “victims”, who were either exploited or cheated, there were also notions that the overt freedom allowed to “young women” is leading them to mistakes.
- Premarital sex and sex outside marriage were identified as social problems which are on the rise in the local communities. Institutional key informants from both the communities observed that there was demand for induced abortion from young women, some under-age. Under-age pregnancies were considered indications of neglectful parenting. One of the ASHA workers from Kerala observed that if someone from the community approaches her for guidance with regard to such a situation, she refuses to give any concrete answers and evades as these could lead to “trouble” later.

The key informants from the health system stated that they did not encourage abortion seekers and did not provide abortion services at the local facilities. If they felt that a specific case was genuine or found the demand for abortion to be valid, they referred them to more equipped government health facilities in the cities or suggested the use of nearby private facilities. If they felt that a case was not genuine or valid and if the abortion seeker/seekers were unwilling to continue with the pregnancy, they referred them anyway just to transfer the responsibility. There was a general reluctance to perform induced abortions and this went beyond the personal positions and conscientious objection of individual providers. The insights from the key informants indicated that avoiding induced abortions in the communities, especially among married women, was seen almost as a moral responsibility and a noble act.

The role of patriarchy in the construction of medical education and women's health also needs to be examined in this context. The denial of essential services needed only by women, such as abortion, is a manifestation of the systematic denial of sexual and reproductive health to women and such violations are often due to deeply entrenched beliefs and shared values pertaining to women's sexuality. The patriarchal conception of women's roles means that women are valued on the basis of their ability to reproduce. [64] Feminist literature on medical education states that despite the incorporation of aspects of social science and humanities into it, modern medical education is still firmly rooted in biomedicine in many settings, which in turn is deeply ingrained in patriarchy. Radical feminist theory, focuses on patriarchy as a primary method of oppression, gender as the primary oppression, and the need to alter the structure rather than introducing mere reforms. The incorporation of radical feminist theory into medicine is required to ensure that future medical practitioners learn to identify and acknowledge this structure and develop notions of *rights* of women - sexual, contraceptive and reproductive rights - in the practice of medicine.[65]

The absence of such training and conditioning is visible in the functioning of the health system and in the prevalent health care practices in India, particularly, the rampant denial of abortion services by doctors. Some of the common reasons cited for denial of abortion services by providers include the need for the consent of the spouse or partner and the potential risks of abortion during the second trimester. It was also reported that the providers favoured married women in providing counselling, referral, and abortion services over unmarried women. [44, 48] Another instance of patriarchy operating in the health system is the less enthusiastic attitude of the providers to giving contraceptive information and contraceptive services to girls and young women. An audit of sexual and reproductive health services such as the provision of emergency contraceptive pills, counselling, and abortion services, in Lucknow, found that the public health sector lacks the infrastructure to provide quality services. While this is partly due to them being overburdened by work, a significant reason for this was also the conservative attitudes of health care professionals on providing information and services on sexual health. When young people attempt to access these services, they are often humiliated by subjecting them to intrusive services regarding their private life. [66] A qualitative study from Kerala conducted to explore the perceptions of health workers and programme managers on adolescent reproductive health care needs revealed that, although the respondents generally agreed upon the idea of enhancing the utilization of sexual and reproductive health care services among adolescents, the specific solutions proposed largely focused on the provision of counselling services and awareness classes over regular adolescent clinics. [67]

The key informants from our study observed that adolescent health primarily involved the process of imparting the knowledge to adolescent girls that they should use their bodies wisely and judiciously and also groom them to be healthy and safe mothers of the future. The young people and

the communities clearly observed that the health system did not take the necessary steps to inform them adequately about matters related to sexuality, contraception and reproduction. They also had specific concerns that the system, including the ASHAs, were too involved in the health of pregnant women, that the other health needs of women got neglected. This is in fact, consistent with the patriarchal construction that women are valued for their ability to give birth, resulting in a situation where women's health has been narrowly defined as maternal health. This also mandates an examination of the problematization of sexual and reproductive health in India. The state has traditionally problematized reproductive health as "population control", rather than the "rights of women to exert autonomy over her own body and effectively exercise her reproductive intentions".

The overarching aim of the family planning programme of this country has been controlling or stabilizing the population rather than ensuring the rights of women to engage in safe and fulfilling sexual relations (PLD & SAMA, 2018). This is also demonstrated in the manner in which the overwhelming statistics of female sterilization in the state of Kerala is ignored, placing the focus on its near replacement fertility level.[55, 68]

Social norms are known to significantly influence the pathways to care in case of abortion, thus creating barriers for women to access this essential component of sexual and reproductive health care. The descriptive (what others in a group do) and injunctive norms (what others in a group approve of) around female sexuality and reproduction are kept firmly in place in patriarchal societies by the anticipation of positive and negative social sanctions. [69] The findings from both communities indicate that the notion of immortality of induced abortion is widely prevalent. An unmarried woman seeking abortion faces the dual burden of stigma – the violation of her motherhood and the issue of premarital sex. Public and private shaming, judging, spreading gossips and stories about her character, and openly stigmatizing her are some of the commonly reported consequences. Despite the stigma, the respondents considered abortion among unmarried women as justified under certain circumstances, such as, if she was given false promises and cheated by a man. This is especially so if she is underage, where the responsibility of the "indiscretion" would be attributed to her innocence and neglectful parenting. A study conducted among abortion-seeking women aged 15–24 in Bihar and Jharkhand in 2007–2008 reported that compared to married women, unmarried women were more likely to travel long distances and experience more delay in getting an abortion. [71] In India, the need for secrecy and confidentiality was strongly felt by women seeking an abortion, especially young women, which also forces them to seek help from pharmacists, nurses, or unregistered providers, enhancing the risk for unsafe abortion.[44]

A married woman choosing abortion was also considered unnatural and difficult to accept by the communities unless the woman or the foetus are facing grave health concerns. Even if the decision to terminate the pregnancy was taken jointly by the woman and the husband, the community members would raise questions around the fidelity of the concerned woman and the paternity of the foetus. The reasons for this gendered judgement lead us back to the centrality of motherhood and gendered notions of parental responsibilities. The young people and key informants from the community and institutions, overtly and covertly endorsed the idea that the woman was the primary parent and a woman choosing abortion or choosing her own life over the foetus is an abomination to motherhood. There were also themes justifying the greater blame that the society placed on women who sought an abortion, over the male partner or the circumstances that led the women to take such a decision.

We examined the role of marginalization experienced by the communities in their perceptions related to abortion. The themes which emerged from both the settings, from young people and older members regarding the legality, safety, availability, and social acceptability of induced abortion coincided with the extant literature. The communities were neither more or less informed about induced abortion compared to the general population nor were their perceptions regarding its acceptability more negative or regressive. Studies conducted among educated, urban women from Kerala, urban poor women of Vadodara, and medical interns of Maharashtra indicated the deeply patriarchal mindset of respondents from different walks of life in their perceptions regarding sexuality, contraception and abortion. [41, 55, 63] However, the social and economic marginalization of the communities did have a clear impact on their access to health determinants like nutrition, water, and sanitation, consequently their health status, access to health care, contraception, induced abortion and the options available to community members.

Although both the communities were marginalized, there were specific differences between them in the pattern of contraceptive use, physical access to health care, and consequences of poor abortion access. Although respondents from both the communities observed that the health system promoted female sterilization, it was apparent that its use as a contraceptive method was much more prevalent and accepted in the traditional fisherfolk community, compared to the tea plantation community. This difference clearly aligns with the differences in patterns of contraceptive use between the two states – Kerala and Assam – according to the data from the last two rounds of National Family Health Survey. While female sterilizations constituted an overwhelmingly high share of contraceptive use in Kerala, it formed only a small proportion in Assam, where the use of Oral Contraceptive Pills held the highest share.[53, 54]

The differences in terrain, transportation facilities and the extent of public sector health care delivery network between the two states indicated that that the traditional fisherfolk community had greater access to secondary and tertiary care government facilities that provided induced abortion services, compared to the tea plantation community. This difference between the two communities coincides with the difference between the two states in health care access. A global study which assessed the personal healthcare access and quality using the Healthcare Access and Quality (HAQ) Index across 195 countries, as well as subnational locations, between 1990 and 2016, found that Kerala was positioned in the sixth decile in HAQ scores, much ahead of Assam which was in the second decile.[71]

The third and final difference between the two communities is with regard to the consequences of poor access to induced abortion. The unavailability and/or denial of abortion services from local government facilities forced the women from both communities to seek care from other sources. While the other sources for women from the fisher folk community were higher level government services located away from the community and private health facilities, the tea plantation community had an additional option – untrained, unregistered medical practitioners and/or local healers. The barriers of the high cost of private health care and indirect costs of travelling to remote government facilities may lead the women from the fisherfolk community to experience delay in seeking and obtaining abortion care. It could also force these women to continue with unintended pregnancies. However, the women from the tea plantation community have a clear risk of undergoing unsafe abortions if they get the procedure done by untrained, unregistered medical practitioners or local midwives.

The vulnerability of youth to access information and services pertaining to sexual and reproductive health, such as contraception and abortion, has been well documented in the literature.[48] No systematic difference was observed in the themes which emerged from the young people who belonged to the traditional fisherfolk and tea plantation communities and those who did not belong to these communities, indicating that mere membership in a marginalized community does not influence the perceptions of young people. On the contrary, both categories of young people observed that the lack of access to adequate information on sexual and reproductive health and the absence of platforms in the community where youth, especially young women can gather and discuss their concerns and clarify their doubts affected them. There were systematic differences between young people and older members and gatekeepers of the community with regard to their perceptions regarding the need for sex education and the use of modern contraceptives. While the young people were unanimous in their opinion regarding the need for sexuality education for the youth, the community key informants' opinion was divided in this regard. Some of them believed that too much information too early can be counterproductive. The youth were relatively more open to

the idea of modern contraceptives, while many of the older members vouched for natural methods like withdrawal. This preference of older adults for natural methods was more pronounced among the traditional fisherfolk community, potentially due to the influence of Catholic faith. A framework examining abortion stigma at the individual level states that it operates at three levels.[69]

- **Perceived**: Fear or expectation of being stigmatized
- **Internalized:** Self judgement or negative feelings of one's own abortion
- **Felt**: Experience of negative treatment arising from stigma

However, in this study we have not examined abortion stigma from the perspective of the individuals who have sought an abortion, rather we have attempted to understand how it has been constructed by the two communities through the perceptions of a diverse range of respondents. We have adapted the ecological model of stigma and explored the situation in the communities from stakeholders at three levels namely – individual level (young people), community-level (gatekeepers), and institutional level (providers, health care workers, and authorities from local self-governments). [29]

INDIVIDUAL

- *Poor access to information on about sexuality, contraception and the legality, safety, and availability of induced abortions.*
- *Barriers to access information and services due to the due to the secrecy and negative attitudes.*
- *Fear for induced abortions inculcated by a combination of religion, patriarchy, inadequate information, and negative social sanctions.*

COMMUNITY

- *Abortion was considered "unsafe" and "illegal".*
- *Acceptable under few specific and unavoidable circumstances, but it was largely considered immoral, sinful, and unacceptable.*
- *Patriarchal social norms and views upholding the value and rights of the fetes - root of social judgement and sanctions against women seeking abortion*
- *Abortion considered "shameful" to families and communities and there was reluctance to accept that there is a demand for the service.*

INSTITUTIONAL

- *Patriarchal construction of women's health "Population control" orientation of family planning.*
- *Concept of "rights" not central to the construction of sexual & reproductive health by the system*
- *ASHAs from both the communities endorsed that abortion is illegal and unsafe.*
- *Poorly equipped local health facilities & lack of privacy precluded access to information & services & deepened the taboo.*
- *Conscientious objection & personal moral judgement by providers*
- *Women's lack of intention to bear child was not considered a genuine and/or valid reason for induced abortion.*

Figure: Socio-cultural construction of abortion in the two marginalized communities at individual, community, and institutional levels

- **At the individual level**, the most critical component of abortion stigma among the communities is the poor access to information about sexuality, contraception, and the legality, safety, and availability of induced abortions, especially among young people. The community members, especially young people face several barriers to access information regarding sexual and reproductive health issues and services including induced abortion, due to the secrecy and negative attitudes of family members, community gatekeepers, and the authorities from the health system. Young people from both communities had relatively open views about modern methods of contraception, however, they held fear for induced abortions inculcated by a combination of religion, patriarchy, inadequate information, and negative social sanctions.
- **At the community level**, abortion is perceived as "unsafe" for women even if it was done at a medical facility under supervision. These views regarding the adverse consequences of abortion for the health of women were prevalent in the community and these were endorsed by institutional representatives such as ASHA workers and social and public health activists. This was also the case of the legal context of abortion, where the dominant view was that abortion is “illegal.” Except for a few specific unavoidable circumstances, such as danger to the health of women and/or foetus or to ensure the future of young unmarried women, abortion was considered unacceptable due to its sinful and immoral nature. Patriarchal social norms around female sexuality, the centrality of motherhood, and gendered notions of parenting roles along with the views upholding the rights and the value of the life of foetus, led to the questioning of the integrity and dignity of women seeking an abortion. This was enacted as social judgement, ridiculing, malicious gossips, and social sanctions against women. Induced abortion was perceived as a “shameful” act bringing disgrace to families and communities, making conversations around it difficult and infrequent. There was a clear reluctance demonstrated by the communities to accept that there was a demand for the service.
- **At the institutional level**, the patriarchal construction of health and the "population control" orientation of family planning took away the concept of "rights" from the way the health system engaged with sexual and reproductive health. ASHAs from both communities endorsed the view that abortion is illegal and unsafe. Lack of privacy in poorly equipped local health facilities not only precluded opportunities for women to seek information and care but deepened the taboo and secrecy. Conscientious objection and personal moral judgement of providers heavily weighed in with regard to their decisions

with regard to women seeking an abortion. Women's lack of intention and/or preparedness to bear a child was not considered a genuine and/or valid reason for induced abortion.

The negative attitudes of the key informants from the local health facilities towards the communities and the extent of stereotyping reflected in their perceptions are clear instances of how their social and economic marginalization proves to be disadvantageous in their abortion access. The instances cited by the institutional key informants, where they undermine and trivialize the women's demand for privacy (*the women in this area are not very shy or anything. They openly say anything. They will talk anything in front of anyone. They don't have much shame or awkwardness to talk about their problems*), label them (*most of them are happy to be pregnant and they believe that having 4 or 5 children is some kind of a credit for them)* and use their faith to manipulate them into decisions (*To bring the women to line, we use their faith to convince them. This community is very serious about their faith in God. Then, when we mix some Godliness in our words, they will be okay (laughs). God has given this baby*) indicates their poor understanding of the vulnerabilities of the communities they serve, with potential implications for their attitudes towards the patients and the quality of health care delivered.

Major barriers to accessing safe abortion

Based on the themes which emerged from the respondents, we have conceptualized the barriers to accessing induced abortion at three levels: namely individual-level barriers, community-level barriers, and institutional barriers.

At the individual level

- Fear of abortion constituted by religion, patriarchy, inaccurate or incorrect information regarding safety and negative social sanctions imposed by the communities
- Lack of access to adequate information regarding sexuality, contraception, and reproduction necessary for informed and appropriate decision making
- Financial distress affecting affordability of private health care
- Inadequate support from families, community, and institutions

At the community level

- Social and economic marginalization limiting access to quality abortion care
- Religion, patriarchal norms and gendered roles restricting sexual agency and reproductive autonomy of women and glorify motherhood as the defining role of women not only precludes access but also conversations around induced abortion
- Negative social sanctions and stigma against abortion further fuels the silence, secrecy, and shame
- Lack of community level platforms and organizations which prioritizes sexual and reproductive health and rights and promote conversations and discussions

At the institutional level

- Low priority accorded to sexual and reproductive health and rights of women by the health system reflected in the poor orientation of providers and health workers towards any such concerns other than maternal health
- Lack of adequate infrastructure, facilities and human resources to ensure good quality abortion care ensuring privacy and confidentiality of clients in local government health facilities
- Conscientious objection of providers and health workers and their personal values interfering with the provision of abortion care
- Poor conditioning of providers and health care workers to understand marginalization and consequent vulnerabilities leading to negative attitudes and stereotyping of communities
- High cost of care and untrained, unregistered practitioners and local healers practicing abortion care enhancing the risk of unsafe abortions due to a poorly regulated private sector in health

POLICY IMPLICATIONS OF THE STUDY

The findings of this study have directed us towards the following key areas where policy interventions could be developed.

Reorient sexual and reproductive health to centralize a rights perspective

One of the critical findings from the study was the absence of a rights framework in the construction of sexual and reproductive health in both settings. It is maternal health that continues to predominate the space of women and, hence, sexual and reproductive health concerns have not received adequate focus or priority. Further, the centrality of women's sexual agency and reproductive autonomy has not been recognized as the basis for birth control and family planning. The lack of such an orientation allows the conscientious objection and judgements of providers to continue unchecked, the consequence being that not all women who seek abortions are given the necessary information and prompt referrals. Hence, there is a need for a concerted effort from the system to reorient the construct of sexual and reproductive health to make the rights of women its central theme.

Government health facilities at all levels have to be responsive to the specific needs and vulnerabilities of women

While the need for privacy in interactions with the health care providers and that of assured confidentiality of the information shared emerged as definite needs from both the communities, the providers and institutional representatives were not only unaware of these needs but were also dismissive of them. The lack of adequate facilities and infrastructure, manpower, and medicines at the local government health facilities compelled the women to either forego health care or resort to remote and/or expensive health care. This was of particular concern in the

case of unintended pregnancies, where women had no other option either to continue with the pregnancy or resort to expensive, distant, or even unsafe options.

Need to disseminate accurate and comprehensive information about contraception and induced abortion

The community members, especially the young people were either unaware, had inadequate/incomplete information, or were misinformed about contraception, the various methods of contraception, the legality, safety, availability and the methods of induced abortion. This contributed significantly to the fear of abortion in the community. Additionally, inadequate information and misinformation were also endorsed by many of the institutional representatives including the ASHA workers. This presents a clear need to sensitize the ground-level workers like ASHAs, social and public health activists, Anganwadi workers, and other institutional representatives on induced abortion so that they can be part of initiatives information dissemination in the communities. Local self-governments and local health systems need to take greater initiative to organize campaigns and develop platforms in collaboration with the civil society organizations to dissipate the prevalent misperceptions about the legality and safety of induced abortion.

Specific requirements raised by the community members regarding their expectations for better provisions at the local health facilities include the following:

- Services of a female doctor who specifically focus on the health concerns of women and children
- Services of at least one doctor 24X7 to ensure that the emergency health care needs of the community members are addressed especially during night
- The number of doctors should be increased in such a way that the overcrowding at the facilities can be reduced to some extent
- Need of more spacious cabins and preferably separate cabins for male and female patients in the facility
- Necessary steps should be undertaken to start delivery services at the facility including the services of Obstetrician and Gynaecologist at least twice a week
- Steps should be initiated to ensure that at least life-saving interventions like basic trauma care are provided during emergency situations
- Abortion services should be offered at the initial weeks of pregnancy at the facility and if the service cannot be provided for any medical or health related reason, then prompt referral of all the cases should be ensured
- Regularize the availability of medicines and basic diagnostic procedures at the facilities

Box 1

Need for community-based campaigns and initiatives with a renewed focus on socio-economic marginalization and patriarchy

The marginalization and economic decline faced by both the occupational sectors- fishing and tea plantation – and the gender role strain consistent with masculinity reflected in risky and unhealthy behaviours of men seriously impact the lives of women. Consequently, women experienced serious social issues such as domestic violence, marital rape, financial distress, frequent and multiple pregnancies & childbirths, and unintended pregnancies. Both the communities have a plethora of civil society and youth-based social and cultural organizations which could take the initiative in association with the local self-governments to bring these issues to the forefront and organize campaigns and build platforms where these can be discussed freely. The issues faced by women also need to be brought to the attention of elected representatives to the Legislature and Parliament and the findings of this study could form the basis of such an initiative.

CONCLUSION

This qualitative exploration highlights the profound role played by structural and socio-normative barriers in determining abortion access. The findings underscore that even when the legal environment is relatively unrestricted, a combination of factors like inadequate and inaccurate information, prevalent social and gender norms, the patriarchal orientation of the health system, negative attitudes and judgements of the providers, and religious beliefs can significantly limit the access to birth control and induced abortion services. The social and economic marginalization of these communities exacerbate the impact of these barriers because their poor social and economic capital further limit the options to prevent and terminate unintended pregnancies. The study findings also clearly suggest that these structural and normative barriers weigh most heavily on young women, as they are overwhelmed by multiple disadvantages including strong patriarchal conditioning, cultural expectations of femininity and motherhood, economic dependence, and sexism. There is a clear need for the health system to acknowledge these vulnerabilities of women and reorient the concept of sexual and reproductive health towards their rights, aligning with local self-governments, local health facilities, and civil society organizations.

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