# REPORT:
# DEMYSTIFYING SUBJECTIVE EXPERIENCES & DEPTH OF KNOWLEDGE WITH REGARDS TO SELF-USE OF MEDICAL ABORTION

By: PURPLE AUDACITY RESEARCH & INNOVATION PVT LTD
For: THE DAVID & LUCILE PACKARD FOUNDATION INDIA
Date: 25.02.2020

**TABLE OF CONTENTS**

TOP LEVEL FINDINGS: UNDERSTANDING THE CONTRACEPTIVE-ABORTION CONTINUUM 4
CHAPTER 1 - SETTING THE CONTEXT 9
1.1 Research Background 9
1.2 Research Objectives 9
1.3 Research Questions 9
1.4 Research Approach 9
1.4.1 Phase I: Assisted Simulations: With Married Women Who Are Aware of MA 10
1.4.2 Phase II: Ethnography - Exploratory Design to Understand the Factors that Influence the MA Experience 10
1.5 Sample Selection and Centres of the Study 11
1.5.1 Phase I: Simulation- Geographical Centres & Target Sample Outline 11
1.5.2 Phase II: Ethnography- Geographical Centres & Target Sample Outline 12
1.5.3 Sample achieved 13
CHAPTER 2- RESEARCH FINDINGS PHASE 1 SIMULATION 15
2.1 Contraceptive Knowledge 15
2.2 Abortion & MA 15
CHAPTER – 3: RESEARCH FINDINGS PHASE II- ETHNOGRAPHY 16
3.1 Understanding the Location 16
3.2 Understanding the P2/P2+ Woman 17
3.2.1 The P2/P2+ women- Own Aspirations, Fears and Trust 17
3.2.2 Role in the family (Maternal & Marital home) 19
3.2.3 Social Interaction & Information Seeking 19
3.2.4 Sense of Self 23
3.2.5 Mobility 25
3.2.6 Seeking External Support 26
3.2.7 Attitude Towards Health 28
3.2.8 No active information seeking about MA: 31
3.3 Understanding Family Planning & Contraception 31
3.3.1 Family Planning 31
3.3.2 Contraceptive Awareness & Knowledge 34
3.3.3 Contraceptives – Method-Wise Awareness 35
3.3.4 Understanding Contraception Timelines & Behaviour 36
3.4 Abortion & MA – Knowledge 39
3.5 Understanding MA Among P2 &P2+ Women 40
3.5.1 Detection of pregnancy, it’s circumstances 40
3.5.2 Trigger for MA and Decision-Making Process 41

3.6 Decision-making for MA 42
3.7 Planning MA Self-Use 44
3.8 The MA Experience 47
3.9 Complications Involved with MA 49
3.10 Understanding Contraceptive Timelines of MA Users 51
CHAPTER 4 – CONCLUSION 54
4.1 Women suspend their emotions and stigma when deciding to carry out medical abortion 54
4.2 The focus on informal touchpoints 54
4.3 The introduction to MA for the woman takes place in the form of overhearing or in an unassuming, and most casual conversation 56
4.4 Severity of symptoms of the MA experience are not correlated with 'Complications' 57
4.5 On the contraceptive-abortion continuum, Medical Abortion is closer to contraceptives than it is to abortion 57
ANNEXURES 59
*ANNEXURE-I: REVISITING HYPOTHESIS FOR PHASE 1* 59
ANNEXURE-II: DETAILING OUT THE METHODOLOGY: PHASE ONE: ASSISTED SIMULATION 64
*ANNEXURE III: DETAILING OUT THE METHODOLOGY – PHASE TWO: ETHNOGRAPHY* 66
*ANNEXURE IV: LIMITATIONS OF THE STUDY* 70
*ANNEXURE V: INSIGHTS FROM SIMULATION-PHASE-I* 71
*ANNEXURE-VI: DETAILED UNDERSTANDING OF THE STUDY CENTRES FOR PHASE 2* 78
*ANNEXURE VII: FROM ETHNOGRAPHY - UNDERSTANDING THE P2/P2+ WOMAN & HER UNIVERSE BETTER* 79
*ANNEXURE- VIII: HEALTH AND NON-HEALTH PROVIDER TOUCHPOINTS BASED UPON THE OBSERVATIONS/ACCOMPANIMENTS* 85
*ANNEXURE IX: DETAILED UNDERSTANDING OF CONTRACEPTIVE AWARENESS AMONGST P2 WOMEN FROM PHASE - 2* 87

## TOP LEVEL FINDINGS: UNDERSTANDING THE CONTRACEPTIVE-ABORTION CONTINUUM

Before diving into the detailed report for this study, this section provides an overview of the composite findings of the study. Within the context of the contraceptive-abortion spectrum, it captures the key insights uncovered with regards to women's attitude, knowledge, access and usage of medical abortion and family planning methods. **It focuses on the following key areas of information:**

1. **Attitude, knowledge, and experiences of medical abortion**
2. **The network of information touchpoints involved in navigating contraceptive and abortion choices and decisions**
3. **The subjective experiences of users of medical abortion drugs and their understanding of complications**

## TOP LEVEL FINDING 1: A WOMAN SUSPENDS HER EMOTIONS DURING SELF-USE OF MA

- **Abortions have NO stigma attached in the woman's mind, it is deemed EXTERNAL:** Most women were of the opinion that the decision for abortion was not a big deal in their minds, and that it was an obvious choice given the physiological and/or psychological difficulties they might face upon having another child – something that was expressed as not being understood by other familial and non-familial stakeholders. Still, women stated that they would rather keep it a secret given that people tend to judge and question the decision to not carry a pregnancy to term after it has occurred. The need to carry out an abortion is expressed to be so high that the societally enforced moral values and principles which deem abortions to be immoral or even criminal in nature, do not even cross the minds of the women at that time. The 'urgency' of terminating the unplanned pregnancy is the pivotal action point to them.
- **The biggest concern – Ending the pregnancy:** When asked about any fears or concerns they may have with regards to using MA, many women said that in the short time frame when the drug can be consumed, their sole concern was to 'get rid of' the pregnancy. In cases where the woman had not shared news of the unplanned pregnancy with her husband or family members, she was stated to be comfortable dealing with side effects, as long as the process of abortion was initiated. At the time, the relative need to terminate the pregnancy was much higher than considerations of side-effects or other detrimental effects to the body that might occur.
  The acknowledgement of any moral dilemma related to the act was only stated to be felt post the event of using medical abortion, once the initial worry regarding the progression of the pregnancy had been quelled.
- **Moral Dilemma:** The sense of moral dilemma and reflection doesn't seem to be felt at the time when women have decided to consume MA pills. She just wants a 'riddance' at that point in time and nothing else – a feeling that reigns supreme upon discovering the unplanned pregnancy. The thought process expressed at this point is logical and non-emotional. Later on, women can sometimes start feeling a sense of moral guilt about it.
- **Profile of women who consume MA: Most women see the maximum legitimacy in P2 women (having had two childbirths or more) having abortions, given that they are likely to have achieved family completion.** According to most of the women interviewed, out of a supposed 100 women who may have used MA, the largest chunk of women who consume MA pills were likely to be P2 women (an average of 60-70 women), because they probably do not want another child (mostly due to financial considerations). This was reflective of the normative expectation that a minimum of 2 children are necessary for family completion. But women also expressed that even P1 women have started seeking abortion as an option because given the

current cost of living, even one child can be enough to manage in terms of expenditure. However, they mostly felt that P1 users of medical abortion account for a very small proportion of the larger universe of MA users. An interesting fact is that whilst many women accounted for unmarried women using MA citing the increase in premarital intercourse as a 'questionable but undeniable' trend, they **did not seem to see any merit in a newly married (P0) woman voluntarily undergoing an abortion using any method unless there was a health concern involved. For the former,** women also expressed how unmarried women have started consuming MA pills recklessly by saying they end up 'misusing' them and due to the same reason chemists refuse to sell them. For the latter, they reiterated the normative expectation for a newly married woman to almost immediately have the first child in order to prove her fertility and to gain respect from members of her marital home.

**TOP LEVEL FINDING 2: ALTHOUGH THE DECISION TO USE MA INVOLVES BOTH FORMAL AND INFORMAL SOURCES OF INFORMATION, THE EMPHASIS IS ON THE INFORMAL SOURCES**

- **The ideal situation:** Some women respondents in both the centres stated that in case of suspecting an unplanned pregnancy, they would take the pregnancy test themselves and would like to immediately go to a doctor seeking help in dealing with an unwanted pregnancy. However, several women stated that they had been open to 'trying out' MA as an option in earlier days of gestation, rather than going to see a doctor and having to undergo a (surgical) abortion straightaway. The (few) women who were prescribed MA by their doctors had extreme comfort with the idea of using the drug, as it was suggested by a certified source, and they could consult the doctor on their own, should the need arise.
- **No Google search about MA:** It was reported that women may utilize technology to search about minor medicines for cough, cold, etc. but they do not search anything about MA or abortion. Information that is deemed actionable was stated to be received via a 'trustworthy' source like a doctor/husband/friend/confidante, depending on the situation and comfort level of the woman.
- **The tone of information sharing:** The women stated that they believe that positive experience sharing and discussion with a confidante/close female friend acts as a support to build her confidence during the journey of MA. The tone of sharing this information was stated to be non-serious, and matter of fact – whether by way of narrating one's own experience, or discussing a third person's experience. This tone was seen to reflect in her decision to use MA. This friend is credited with priming and positioning the image of MA in the mind of the woman, creating a reference point to a potential solution for an unplanned pregnancy. However, this information sharing doesn't necessarily happen at all stages. This mostly happens first with information-seeking when the woman is gathering knowledge about the options for her to explore after she discovers an unplanned pregnancy, and then ultimately post consuming MA with other women. There have been exceptions when friend/confidante have followed up regularly to ensure the well-being of the women.
- **MA is considered better than surgical abortion:** Most of the women across centres believe that medical abortion is a better option than surgical abortion as it is discrete, there is no need for hospitalization or to undergo an invasive procedure, and that pills are **cheap** in comparison to it.
- **The dilemma about legality:** The most popular dilemma (amongst women and chemists) around medical abortion is that MA "is illegal", a belief that the tablets are harmful for the body and can negatively impact fertility, and that there is a chance of misusing/abusing the tablets by repetitive use. Chemists in Indore also believed that these pills are 'banned' by the

government/ 'DM orders' and are illegal to sell. The legal status of the MA still continues to be a contested confusion among different stakeholders.

**TOP LEVEL FINDING 3: THE P2+ WOMAN TREATS THE SUBJECT OF SELF-USE OF MA WITH GREAT EQUANIMITY**

- **Termination in the first trimester of pregnancy:** Most women reported having their most recent termination in the first trimester of pregnancy and the most popular reason given for termination was birth spacing or family completion. The discovery of this pregnancy for most women occurred within a few days of missing menstruation, and upon identification of symptoms that are associated with the first trimester of pregnancy. This knowledge was stated to occur to P2 women more easily as they have given birth before and can relate to the symptoms of a pregnancy.
- **Shift of preference towards pharmacies**: Women reported that doctors were offering MA pills at an exorbitant cost and not in the original packaging they were being sold in. It was observed and stated by women that the convenience of the availability of MA at a low cost, alongside the anonymity offered to the customer has started to make pharmacies the preferred source of MA for most women who have used it.
- **It is not important to learn brand names of MA drugs:** Most of the women interviewed **could not remember the name of the tablets** they had consumed, and did not seem particular about it. Where they could remember the name, it was when they had a wrapper preserved at home (in case of future need). In a few cases, the women respondents of Indore mentioned receiving pills outside of the packaging and just in brown packets from the chemist.

  **High threshold for potential physiological experience and side effects:** Women who were users of MA tended to recognize the fact that the experience of MA use is subjective and different for each woman. Many women claimed to know of other women who have undergone complications, but themselves underwent what they perceived to be smooth experiences. There is an implicit understanding amongst women that the act of abortion itself will likely be accompanied by significant physiological effects. So, women anticipate at least a few days of bleeding as the immediate consequence of using MA. Thereafter, cause for worry was mostly reported to be felt if the bleeding is prolonged for over a week (given that menstrual bleeding itself tends to last for a few days, and that experience is not unusual), or if extreme dizziness or pain was experienced. In some cases, even extreme pain was discounted as being normal, in comparison to the woman's prior experience with the discomfort that accompanies the process of childbirth. The most commonly described experiences were about moderate to heavy bleeding for 1-3 weeks, weakness in the entire body and abdominal pains or cramps. These were reported to be known or expected side effects of the method and were therefore not considered as 'complications' by some women, although this tended to vary based on women's perceptions of them. Some women even expressed having psychological side effects like irritability, anger, feeling unenthusiastic about everything etc.
- **Repeat use of MA is avoidable BUT is a last resort that exists:** For a woman, the **threshold of frequency of using MA pills is the number of times she has used the pills herself and vice versa.** Women across centres unanimously expressed that in theory, the pills are bad for a woman's health but then if a woman is pregnant and doesn't want a to carry it to term, then she is bound to take that pill and perhaps has no other choice in the matter.
- Though FP methods and MA are not seen as interchangeable, there is **a definite comfort in knowing that an easy termination option is available,** and this often results in lesser care or concern being given to inconsistent use of contraceptive methods. **The risk perception of an unplanned pregnancy reduces because the solution is not cumbersome, nor is it public.** In

a group, women stated that if the entire process of procurement and carrying out the abortion could be made even more covert, without requiring any intervention from anyone but the woman could carry out MA entirely on her own without anyone's involvement -it would be an ideal solution.

**TOP LEVEL FINDING 4: HEIGHTENED NEED FOR CONTRACEPTIVES POST ABORTION OFTEN REMAIN UNMET. THERE IS A MINIMAL SUPPLY SIDE INTERVENTION COUPLED WITH EXISTING BARRIERS ABOUT CONTRACEPTIVE METHODS. THIS PUSHES MA CLOSER TO CONTRACEPTIVES AS A NEAR-ALTERNATIVE TO CONTRACEPTIVE USE.**

- **There is a stated heightened need for using contraceptive methods more rigorously after an MA experience.** The impact of this need appears to be short-lived for a few months. However, if in the window following MA, the woman adopts a long-term method of contraceptives like injectables or intrauterine devices* (like Copper-T), she is likely to sustain usage for a longer duration. **In some cases, in spite of previous experiences with modern methods of contraception, the couple resorted to traditional methods of contraceptives, believing in a greater level of control between them, versus relying on an external method, which may have failed them in the past.**
- **Post-abortion family planning:** Women were asked whether they had started using any form of contraception after their abortion and there was a mixed set of responses. Some of them stated that they did start using contraception or continued using the method which they used after their most recent abortion. The remaining contraceptive non-users said they or their husbands did not want to use a modern method. Women who had had a medical abortion without any intervention from a formal healthcare provider, were seen to be less likely to take up contraception methods following their abortion and were seen to cite a lack of information as the reason why they didn't opt for any method.
- **The reliance on experienced contraceptive method** is so high that change in method happens only if there is a strong positive association via word of mouth. There appeared to be greater comfort in changing switching from a chosen method in case the ideal family has been achieved, in which case a long-term procedure was cited seen as a permanent option. This could be the use of injectables, IUD, or even sterilization. Even in this case, some women expressed comfort in not consistently using any modern methods of contraception because in the back of their minds, MA pills are present as an option.
- **MA has moved closer to the contraceptives on the contraceptive-abortion spectrum:** It was observed across centres that MA has started to enter the contraceptive basket, as an available alternative for non-usage or inconsistent usage of contraceptive methods. Plotted on a continuum, MA itself appears to have moved further from the term 'abortion' (typically associated with an invasive, surgical procedure that necessarily requires a doctor's intervention) Women see it as an **emergency solution** to an unplanned pregnancy, which helps prevent reaching the stage of having to seek a surgical solution. Even in terms of terminology, women refer to MA as 'medication or a way to induce a miscarriage' bringing it closer to contraceptive methods on the spectrum.

**Intrauterine device is referred to as Copper-T (as understood by the women respondents) in the subsequent sections of the report.*

# DETAILED REPORT

**The following document is a detailed report of the study conducted to understand in great detail the subjective experiences and depth of knowledge of women with respect to medical abortion.**

# CHAPTER 1 - SETTING THE CONTEXT

*This chapter outlines the methodology of this study as well as the background characteristics of the centres and women chosen.*

## 1.1 Research Background

The David & Lucile Packard Foundation had commissioned a research among married women with 2 or more children in the locations of Varanasi and Indore with the key goal of exploring medical abortion (MA) knowledge, use and experience. The 2-part study constituting a simulation exercise in an orchestrated environment, followed by an ethnography exercise in the respondents' home environment, was aimed to map the user journey for self-use of MA and to understand the current positioning of Self-Use of Medical Abortion among the various contraception options available. The study also focused on exploring a nuanced understanding of the beneficiaries' experience of self-use of medical abortion (MA) so as to inform the communication and language suitable for communicating the MA experience. The study helps advance the foundation's efforts in positioning MA adequately in the RH continuum. Further it will inform an approach to supporting provider-led interventions.

## 1.2 Research Objectives

The key objectives of the study were:

1. To map women's lives and decisions in the universe within which they exist, operate and are influenced. This includes exploration of lifestyles, relationships, confidants, aspirations, information channels, gatekeepers, influencers, social norms.
2. To determine the comparative value attributed to contraception, family planning and medical abortion through the lifetime of the married P2 woman and exploring rational, emotional and psycho-social reasons of the value attribution.
3. To comprehensively understand intent, knowledge, access and decision-making for self-use of MA and the resultant physiological and psychological experience of the same.

## 1.3 Research Questions

The research questions fell into four main lines of inquiry:

1. What is the perceptual difference between MA, Emergency Contraception, other contraceptive methods, and surgical abortion if we were to place it on a continuum?
2. How do MA users know what to expect from the 'self-use of medical abortion' experience, and what are the sources of information?
3. How do users recognize signs of 'danger' and actually get help when it is required? What is the extra distance a woman goes, to get help?
4. What do medical abortion users do when they know something is going wrong?

## 1.4 Research Approach

Research conducted on the subject of MA self-use is in itself a mammoth undertaking, given the moral and normative taboo surrounding the issue. Within this context, the studies that have been conducted in the past have been subject to such limitations leading to a restricted view of the actual MA self-use experience, and how it fits into the life of the user. This study followed a two-phase methodology, which aimed to circumvent the constraints regarding MA in prior studies. This was undertaken by breaking away from standard interview and group setups to interact with respondents in comfortable environments that enabled them to wholly express their perceptions, opinions and decisions related to contraception, pregnancy and abortions. The following two-step strategy was followed to this end:

**TWO-STEP STRATEGY**

**Phase 1: Simulation**

Articulation of the decision-making journey in a non-threatening simulated scenario to determine how an unplanned pregnancy is approached, perceptions about available touchpoints, influences on decision-making and what they understand about the process of medical abortion

**Phase 2: Ethnographic Study**

Validation of articulated responses through an immersive observation and interaction exercise, to understand the woman's interaction with her ecosystem to understand how this shapes her subjective experiences of usage of medical abortion

### 1.4.1 Phase I: Assisted Simulations: With Married Women Who Are Aware of MA

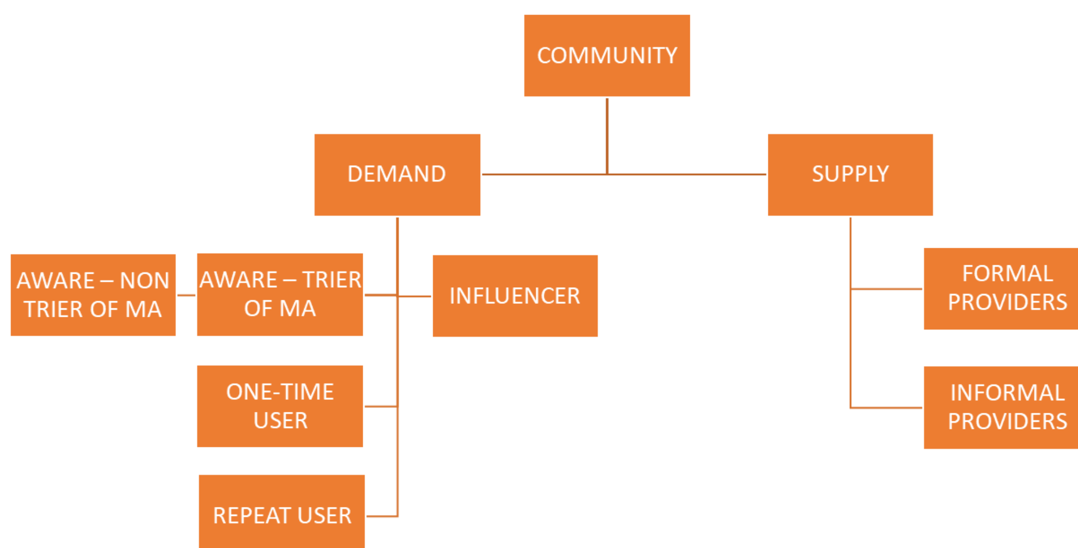
Prior to undertaking an extensive ethnographic exercise, it was important to arrive at a definition of the ecosystem within which beneficiaries seek information and take decisions, and the quality of interaction with the stakeholders they might encounter during the course of their decision making and experience. In this context, the study aimed to apply the understanding of simulation-based learning to the subject matter at hand in order to devise a detailed framework within which the beneficiary of MA operates. The concept entailed involving a fixed number of P2 women, irrespective of their MA experience, to participate in a number of simulated situations relating to an unplanned pregnancy. In a non-threatening environment, a simulation enables respondents to articulate their positive and negative associations with various touchpoints in their ecosystem, without the fear of implication upon their own lived realities.

**"We know that they know. But we don't what they know (or how they know it)."**

With simulations, the aim was to arrive at finding the grapevine that is working within the target group to help accumulate information, along with the respective associations with each element, which kicks in **when the need arises, leading to the decision-making and information-seeking behavior found in past studies.**

### 1.4.2 Phase II: Ethnography - Exploratory Design to Understand the Factors that Influence the MA Experience

Once the width of topics, stakeholders and various interactions to be covered were established through the simulation exercise, the study took an exploratory approach to understand how these factors interact with each other in real-life situations. The objective of ethnography was to understand the ecosystem, for accessing and using MA pills and the understanding of a woman's considered contraceptive basket. To this end, to arrive at the answers of our key research questions, the second step was an ethnographic exercise with the beneficiaries and their respective stakeholders and touch-points, as described below:




***Note to reader:*** The hypotheses arrived at in the first phase of this study, were used as the starting point for the second phase. At the end of Phase 2, these hypotheses were revisited for validation/invalidation. ***These hypotheses and their validation/invalidation based on Phase 2 are captured in Annexure I of this report.***

**1.5 Sample Selection and Centres of the Study**

**1.5.1 Phase I: Simulation- Geographical Centres & Target Sample Outline**

**Geographical Centres**

The study was conducted in areas where MA is easily accessible and found at multiple sources, in order to arrive at an increased likelihood. Thus, 1 urban centre each in the states of Uttar Pradesh (Varanasi) and Madhya Pradesh (Indore) – both states where MA is easily available - were chosen.

**Target Sample Outline**

The selected centres in both states (Uttar Pradesh & Madhya Pradesh) whilst urban centres within the states, are representative of lifestyles and attitudes that are characterized by a combination of access to healthcare resources as well as physical and virtual information touchpoints, along with mindsets that are relatively conservative in comparison to more exposed or globalized metros. This was undertaken to aid the ease of to be able to recruiting respondents who would be able to represent relatively conservative societal outlooks, but would also be able to contribute effectively to the simulation exercise.

**Defining the demographic & psychographic profiles:** Considering that the outcomes of this phase would impact the course of action in Phase 2 of this research, there was a need to establish consistency in both demographics and psychographics in Phase 1 and Phase 2. This enabled us to map the similarities or differences within the same universe and to aid comparability. The study specifically selected women with certain behaviors/markers based on lifestyle choices that imply similar psychographics.

| **Demographic Criteria** | **Respondent Profile** |
|---|---|
| | Married Women |
| Age | 20+ to 35 years |
| NCCS Category | NCCS A3, B2, B1, C1 |
| Parity (Number of childbirths) | P2 and P2+ |
| Education | Matriculation and Matriculation above (Quota-30:70) |

| Employment Status | Working and Non-Working (Quota-50:50) |
|---|---|
| Family Size | Extended Joint Family (Quota-25), Joint Family (Quota-25), Nuclear Family (Quota-50) |
| Husband's Occupation | A mix of Salaried and Self-Employed (Business) |
| Phone Ownership | Smart Phone |
| | First Generation Urban Women |
| | Monthly School Fees of Children |

| **Psychographic Criteria** | **Details** | **Rationale** |
|---|---|---|
| **Media Viewing & Consumption** | ***TV Content*** (On basis of Channel Viewership)<br>Entertainment- Star, Sony, Zee, Colors, Sab<br>News- Aaj Tak, Star News, etc<br>Music Channels- MTV, 9XM, etc<br>Other Regional Channels | Sensibilities in terms of quality of content consumed is a good way to establish like mindedness between the different sets of respondents |
| | ***Internet Content*** *(Hoot, JioTv, Youtube, ALT Balaji, etc)* | Exploration of content on the internet represents the inclination to explore and comfort level with technology, as well as an understanding of |
| **E-Commerce** | ***Shopping*** *(Amazon, Flipkart, etc)* | Indicative of agency to make purchases of her own accord, with adequate financial access and the scope for impulse purchases. Also indicative of comfort with technology use |
| | ***Payment Apps*** *(Google Pay, Paytm, PhonePay, etc)* | Access to money for use - financial access, and comfort with making online transactions. Representative of progression from traditional payment methods |
| | ***Food Apps*** (Zomato, Swiggy) | Replacing homecooked meals with home food delivery - representative of the ability to indulge, and to replace meal preparation with pre-ordered meals in the home. |
| | ***Transport*** (Uber, Ola) | Indicative of level of independent mobility, and comfort with technology in moving around on her own. |

***Note to reader: The detailed methodology for Phase 1 is captured in Annexure II.***

### 1.5.2 Phase II: Ethnography- Geographical Centres & Target Sample Outline

**Geographical centres**

This phase of the research was conducted in the same centres (Varanasi & Indore) where the simulation exercises took place.

**Location for ethnography**

Location selection within the cities was carried out carefully to ensure the identification of potential self-users of MA – these were the same localities/communities from where the respondents for the simulation had been recruited. Next, a few women who had participated in the simulation exercise were

identified as key informants, who were able to introduce the team to the community in the ethnography phase. Within the identified location, our recruitment teams had used the **contact and referral method, with the help of key informants** to identify some self-users of MA. Past experience has shown us that usually, MA users are able to provide further references to other women who have also used MA. By identifying a minimum of 4-5 MA users in the selected location, we were likely to get access to a larger group of MA users. In such cases, if the women identified through referrals matched the required demographic and psychographic profiles, then they also became a part of the investigation.

**Target Sample:**

| Activity | Centre(s) | Respondent Profile | Total Activities |
|---|---|---|---|
| Accompaniment/ Observations/ *Mohalla* Groups/ Peer Groups/ Dyads/ Triads/ One-on-One | Varanasi & Indore | Married (P2+) **women who are aware but not tried MA** 20+ to 35 years NCCS A3, B2, B1, C1 | *Since the objective of the exercise was to keep the process iterative, the total sample was kept flexible to fit into a period of 7 days* |
| | | Married (P2+) **women who have used MA once** 20+ to 35 years NCCS A3, B2, B1, C1 | |
| | | Married (P2+) **women who have used MA more than once** 20+ to 35 years NCCS A3, B2, B1, C1 | |
| | | *Influencers:* Including partners, friends, other older women, etc. | |
| | | *External touchpoints:* Other purchase points or community touchpoints etc. | |

***Note to reader: The detailed methodology for Phase 1 is captured in Annexure III.***

### 1.5.3 Sample achieved

*The subsection highlights the sample achieved across Phase I (Simulation) & Phase II (Ethnography)*

**SAMPLE ACHIEVED IN PHASE I- SIMULATION**

**Varanasi & Indore** –

- In Phase 1 of the study, the simulation exercise had been conducted in Varanasi and Indore, with 30 (15 in Varanasi and 15 in Indore) women belonging to the target demographic *(Women aged 20-35 years with 2 or more children, NCCS C1, B2, B1 & A3, educated upwards of 10$^{th}$ standard).*
- Out of the 15 women, researchers identified key informants, across two key localities in both cities respectively, over a 3-4 sq. km area to carry out the ethnography exercise for Phase 2.

**SAMPLE ACHIEVED IN PHASE II- ETHNOGRAPHY**

**Varanasi & Indore** –

- In Phase 2 of this study, ethnography was conducted starting with the women identified in the simulation exercise as the key information, snowballing to identify other women in Varanasi who were close to our target profile criterion and were aware of medical abortion – some users and some non-users. *(Target profile: Women aged between 20-35 years with 2 or more children, married between the age of 17-25 years, completed a minimum of 5 years of marriage, child gap pattern of minimum 2-5 years, NCCS C1, B2, B1 & A3, educated upwards of 10$^{th}$ standard).*

**Varanasi & Indore:**

| **Activity** | **Number of units** |
| --- | --- |
| Pilot Interviews | 2 |
| Physical & Social Mapping | 8 |
| Mohalla Groups | 8 |
| In-depth Interviews | 46 (30-MA Users, 12 Non-users) |
| Home Visits | 20 |
| Peer Groups | 12 |
| Observations | 47 |

***Note to the reader: The limitations and challenges of the study are captured in Annexure – IV of this report.***

## CHAPTER 2- RESEARCH FINDINGS PHASE 1 SIMULATION

This section covers the overall insights garnered across the simulation exercise conducted in the two centres (Varanasi & Indore).

***Note to the reader:*** *This section focuses specifically on the findings from Phase 1 regarding contraceptive knowledge and medical abortion. The detailed, segregated findings for Phase I (which served as an input for Phase II) have been included in* ***Annexure – V*** *of this report.*

### 2.1 Contraceptive Knowledge

- **Inconsistent Knowledge:** Women hold a combination of myths and beliefs about various contraceptive methods – with an inconsistency of knowledge on clarity about efficacy, duration, the safety of use of various hormonal methods like OCPs, Injectables, and IUCDs
- **The onus of decision making on the husband:** Across modern contraceptive methods, there is an apparent apprehension to take up a method. There is an expectation that after two childbirths, the husband should be the one to take up responsibility for family planning and pregnancy prevention. Most of the women stated that the woman is the one to face an explicit expectation from all involved stakeholders (including providers) that she will be the one to adopt a contraceptive method.
- **Choosing Contraception:** The decision for choosing the contraceptive methods is not solely in a woman's hands, even though in most of the cases the woman is able to express her choice amongst methods, and even argue her case at least with her husband to a certain extent but the onus lies in the hands of the husband.

### 2.2 Abortion & MA

***Women's knowledge about MA and attitudes towards abortion were reflective of whether or not they have had an abortion themselves (or heard a first-hand experience of a close confidante).***

The key findings from this exercise have been the following:

- **No personal stigma:** The women respondents were enthusiastic and very forthcoming when it came to sharing information and intelligence about abortions and MA. Women themselves do not view medical abortion as a stigmatized phenomenon. Most of the women feel constrained by the various negative perceptions and stigmas imposed on the process by all their surrounding stakeholders – including their husbands, mother-in-law, the doctor, and the pharmacist
- **No Moral Dilemma:** The respondents were found to **not associate MA with sense of moral dilemma of terminating a pregnancy**. A lot of women expressed the feeling of 'wanting to get rid of' the situation and find a solution immediately. It seems that the unplanned pregnancy is seen as a possibility for others to wield control over her body, and the need and urgency for terminating it take precedence, making it a very practical decision
- **Knowing a Kavita**- Each of the 30 **women claimed of knowing a 'Kavita' as a friend or an acquaintance.** At least half of all respondents claimed that they had experienced MA themselves. They were not shy of admitting to this fact in a group of unknown women nor sharing other life-stories in a non-judgmental atmosphere.
- **Low Privacy & High Intervention**: The absence of privacy, and various parties intervening to dictate the motivation for wanting to terminate an unplanned pregnancy, puts women in a place of having absolutely no trust for most of the stakeholders surrounding them. In some cases, the husband is taken into confidence, because the woman is sure that he is aligned on the objective of not having more children owing to economic considerations. Even in these situations, the roles portrayed by women as husbands were seen to be only partially involved in the entire process of abortion, expressed mostly as an approving party, than someone who is actively participating

- **Home Remedies**: Home remedies like eating papaya, drinking hot '*kaadha*', lifting heavy objects, etc. propped up as a home remedy to terminate a pregnancy secretly (if not using abortion pills). Many of the women respondents discussed about the effectiveness of these methods or trying them out before opting for pills.
- **Underground Network of Women:** Women have formed an underground network of sorts with other women whom they meet through any of the avenues available to them – neighbors, company at parlors, other children's mothers, friends/sisters in their maternal home, etc.
- **'Friend'- the primary source**: Amongst sources of information, the woman's primary source of information was a friend who has had an experience with MA, followed by the pharmacist and then the doctor (who was portrayed as being reluctant to prescribe MA).
- **Final Trade-off:** When the final decision of the woman is not to conceive then irrespective of whatever the trade-off she proceeds to take a chance with MA. If it comes down to lack of support from an important stakeholder, she seeks validation from a 'confidante' and goes ahead with consuming the pills.

## CHAPTER – 3: RESEARCH FINDINGS PHASE II- ETHNOGRAPHY

This section covers the overall view of insights garnered across ethnography across both the centres (Varanasi & Indore).

### 3.1 Understanding the Location

The study was undertaken in two different cities of India: Varanasi and Indore. Different localities were chosen in each city, based on which were the most urbanised and geographically dispersed. In Varanasi these locations were: *Chetganj, Aurangabad*, *Madanpura* and *Bengali Tola*. In Indore, the localities were: *Nanda Nagar, Subhash Nagar, Badi Bahmori and Khajrana.* Some key observations about the locations were gathered via Mohalla Groups conducted in both the centres i.e. Varanasi and Indore.

**Varanasi-**

As expected in ethnography, some differences were observed between the two locations in which the team conducted the exercise.

*i.* There seems to be a physical as well as SEC difference between residents especially women of *Chetganj, Aurangabad* and *Madanpura* and *Bengali Tola*. The former locations consist of families that are better off in terms of economic, social and educational backgrounds than *Bengali Tola* and *Madanpura.*

ii. There are intergenerational, inter-religious communities including migrants (*Bengali tola and Madanpura*) living with each other. All these areas have *cemented* houses with 2-3 floors. In case the residents have access to the terrace, they usually use it for drying washed clothes and making small conversation. There is a mix of owners and retees living. Predominantly families live on rent with one-two rooms maximum. There are a lot of internal lanes within each *mohalla,* yet the routes, by-lanes shortcuts of all sizes and types of lanes were expressed by women. There were small grocery stores, chemist stores, general stores, tailor, a religious place like a mandir or Masjid all within the narrow lanes of the *mohalla*.

iii. *Aurangabad and Khajrana* stand very similar in physical as well as SEC difference.

**Indore-**

Some differences were also observed between the locations (*Nanda Nagar, Subhash Nagar, Badi Bahmori Vs Khajrana*) in which the team conducted the exercise.

i. There seems to be a physical (in terms of surroundings) as well as SEC difference between residents especially women of *Nanda Nagar, Subhash Nagar, Badi Bahmori and Khajrana*. The former locations consist of families that are better off in terms of economic, social and educational backgrounds than *Khajrana.*

ii. **In Indore**, **Subhash Nagar, Badi Bahmori and Nanda Nagar** appear to be a little above the physical setting of Chetganj where most of the respondents had self-owned houses in contrast to Varanasi. The area constituted of wider roads, better employment of husbands (mix of self-owned and private jobs), bigger cars, more space to park vehicles and better-planned colonies. These colonies constituted a mix of Hindus from all castes and some migrated Maharashtrians.

iii. *Khajrana* is a smaller *Mohalla/Basti* constituting primarily a Muslim community. It has a lower SEC than the former areas and there just smaller, congested areas with only small tuck shops, departmental stores, small schools, etc.

*The main crossroads of Nanda Nagar, at this side, opposite, there is a Yashoda Gate. At one side there is a Neha collection and at one side there is a medical.- **Married, Mohalla Group, Nanda Nagar, Indore***

***Note to the reader: Detailed description about the location of study is included in Annexure-VI***

### 3.2 Understanding the P2/P2+ Woman

#### 3.2.1 The P2/P2+ women- Own Aspirations, Fears and Trust

***A woman's reflexive response is to think about familial (and children's) aspirations, trusts and fears than thinking about her individual self.***

**Aspirations:** Most of the women's **aspirations** are first related to their children and subsequently, themselves. Women want their children to succeed in life, be self-dependent and own a house. Upon probing, these women discussed about individual aspirations, like wanting to dance, or sing, or act, and to be appreciated and valued. The passion to begin one's own business such as starting a small tiffin business or a tailoring shop, or to secure a job such as becoming a teacher was expressed across centres. In some cases, women's spontaneous answers were of having no aspirations for themselves.

*I have to do every possible thing for my son. He should get a good education. His mom-dad remained here, so he should get a better life. I want him to become an IPS. It's my dream but I don't know what he is going to do. He says I am going to become a pilot. He will go wherever he wants to; even his dad wants him to go. **Married, 30 years, P1, MA User, Chetganj, Varanasi***

*I wish to do a job later and now also I can do the job but I feel that kids should study properly and progress in life. I am interested in the teaching line only but as kids are small now so I remain busy with them. **Married, 28 years, MA User, Chetganj, Varanasi***

*Everyone should be happy and I should be able to give a good education to the children. The generation has changed now, in our time, the study was not so much importance, but in today's time, study and long with those activities are very important. **Married, 27 years, P2, MA User, Nanda Nagar, Indore***

*As many girls are doing the job, I was having a desire to go for a job outside, and come home in the evening and rest, this is such a thing that if you are into it. You have to keep on doing household work but a job is such that you keep on doing it and your salary keeps on coming and you will rest coming at home. But in this work, you don't get any time to rest. **Married, P2, MA User, Subhash Nagar, Indore***

**Fears:** Fears of women are related predominantly to the safety of children and the family's economic well-being. On a personal level, most women said that they '**didn't want to disappoint'** their husbands or family members. They don't want to do anything which will cause hurt, conflict or disappointment

among their family members. Due to this reason they wish to live their life in accordance with their husband and in-laws.

*I am scared because we get to see so many things happening around like rape case and all. Some children mislead, and some start doing bad things because of bad friends and all that.- **Married, 28 years, P2, MA User, Chetganj, Varanasi***

*My elder son is not studying properly, he is lazy but he is intelligent. He is very careless and he wants to become a hero, so I tell him that if you want to become a hero then do it by studying.- **Married,30 years, P2, MA User CChetganj, Varanasi***

*She has a fear that if something wrong in the work, like the food, is not cooked well or I went somewhere without asking and when she goes home, she will be questioned by the in-laws and husband, so those are the fears. -**Married, P2, MA User, Kalyani Nagar, Indore***

**Trust:** When speaking of trust, an expression of 'facing hardships' or 'dealing with difficult circumstances' came to the fore, with women expressing a need to 'trust themselves.' This trust was seen as necessary to be independent, to not ask for help, to manage an efficient household, etc. This would be complemented by the trust of their husbands, and then the rest of their families. Trust continues to hold a two-faceted meaning for a woman i.e. **trust in oneself and trust on being able to add value in the lives of her husband and children so that they could depend on her**. **Women also relate to 'trust' in the form of sharing their feelings**. This extends to close friends (childhood/neighbor), sisters, and elder family members like an elder sister, elder sister-in-law, *etc*.

*I trust my husband and he trusts me. I trust him that he will not do anything wrong behind my back and he understands me very well. **Married, 34 years, P2, Repeat MA User, Nanda Nagar Indore***

*Trust is important, on family, husband, children or anyone for that sake. I also trust my childhood friends also. We have been together for so many days, so I trust them I also trust myself.- Married, **P2, User, Subhash Nagar, Indore***

*Firstly, I believe in whatever I do, and I believe in my husband. I cannot say about my children because they're too young. **Married, 28 years, P2, MA User, Chetganj, Varanasi***

*I feel that I should not break the trust of anyone in my family because trust is the main thing on the basis of which relations are maintained. Trust is the root of any relationship and once you break the trust then even after doing good for 10 times there would still have doubt on that person. I trust my husband and my family and my parents. Children also. **Married,28 years, P2, MA User, Chetganj, Varanasi***

*I don't have trust in anyone; I just believe in my own self. That's it. I believe that I can do this thing; I have that belief. **-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

***Note to the reader: Detailed description about the women's lifestyle, preferences, technology access and usage is provided in Annexure VII of this report.***

### 3.2.2 Role in the family (Maternal & Marital home)

**Maternal Home:** Regardless of their education level, women claimed that they were married at a considerably young age (minimum 17-18 years). Most of the women viewed their maternal homes as spaces where they go back to 'relax' and 'rest' for a few days. In their maternal homes, women claimed, they could be the **'daughter'** of the house again. The support of a 'father' (especially to let his daughter (s) pursue education) is seen as the backbone in these women's life.

*When I go to my mother's house I don't feel like coming back home because at mother's place I get to relax. - **Married, Mohalla Group, Nanda Nagar, Indore***

*Yes, there is a lot of difference. Earlier we use to feel comfort at the maternal house and now we feel comfortable at the paternal house. **Married, Mohalla Group, Nanda Nagar, Indore***

*Yes. My elder father decided on our marriage at a young age, and their in-laws stay behind my house. **-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*There we were 7 sisters and 2 brothers. Previously it was like there has to be a boy so due to that there were 7 sisters and 2 brothers. Now all of my sisters are married and also my parents have educated all of us. All of my sisters were good in studies and are well educated.**- Married,30 years, P2, MA User Chetganj, Varanasi***

**Marital Home:** When asked about their marital home, the women defined themselves as a **'home-maker.'** This role was embodied in the variety of tasks/responsibilities the woman might need to fulfil for her husband, her family, her husband's and her children. Regardless of the status of employment, the majority of the women reported that they take care of all the household work i.e. cooking, cleaning, dropping children to school/coaching, washing, buying groceries, etc.

In a few cases where the woman was employed, she stated that she had the option to work because she could leave behind her children with her in-laws. Most of the women the research team met in the *Mohalla* groups were homemakers. It was inferred across centres that as the woman became older, and her children grew up, her decision-making ability in the household also tended to increase.

*It is good, everyone is nice here. My sister-in-law, my mother-in-law is also nice, and I didn't felt like I don't have parents. She is my co-sister. **Married,35 years, P2, Non- User, Chetganj, Varanasi***

*No. Everyone lives separately now. In-laws are there but father-in-law is expired. And my mother-in-law is there. **-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

### 3.2.3 Social Interaction & Information Seeking

***The relationship women have with their husbands and family was seen as being of paramount importance. It comes before having friends or any other stakeholder in their lives.***

Women in both the centres stated that information gathering takes place first **from their respective confidantes** – who could be the husband, sister, friend and at a subsequent stage, the internet or as they stated specifically – ***Google 'baba'***.

The exchange of information happens in a **free flow of gossip**, either in person or on call. Text-based communication is used usually for keeping in touch, sharing greetings and jokes, and forwards. Most of the communication in both Varanasi and Indore between friends and neighbors (women) happens in person when they visit each other's homes. This could be from the terrace to terrace, during sitting in the sun, while running into someone on the way to or in the market or on occasions like weddings and

birthday parties. Most women established that all the communication that happens when women meet and talk, **especially in groups,** is light-hearted and humorous. They claimed that they have casual conversations on various subjects like children, daily routines, new TV serials, etc. as they feel unwilling to talk about serious things, after their hectic routines and responsibilities.
In Varanasi and Indore, when women are not able to meet their friends or family members for a long time, or if they live far away, they use phone and video calls to contact them on the weekend.

*My friend lives in Bihar and I talk to her on phone daily. Sometimes she also video calls me but I feel shy as I'm not always ready and looking good. -* ***Married,35 years, P2, Non- User, Chetganj, Varanasi***

**The Husband:** Across locations, a supportive husband was defined by the respondents as one who supports her to make decisions about herself and the family. He was seen by most women as the gateway to fulfil their wants and needs because it was seen as legitimizing her actions. The husband's support was deemed paramount by all women and most respondents claimed that the husband's support can help them face any difficulty in life.

- **Seeking external support:** In both centres, it was inferred that women who did not have enthusiastic support from their husbands, expressed a strong need to seek and forge strong bonds with any other member in the family, or with a neighbor or with a friend, owing to the lack of emotional support they expressed feeling. Instances of lack of support from husbands were not expressed explicitly, but in the way that a third person like a sister, mother, close friend was able to understand them like no other person or cared to ask them about their well-being, which the husband did not. Even in these cases, the husbands were not portrayed as being unsupportive, but as being 'not too involved' in the wife's life, needs, or emotional well-being. The observation, in this case, was that the women would not explicitly say anything negative about their husbands in a group setting. Additionally, in instances, even when husbands were supportive there was a sense that not 'everything' can be shared with the husband. There are some things which you can only share with your close confidante.

*You can't share everything with husband, some things can only be shared with friends.* ***- Married,30 years, P2, MA User Chetganj, Varanasi***

*I don't share it with my husband. I used to get along before. Later on, I started realizing things. She does not let me go anywhere. He doesn't support me, there is a money issue, children problem. He does not give me money for anything.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*He is a person with a free mind, very nice, does not stop me for anything and lets me do things that I want to.* ***Married, 26 years, P2 User, Mansab Nagar, Indore***

**The husband's role:** The role of the husband was mostly stated as being restricted to working to earn for the family and going out to make monthly purchases for the household from wholesale shops. The husband was seen as the focal point for major decisions to be taken including large purchases, healthcare needs of the family, etc. In cases where the nature of the relationship had been a pre-marital association, the role of the husband was also described to be that of the person who understands the woman, who supports her the most, and who cares for her well-being. That said, even in these situations, there was an explicit understanding that the husband may be disapproving of certain conversations or actions, and therefore it was necessary for the woman to be mindful of not making him displeased by ensuring she fulfilled her duties and responsibilities, and did things that make the husband happy.

- In Indore specifically, some of the supportive husbands took out the time to take care of their wife and children by taking them to outings like marriages, restaurants, malls etc. They

sometimes even entertained the family by ordering food from outside and sharing meals with the family after a long day of work.

*The husband plays a role like- if I am sitting here and if I had to pick my kids from their coaching place. Then he goes and brings them back. If we have to go and shop from the market then we go together. But I prefer and I love going to the market alone.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

**In-Laws:** In cases where women in both the centres expressed that they have supportive in-laws, the woman seemed to have greater agency to go out to work and leave her children behind in their care. With the passage of time, the bearing of children, and taking on responsibilities in the household, the woman's decision-making ability also increases. Women claim that when they marry into a home, it takes a certain amount of time for them to adjust to new routines and traditions and to understand the locality/environment they are living in.

- ***Overall, with the passage of time and life-stage, women find themselves embedded in the husband's family. This leads to agency and self-efficacy to do as she wants. However, the mother-in-law is considered a figure of authority whose decisions cannot be overruled. This cultivates an environment of secrecy for decisions where the mother-in-law is perceived to be either not involved or is likely to object. Bypassing or hiding decisions from mother-in-law is found to be the easy option to circumvent or avoid confrontation.***
- There were some women in the groups who also expressed that mothers-in-law are not generally nice in a light-hearted manner, reflecting that there are some MILs who tend to be stricter and the women feel they are not very understanding.
- Most of the women respondents in Indore even expressed their MILs to be supportive but didn't share personal details with them due to the fear of displeasing them. They didn't want include a MIL in all types of decision-making especially which necessarily does not require her consent or approval.

*They have good nature and never forced me to do anything or for cooking food or something. Whatever I do is fine as I do small mistakes in cooking also. I share all the things like whatever family-related things as I am the elder daughter-in-law so I have to share things with her. Nobody is there to whom to tell then.* ***Married, 28 years, P2, MA User, Chetganj, Varanasi***

*My In-laws treated me well. I would never say anything to them, and even they would not say anything. I wanted to take care of my mother, so I had to take this decision. If family members are good, then there is no problem. You can do anything. I did not face a problem with cooking food and all that. They told me to wear a sari. I was not allowed to wear a suit in the village. I already had two children, and we were expecting a girl child but then I gave birth to a baby boy. My husband doesn't earn so much that we could afford to take care of the third child.* ***Married, 28 years, P2 User, Chetganj, Varanasi***

*I don't have a father-in-law, I have a mother-in-law and a brother-in-law and sister-in-law. There are other sisters-in-law but they are married, but this sister-in-law I have is very good. Here this family is very nice, just like my mother's house. My mother- in- law comes here once in a while but she doesn't feel good here since this house is on rent and we have our own house there. She feels suffocated here, there is not an open environment.* ***Married, 30 years, P1, MA User, Chetganj, Varanasi***

*No. You can't share everything with your mother-in-law means you can but whatever that is necessary but not personal things. She stays very nearby to me. Our in-laws and real families also stay nearby our home.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*My mother-in-law is nice and supportive, but I don't talk about everything with her.* ***-Married, 26 years, P2user, Mansab Nagar, Indore***

**Children:** ***Children, their growth, welfare and success came out as the most important goal of the mother's lives. The respondents were found to have high ambitions for their children and make sacrifices for their children's education and overall growth. There was a premium to be fluent in English and most respondents claimed that private schools are preferred for English education. For their children, they aspired for job security provided by a government job. No significant difference was found between the respondent's aspirations based on the sex of the child. However, patriarchal norms of boy-preference in the family were mentioned by a few.***

- ***All of the women are emphatically and explicitly committed to giving their children better lives than themselves*****.** There was a collective expression of wanting to give the children a good - English medium - education, in order to enable both girl and boy children to be equipped for employment in the future. In Varanasi, there was a mix of preference for government and private schools dependent on proximity and access to schools in each locality. In *Chetganj* area, there is a prevalence of a greater number of private schools. There is a strong culture of enrolling children in coaching classes both at centres as well as in the form of home tutors, across localities. The charges for a home tutor was found to vary from around Rs 800-2000 for all subjects. **In a group dynamic, it was observed to be a visible marker of greater investment in the child's education to enroll them in coaching classes from a young age.**
- In Indore, a few women expressed how having a male child is important to them and their family (especially, in-laws). The majority of the parents, irrespective of socio-economic backgrounds, prefer sending their children to private schools. They said that they value and prefer an English-medium private school because it indicates stature, affluence and a sense of achievement if their children are able to communicate in the language. It also reaffirms that they can have a better future for themselves and move out of the economic cycle they are trapped in currently. There is a sense of prominence that is given to 'government jobs' as they are seen as more respectable in society or to enroll children into prestigious institutions like IIT.

*I have two sons. They are studying in a government school. Private schools are more expensive. I studied till 8th standard in the private school. There is a Bright school here.* ***Married,35 years, P2, Non-User, Chetganj, Varanasi***

*He is in kindergarten as he is 5 years old. He goes to Bright Learning School. It is a private school. It is okay but I need to take care as teachers give more homework to kids. More time needs to be given to kids at home only as kids don't sit or walk properly that much. So we have to care more for them. They take Rs.1700 for the fees per month.****-Married, 28 years, P2 User, Chetganj, Varanasi***

*They both go to Kids Convent here at number 3. That's only till 8th standard and then we will have to move them to another school. My daughter is in 2nd standard. And he is in the 5th standard. My daughters' fee is Rs. 8,000 and my son's fee is Rs. 12,500.* ***Married, 34 years, P2, Repeat User, Nanda Nagar, Indore***

*My children study at MGM School MGM is more and around 10k and 8k. The younger one is not going because of his health. He hasn't been to school for the last 2 years. In fact we were in Mumbai for almost 1.5 years due to his health condition.* ***-Married, 26 years, P2, MA User, Mansab Nagar, Indore***

### 3.2.4 Sense of Self

i. **Her self-image:** Women were found to have a deep sense of duty towards their families. They find themselves in a supporting role to their husbands, children and families so as to allow them an opportunity to succeed. As a non-earning member of the family, they feel a need to contribute to the family by easing other's lives even at the cost of their own aspirations. Combined with a very high focus on their children, women often feel a deep sense of guilt in compromising on the family's comfort and support in order to pursue their personal ambitions. Due to this mindset, women require a strong supporting anchor to break away from the traditional role and pursue their personal dreams. The respondents claimed that those who manage to work, have a supporting father or husband. While the women were found to strive to be the best homemakers and mothers, they continue to search for their own identity; harbor the desire to accomplish something of their own and contribute to the household income and status.

ii. ***The 'sense of self' a woman derives for herself is defined primarily by the role she plays in the life of her own family and children***. The women expressed that they base their lives around providing the best for the lives to their families and children, and not falling short on performing their duties. Getting a job for themselves comes in secondary. A common theme was found among women with regards to the 'will to do something for herself' being secondary to providing support the husband and finances, and giving a better life to their children first and only then to focus on realizing her own dreams and aspirations.

*iii.* **Attachment to maternal home:** Most of the women express deep affection towards their maternal home – **stating that the freedom in the maternal home cannot be compared to their current lives**. Especially those women who had been educated till 12th or college had a specific reverence for their parents for having educated their daughters. The women who were not able to achieve this level of education, do not express disdain, but a regret (and recognition) for not having explored possible opportunities for growth and potential employment. To some extent they contributed early marriage between the age of 18- 23 for the failure to pursue education. Further, the belief amongst some women is that if they had studied further, they would have married more educated husbands, and therefore would have had better lifestyles after marriage.

   a. For example, in one Mohalla group a woman expressed how they got married at an early age which became a hindrance to pursue further education. A few women in Indore were also of the opinion that though they are attached to their maternal homes, they tend not to spend too much time there, given the understanding that their marital home is their true home now.

iv. **Dip in freedom and agency after marriage:** In both the centres, the change in terms of their maternal homes to the current ones can be gauged when women express the sole dependence of the household on their shoulders. This was something women related to and laughed about in the groups – when one woman talked about the burden of work, several chimed in and then shared a laugh over their situations as if to say this was expected of marital life. A few respondents were active participants of SHGs (Self-

help groups). However, most of them seem to be getting pushed into becoming SHG members since their husbands or families believe that to be an additional source of money. The roles and responsibilities shift from being somewhat carefree in the maternal home to running the house in the marital home.

*Over here I have to take care of everything back at my maternal home my mother gives everything to me in hand and I can wake up (late) whenever I want-* ***Respondent, Married, Mohalla Group, Chetganj, Varanasi***

*I was thinking about what can I do for it, but I can't do anything with them, they were not allowing me to learn the stitching. I have learned to stitch the suit at my mother's place. I didn't take much interest in the blouse stitching. Before marriage what can we do with it, before there was no need to learn it. After marriage when I got to understand, I told them to allow me to learn. They refused me and not allowed me to go anywhere, not even to the neighbor's place. They used to keep me caged, so I was not able to do anything. And my husband was staying with his parents, so he said no; don't do such things by which they don't like, so I used to break my desire. -* ***Married P2, MA User, Subhash Nagar, Indore.***

v. **Recognition of aspirations that have been suppressed:** However, aspirations are recognized, but actively suppressed by the women of Indore and Varanasi. Many of the women talked about having hobbies and passions, and the desire to enhance their skills, and therefore their abilities on the whole. Many women expressed the eagerness to do something for themselves seen to manifest in situations where women work out of their homes by doing stitching, making lunch boxes, teaching their own children amongst several others.

vi. **Larger aspirations for herself take a backseat:** The larger childhood dreams to become an actor, teacher or entrepreneur tend to be eclipsed by the woman's current set of relationships and responsibilities towards her family and children which almost all women expressed by saying that they had little to no time that could be considered their own. Further, most of them stated that when they had time to themselves, they spent it unwinding with a short nap or listening to/watching something on their phones. In Indore, most of the women expressed a desire to 'go out and work' or earn money for themselves and their families. The only thing that restricts them to do so is either their non-supportive family or the age of their children. Some of the respondents even expressed that they had to give up on their jobs after they had children. They expressed that when their children reach due to age; they might be able to act on their aspirations to work and support themselves. Normative thinking alongside all real-life references of 'good women' hover around keeping herself last in her family and overall low self-worth.

*He says there is no sense in doing an Rs. 10,000 job instead of that takes that money from me since you already take care of my child and the family. Once I wanted to go and try for a teaching job in my son's school. They called me for teaching young students because I had no experience at that time. My husband said no, who will take care of the child, who will look after the house. You will not get time, neither for the child nor for him. One can understand that a working woman is unable to give enough time to their family.* ***-Married, 30 years, P1 Woman, MA User, Chetganj Varanasi***

vii. **Mix of personal space:** There was a mix of family setup in terms of joint and nuclear families in Varanasi. Most of these families lived in a one/two-room set up and the women expressed the lack of space in their homes, with a **key aspiration being to be able to afford a larger home for the family.** This was visible across the facets of her life – be it in terms of interaction with other family members, the husband, her children, or with her in-laws. In contrast, Indore had families (nuclear or joint) living in separate rooms, floors or buildings. This ensured that women received some personal space with her own husband and children and meanwhile kept close relationships with other family members.

viii. **Investment of time in a vocation:** In both the centres, most of the women had a ***'sewing machine'* at home** and knew how to stitch clothes. If they were not stitching to earn money, they were stitching their 'own' garments to reduce the cost they would have to incur by paying a tailor or a boutique. Access to technology (using YouTube) -enabled them to look for a variety of designs and techniques.

*I make things using stitching and sewing machine and other ways as well. I learn designs from YouTube.* ***Married, P2 Woman, Peer Group, Chetganj Varanasi***

*ix.* **Source of dependence:** It was noted that most women explicitly stated feeling empowered by way of higher education and 'open' or 'modern' mindsets, and expressed a level of confidence in moving out of the house on their own, contributing to the home in terms of decisions or earnings, or taking charge of raising children; commonly reported having support from one particular person in their lives. This could be the father, mother or elder sibling, or husband. The pattern that emerged is that this **single source of support** seemed to be sufficient for a woman to hinge her self-confidence to do things on her own terms, and to assert her efficacy and opinions.

### 3.2.5 Mobility

***As a woman's role in the family increases (with the passage of time), her license to move around also increases. Women are self-reliant and mobile to go to nearby places. The dependence on others arises only to go somewhere for recreation with family (especially husband) or to go visit a health care provider in case of illness***

**Independent mobility:** It was found that the independent mobility of women across the localities varies, depending on the respective socioeconomic profiles of those areas. Most of the women were independent to go to nearby places.

As the stated socioeconomic profile went up, the comfort level in independent mobility seemed to increase as well. In Varanasi, this movement was mostly to nearby places of access like temples, small shops, local chemists, etc. Women state that they do a variety of routine work like depositing bills, going to banks, schools, coaching centres, etc. The husband/FIL tends to take up occasional/ planned tasks like purchasing monthly groceries, organizing family outings, as well as most healthcare-related activity – in the event that a family member has a health concern. In Indore, women's mobility wasn't restricted to areas she resided in. In most cases, the women were seen to be mobile irrespective of a supportive or a non-supportive family.

- The movement was predominantly to nearby places like chemists, temples, general stores, *chaat ki dukaan (snacks shop/vendor),* banks, schools, etc. via foot. All these women claim that they do not require company to cover short distances on foot. To cover long distances, they opt for sharing public transport, auto, or ride '*Activa'* (if it's for her personal use or is available at home). There has clearly been an evolution of freedom of movement from the point they had no children(restricted) to two children in movement (non-restricted). It is believed when the children grow up the woman's

mobility increases two times as she needs to go to places like schools, coaching centres, hobby classes, etc to pick and drop her children.

> *I have an Activa which I use to go to far off places else I prefer to walk. -* ***Married, Mohalla Group, Nanda Nagar, Indore***

> *I go to the market all alone and to my mother's home also. I sometimes go whenever I feel like going, it's not fixed. I go whenever I feel like going. I go to the temple. I don't go to the temple often but my husband only tells me to go. Nothing like when they'll ask me to go to the temple that I will not refuse.* ***-Married, 35 years, P2, Repeat User, Varanasi***

> *I go alone, and I go along with friends also.****- Married, 28 years, P2, User, Chetganj, Varanasi***

> *I go by Ibus if you have to go till the LIG corner. My daughter is in the 10th class, so I have to drop her for coaching. I also go to pick her at 8:30. My son goes by himself.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

- **Dependence on others:** In Varanasi, within a 2-3-kilometer radius, there is no stated dependence on anyone for mobility. Women are self-reliant and mobile to go to nearby places of access. In case they want to go somewhere far they prefer to take another family member - especially the husband along. If the husband is unavailable, this role is fulfilled by person of trusts like MIL, sister or friend. Sometimes, in the same situation, they chose the company of a friend over anyone else to accompany her to go to a mutual place of visit i.e. Nagar Nigam, school, bank, etc. In Indore, women are not dependent on anyone for mobility. In case they want to go somewhere far they prefer the company of a friend over another family member. If any of their first point of contact is unavailable, they reach out to someone else for company.

> *If my husband isn't free on Sundays, in fact husband always accompanies us but if he's busy then my friend says that she will accompany me to go out.* ***-Married, 28 years, P2, Non User, Chetganj, Varanasi***

> *I call my friend up and she comes and we go both to market if she wants to buy and everything.* ***Married,34 years, P2 Woman, Repeat MA User, Nanda Nagar, Indore***

> *No, I would go along with my husband. He would stand near the vehicle and I would go and buy from the store. My MIL would never allow me to go out alone.* ***– Married, P2, MA User, Subhash Nagar, Indore***

### 3.2.6 Seeking External Support

***Overall, women seek and value a close compatible relationship with the husband. They desire a husband with whom they could have open honest conversations and who would provide them emotional support. The research revealed a spectrum of spousal relationships from warm trusting spousal relationships to those who were less involved and engaged.***

***Women who desired a closer relationship with their husbands were driven by injunctive norms of projecting the most desirable image of her life, husband, family and home. In such cases they did not find fault with their husbands, rather tried to justify their husband's lack. Further, women had close relationships with a few women of their own age and life stage with whom they managed to speak***

***openly about their feelings without the fear of judgment. They also had a close relationship with a few older women to whom they could reach out for guidance and advice.***

***Women expressed a strong need to seek and forge strong bonds primarily with the husband, followed by any other member in the family, or with a neighbor or a friend.***

In both centres, it was seen that women who did not have enthusiastic support from their husbands, expressed a strong need to seek and forge strong bonds with any other member in the family, or with a neighbor or a friend, owing to the lack of emotional support they expressed feeling. Instances of lack of support from husbands were not expressed explicitly, but in the way that a third person like a sister, mother, close friend was able to understand them like no other person or cared to ask them about their well-being, which the husband did not. Even in these cases, the husbands were not seen as being unsupportive, but as being 'not too involved' in the wife's life, needs, or emotional well-being. Instances of husbands always staying busy in their work were heard as examples of husbands who were not too present in the woman's life. The observation, in this case, was that the women would not explicitly say anything negative about their husbands in a group setting. Additionally, in Indore, even when husbands were supportive there was a sense that not 'everything' can be shared with the husband. There are some things which you can only share with your close confidante.

- **A female friend of the same age:** In both the centres it was observed that the female confidant of the woman also tended to be a close friend from school/college days or a friendship developed by virtue of living in the same locality. These friendships are seen as being open, non-judgmental and offering comfort in times of distress. The reliance on these friendships is given significant importance, with several women stating that the 'friend' would be the one to express concern, ask her about her well-being and to offer advice without any vested interests.

*Like if we are going to drop kids to school and there if we find someone or online also we get friends or there are neighbors also.- **Married, Mohalla Group, Nanda Nagar, Indore***

*In friends we can share everything, we can also complain about my family members. I know she will not tell anyone as both of us have different families. Something we cannot share with our sisters also, so friends.- **Married, 30 years, P2, MA User, Chetganj, Varanasi***

*My neighbors' daughter- I'm very close to her. I share about food dishes and things that I get or don't get easily. So, she guides me, or I guide her. I do not allow others to interfere in my life nor do I interfere in their life. I belong to a low-income family, but I think positively, and I share only the truth. I do not have manipulative behavior. I share stuff related to my husband and me. Suppose if I'm facing any problem-related to in-laws, husband, and all. I even discuss medication with her. When I conceived also, I discussed it with my friend, and she guided me in the right way. She had experienced that thing and she had even consulted a doctor and whatever medicine was prescribed to her, it suited her. Suppose if I face any problem, then I discuss it with my friend. Her family is working in the medical field like some are doctors and all that. – **Married, 28 years, P2 User, Chetganj, Varanasi***

- **An older female confidant:** There is a tendency for women to develop a strong bond with 'elder women' in the family. These elder women were reported to be the MIL (mother-in-law), the woman's mother, elder sister-in-law, an aunt, etc. In some cases, the elder women were also the neighbor or landlady with whom the woman had consistent interaction. This figure is seen as somebody who has better experiences and knows things well in order to talk, help or guide the women under any circumstances.

*I used to get advice from an elder sister-in-law and she advised me to avoid hard work, sometimes my knee pains a lot so I used to sleep along with the supporting pillow. She advised me to apply some oil on that and avoid the use of the pillow.* ***Married,35 years, P2 , Non User, Chetganj, Varanasi***

*If I want to talk I talk to one of my sister's daughter-in-law; she is very friendly. We talk about our personal things like if she is facing any problems in MC (mensuration) or if her husband brings costly medicines for her. She tells me everything, she calls me aunt but she is just like a friend. If anyone says anything to her she tells me everything and she trusts me more than anything. I don't share the secrets of people. Sometimes my mother-in-law also shares something about her, I know everything before her only but I never tell her about this.-* ***Married,30 years, P2 women, MA User, Chetganj, Varanasi.***

*My elder maternal aunt is my close friend. She is not much aged but near about 49 or something. Her daughters are 29 years old - means her elder daughter is 29 years old but she is not yet married. So I think I can share anything with my maternal aunt like any of the problems I am facing at any maternal side or with my in-laws. In most of these situations I take advice from her and I share everything with her. She calls me twice a day for sure. Once in the afternoon I talk to her and once before bedtime.* ***Married, 34 years, P2, Repeat MA User, Nanda Nagar, Indore***

### 3.2.7 Attitude Towards Health

***In case of a minor health issues most women stated that they first resort to home remedies recommended by the elder members of the family. Home remedies are perceived as natural, easy, quick and free. If the problem persists, they visit a known, nearby trusted chemist who prescribes medication on the basis of verbal understanding of the symptoms of the illness. The chemist is perceived to have some knowledge of routine medical problems and medications. He is however not considered as an expert. For prolonged and serious illness or for children's health doctor consultation is taken. Children's health is considered as high priority and respondents said they did not compromise on their health. On an overall level government hospitals/providers are preferred for their low consultation fee while private practitioners are perceived as more knowledgeable and better service providers. Women were comfortable to purchase sanitary napkins from the general store, chemist, door to door salesgirl or the mall. They were also comfortable to purchase a pregnancy kit from the regular chemist. However, contraception purchase was considered the responsibility of the husband.***

- For minor illnesses– headaches, colds, upset stomachs, etc. most respondents of both the centres claimed that they visit the chemist to procure medicines.
- In case of a serious or major illness, they stated that their first point of contact is a doctor, with the understanding that the chemist can only prescribe 'regular use' medicines and may not be reliable for a diagnosis. In the case of children's health, there was an unequivocal understanding that there is no compromise, and the family usually takes the child to the doctor right away.
- Interestingly women respondents used **the internet (Google and YouTube)** to find home remedies for minor illnesses like cold, cough, etc. and in some cases use the internet to search about medicines prescribed by their doctor for their family.

*This Ayurvedic medicine for diabetes I searched on Google. There is one ayurvedic bottle, don't know its name, that was also good.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

- The doctors for the family and the gynaecologist (lady doctor) are usually different – both in private and government setups.
- Some famous government hospital names that came up in Varanasi were -*Marwari Hospital* and *Hindu Seva Sadan Ram Krishna Aashram Charitable Clinic*. In the case of a government

facility like Marwari hospital which is a multi-specialty facility, it becomes the single destination for both the family and the woman herself.

- Some of the popular private providers who were named time and again by Varanasi's respondents were: Dr. Akanksha Singh, Dr. Ekta and Dr. Swarnlata Singh located between Chetganj and Bengali Tola areas.
- Some of the popular private providers (women only preferred going to private facilities as it saves time and is more credible) who were named time and again by respondents in Indore were- *Saroj Nursing Home (Nanda Nagar), Dr.Kalpana Jain (Patnipura), Triveni Medical Centre (LIG).*

*There are ads on TV so that we can get information through that. Any relative also tells us they suggest a doctor were to take information, so that is how we get information. My elder sister also gives me some suggestions regarding health-related issues. .- **Married, 35 years, User, Subhash Nagar, Indore***

***Note to reader: The team visited some of these providers for an understanding of the patient experience. These have been captured in Annexure VIII.***

### i. DISPOSITION TOWARDS MEDICAL PROVIDERS

The women across centres reported a **preference towards an old, trusted chemist** who had become the go-to expert for prescribing medicine for small illnesses like cough, headache, etc. They only visited providers for 'smaller, lighter' (*Halki phulki)* ailments to seek immediate relief. Similarly, as a matter of habit, if the women had established a level of comfort with a healthcare provider, **specifically for the child's health,** there was a stated preference towards a specific doctor or healthcare provider.

*Just tell him the problem and he will tell you the medicine and also how to have it or how many times.-**Married, Mohalla Group, Chetganj, Varanasi***

*First we wait and bring medicine from medical and when there is no cure then we are showing to the doctor. – **Married, Mohalla Group, Nanda Nagar, Indore***

*If I want any type of headache medicine then I will tell the medical store about it and they give the medicine accordingly. I take medicine only for 1-2 days else I believe doctor's supervision is best in all these things. I feel relieved by it then good else I go to the doctor for check-up.- **Married, P2, User, Chetganj, Varanasi***

*Yes, there is a medical is there nearby. Mukund medical. We go there to get medicines for headache, cough, fever and all. The elder brother who sits there is almost a doctor we can ask about any ailment and he gives good medicine. If their medicines don't work even after three days, then I go to the doctor. **Married, 30 years, P2,MA User, Chetganj, Varanasi***

*We will meet a doctor and get medicines. I usually don't do any home remedies. I will rather get the medicines from the medical store. If it is not severe then we buy some medicines directly from the medical store. If it doesn't reduce then we go visit a doctor.- **Married, 26 years, P2, User, Mansab Nagar, Indore***

*I was having a fever and even after taking the medicine for 2-3 days I wasn't getting any well at that time I visit the hospital. I took the medicines before from a nearby chemist shop.- **Married, P2, MA User, Kalani Nagar, Indore***

### ii. INTERACTION WITH PROVIDERS

***Healthcare providers are usually accessed by women (both centres) if a prescription from a medical store failed to address a health concern or if there is an issue which they believed a chemist was not qualified to help with (mostly illnesses with severe and/or long-drawn symptoms).***

- In Varanasi, most women stated spontaneously that the government providers are preferred over private health facilities. This distinction comes due to the large difference in consultation fees charged by the government and private facilities. Some respondents mentioned that how a government hospital prescription slip costs just Rs.10 in comparison to the slip of a private provider (Rs 300-400). Sometimes women exclaimed preferring female private doctors over government ones because they believe them to have better knowledge and would provide better services. Access to the provider is also dependent on the socio-economic level of the family.
    - In Indore, a government provider is not even considered in the list of options and prevalence is only given to 'private providers'. They believe they have better knowledge and would provide better service and there is no need to take risks at the cost of health.
- The chemist shops inside these hospitals or clinics or next to them are only preferred to buy medicines post consultation. In Varanasi, these shops are preferred because they contain all the medicines prescribed by the doctor and sometimes also offer a 10 percent discount* (10 percent discount part in not validated in Indore but women still prefer buying medicines from them because of availability of medicines) on the medicines. Respondents claimed that the chemists are always men. They further described that the chemist is usually a middle-aged/old man with a certain set of experience and authenticity. Women also expressed that after buying the medicine they go back to their respective doctors to get it checked and also understand the dosages. They say it takes a little extra time but it's worth it. (In Indore, this was also an observation made by the research team, whilst conducting an observation in a local clinic.)

*In a government hospital we all have to stand in a queue and then we have to wait and they don't have any facilities there are many problems. That's why we all are going to a private clinic. The fees are between Rs. 300 to Rs. 500. –* ***Married, Mohalla Group, Nanda Nagar, Indore***

*My MC (periods) was not regular, so she (my friend) advised to me consult a doctor immediately. We should never procrastinate going to the doctor. That doctor told me that if your MC is regular then it is okay if it doesn't come again then let me know. Due to God's grace, it went back to being normal and I did not have to go to her again. –* ***Married,30 years, P2, User, Chetganj, Varanasi***

*My sister in law don't ask anything from the chemist but she, she confirms it with the doctor. There are some of the things that the only doctor know, chemist doesn't know everything. She brings only medicines from there. Over here, there is only one medicine at the Chowk. No, there is not a fixed shop whatever is close to the doctor we go there. –* ***Married, 30 years, P1, MA User, Chetganj, Varanasi***

*They charge (private) around Rs. 500. There is one more hospital near it, Bhandari, and there is one more, so they are at the same place there. -****Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*If there is an emergency, then I consult with Dr. Akanksha. She is near to my house. I go to her or else I go to Kabir Chaura Hospital-* ***Married, P2 Woman, Peer Group, Varanasi***

iii. **PROCUREMENT OF HEALTHCARE ITEMS**

- Women in Varanasi and Indore stated that they are quite comfortable procuring items like medicine for small ailments, from a nearby shop. In case there is a minor illness/ injury they rely on the advice and medicines received from the chemist in the locality. Otherwise, the medical shop next to the clinic/hospital that is visited for an ailment is used to procure medicines, once a prescription has been given by a doctor.
- In Varanasi, sanitary napkins are usually procured from the general store and not the chemist by either the husband or the woman herself. Women respondents in Indore even procured sanitary napkins from general stores or malls (especially when offered heavy discounts). Sometimes some women bought them from salesgirls who sell them door-to-door at a cheaper price.
- **Pregnancy kits, when required, are procured by the woman** (Varanasi & Indore) from the chemist. Most women state they do not feel shy whilst purchasing a kit, given that they are married and have the legitimacy to make the purchase. It is usually inferred as something good with even chemists saying, 'This is good news!'.
- In Indore & Varanasi, women explicitly stated that it is the husband's responsibility to procure contraceptives and condoms from the chemist. Women express that they feel hesitant and shy to do this themselves, given that the salesperson is usually a male. They further justified that condoms specifically are meant for the man to use, so he should be the one to procure it. They feel apprehensions about being identified and being seen purchasing an item meant to be used whilst performing intimate acts.

*I knew about it (pregnancy kit) from Kabir Chaura Hospital. The doctor told me to check with it and told me if two lines come in it, then it is positive. It is written on it also, so I read it and understood it.* ***- Married, 30 years, P2, MA User, Chetganj, Varanasi***

*No, I tell to husband to buy it so bring it (pregnancy kit). I feel shy about what a shopkeeper will tell.* ***Married, 35 years, P2, User, Subhash Nagar, Indore***

*I asked for Pregnot Kit from the chemist myself.-Married,* ***27 years, P2, MA user, Nanda Nagar, Indore***

**3.2.8 No active information seeking about MA:**

On an overall level, most women did not express an inclination to actively seek information. Information seeking was carried out for specific interests like cooking, stitching, children's projects, etc. using smartphone apps and internet search. Information related to health, particularly about contraception and unplanned pregnancies took place only when the need arose. Women sought advice from not more than one or two trusted people. In cases where the husband was seen as supportive, the woman tended to share and seek information from him. In other cases, the respondents claimed to seek advice and information from a female confidante.

## 3.3 Understanding Family Planning & Contraception

*This subsection aims to explore women's sexual reproductive health awareness and factors that affect her decision making.*

### 3.3.1 Family Planning

***Overall knowledge of family planning and contraception at the time of marriage was claimed to be low. The discussion about any kind of family planning begins after the first child. At a stated level the decision-making lies in the hands of both the wife and the husband, but the locus of control and decision-making lies with the husband.***

***Having a child soon after the marriage was perceived to augment the woman's position in the husband's family. While most respondents claimed that the ideal family size is two children with their parents, they recognized that a single child is a reasonable choice due to increasing expenses. Consistent with patriarchal norms, there was a desire to have at least one son in the family. The ideal family was considered to have one son and one daughter. Most respondents agreed that there should be spacing between two pregnancies of at least 3 years. However, this seemed to be a flexible guide. The need to avoid pregnancy and agency to negotiate contraception seemed to increase after the second pregnancy.***

a) ***Hum do, Humare do* (We two, our two):** At a stated level, the ideal family size considered to be ideal by almost all women across centres was - husband, wife and two children (one boy and 1 girl). In rare instances women expressed that having one child is also enough if a woman were to conceive today because the cost of care for a single child is very high and only increasing for parents who want to provide for all of the child's needs and wants as well as a good education.

*An ideal family should have 2 children-* ***Married, 26 years, P2, MA User, Mansab Nagar, Indore***

*There should be two children. Four or five year's gap is good. If there are in-laws staying along with us, we can reduce the gap also. They take care of our children. If we are staying alone, keeping a five years gap is ideal. When one child starts going to school then have another one so that we can take care. We can take care of the second child also. If the in-laws are staying along, they will take care of one. –* ***Married, 35 years, P2, User, Subhash Nagar, Indore***

*Husband, wife and two kids is an ideal family.-* ***Married, MA user, Kalyani Nagar, Indore***

*3-4 members should be there in an ideal family. As per today's time children's education is also important and having more kids is not ideal. If you are not able to provide good education to the kids then it's better that you don't give birth to them only.* ***Married, 35 years, P2 User, Chetganj, Varanasi***

*It is only two and not more than that. It should be 'hum do hamare do' (we two, our two).-* ***Married, 28 years, P2, Non-MAUser, Chetganj, Varanasi***

i. **In many cases it was found, that though the 2+2 nuclear family configuration was being stated as an ideal response, there seemed to be a latent desire for at least one male child. Most women who had children of the same gender stated that they felt the need to have both, a son and a daughter for the family to be considered complete.** This expectation seems to come not just from the family or MIL but the woman herself. There is a sense of validation sought from family elders and society at large, stating that a male child is essential to carry on the family name and care for parents in old age.

**ii. In a subsequent conversation, this reflected in the woman's own intent and effort to prevent pregnancy being traded off in the hope of the possibility of having a male child.**

*Yes, we have four families. Everyone has a son and I don't have. I feel that even I should have one. Tomorrow if I'm not there then my daughter will not have a maternal place. We are eight sisters because we did not have a brother my mother gave birth to eight daughters for one son and at that time there was no abortion. So in that way, today I don't have my father but I have my brother with my mother, that is why I look towards the financial condition of my house and say I should have one child, even if I have one daughter there is no problem but at least we should have one son. There is no pressure*

*from my family. Everyone remains happy like me but we should have one son. It's my thinking.* ***Married, P2, Peer Group, Chetganj, Varanasi***

*No, as I said I wanted son also. All my husband's friends are old in age with sons and most of their sons are also getting married.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

b) **Desire for an extended family:** Some women in Varanasi also stated that an ideal family would include parents-in-law, especially in cases where the woman wanted to pursue a profession, as this would allow for the child to have access to care in the home, even if she wished to step out for work. In some cases, women in Indore mentioned other extended family members like apart from supportive in-laws like brother-in-law, sister-in-law, etc. who would constitute an ideal family, as it involves additional support and bonding in life.

*Ideal family means the entire family should stay together. Mother-in-law and father-in-law should mix up well with family members and talk well. Everybody should eat well and lead life peacefully. Two sons and one daughter will be good. When we are aged, then the son can take care of the family and the daughter gets married and shifts to in-law's house. -* ***Married, 28 years, P2 User, Chetganj, Varanasi***

c) **Planning of any kind begins at P1:** The majority of the women across centres expressed that family planning begins after the first child. There seemed to be unanimity in the assertion that there is no use of contraception or any effort to prevent pregnancy before the first child, at least at the woman's end. The reason for this was stated to be the belief that the sole responsibility post marriage for a woman was to conceive a child, seen as a catalyst for greater acceptance of the daughter-in-law into the home. In some cases that a woman had conceived after the first year of marriage, it was reported to be either due to the husband's unilateral decision to use contraception, her tendency to not develop a pregnancy in due time naturally or due to difficulty in conceiving. Most women said that they had very little knowledge about contraception and family planning when they got married, and so had not thought of having a conversation about family size with anybody (in rare cases only with the husband).

- In one case a woman mentioned that after coitus she would immediately go and discharge (without knowing it's a traditional method to prevent pregnancy) and for the same reason she couldn't get pregnant. Later on, after acquiring knowledge from the doctor she stopped to do the same and was finally able to conceive.
- In a couple of cases especially in Varanasi, the couple had had a love marriage. During the period of courtship, there had been idealistic conversations about the desired family size post marriage.

*Yes, 2nd baby should be there after 3 years only. When my son was born my first daughter was around 3 years of age and if we to want another baby then we should start the planning of the second baby.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*No, we did the planning second time and when I gave birth to this baby the first was able to study and eat food himself.-* ***Married, 28 years, P2, Non User, Chetganj, Varanasi***

*No, he didn't use anything, it was normal and after 2 years I got pregnant (at p0).* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*We don't plan immediately. As the first child grows up and we feel let him grow first. Then approximately one or two years first-child planning happens. My mother-in-law has no problem if we have a second child immediately.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*He said we will plan for a second baby after my brother gets married, so my brother got married then we planned for the second one.-* ***Married, 35 years, P2, Repeat User, Chetganj, Varanasi***

d) **Spacing between children:** Most women in Indore & Varanasi claimed that **a minimum of 3 (going up to 5 or 6) years** would be necessary between having two children in order for the first child to receive adequate care, and for the woman's body to be ready to have another child. In several cases though, the women had ended up conceiving short of this spacing goal, and if the difference was over 2 years, had proceeded with their subsequent pregnancy. The intensity with which most women feel the need to prevent the next pregnancy seemed to escalate significantly after the second child – with determination, and greater ability to take action with regards to using traditional and/or modern methods of contraception.

*At least three years gap should be there when the first child starts to go to school, then one should plan for the second child. -* ***Married, 28 years, P2, MA User, Chetganj, Varanasi***

*No. We know it ourselves that we just want two kids not more than that and we should have how many years gap between the first and the second kid. There is a difference of 4 years between my sons. -****Married, P2, MA User, Kalyani Nagar, Indore***

e) **Mutual decision-making, but the locus of control lies with the husband:** The decision-making w.r.t family planning, at a stated level lies in the hands of both the women and the husband. Most women across centres stated that they felt the responsibility was mutual, but that invariably the wives were more concerned about family planning on account of a potential pregnancy having the most impact on their bodies. Most of the women expressed having some agency to make the decision regarding another pregnancy, given that they would be the ones to conceive. However, even in this case, the **need for the husband's support and approval** was reported to be paramount.

f) **The two types of Mother-in-Law (MIL):** Women respondents in Varanasi and Indore report that in case there's a strict or 'conservative' MIL with whom she does not share an understanding relationship, the MIL is the one who expects a child from her at different points of time. Conversely, a 'modern' or 'good' MIL with whom the woman shares a warm and understanding relationship, will be the one who tells her *'bahu'* about Copper T, and offers advice on spacing, limiting family size, etc. In some cases, women respondents expressed having supportive MILs but they never advised the women on the subject of family planning.

*My mother-in-law says that we should have one more son. They say at least one son is important as he will look after you in your old age. I said according to the economic condition, one son and one daughter is enough. -* ***Married, P2, Peer Group, Chetganj, Varanasi***

### 3.3.2 Contraceptive Awareness & Knowledge

***This subsection explores the level of awareness, quality of knowledge, sources of knowledge, myths and misconceptions, negative and positive perceptions of contraceptives***

a) **Awareness about contraceptives:** The majority of the women in both Varanasi & Indore had a spectrum of knowledge about modern family planning methods. They were aware about both modern and traditional contraceptive method-: condoms, copper-T, injection, contraceptive pills and some traditional methods like abstaining from intercourse on certain 'fertile' days of the month, or asking their husbands to use the withdrawal method.

b) **High awareness, but ECP is not on the map:** While women are mostly aware about most of the contraceptive methods (Condom, Copper- T, Birth Control Pills, Injection, MA pills) ECP was not spontaneously mentioned. There seem to be inconsistencies in information about some methods based on hear-say or peer experience. These inconsistencies are largely related to the side effects of using various methods – primarily fear of needles or inserting devices into the body, the possibility of complications like swelling, pain, irregularity in menstrual cycles, and the fact that it could hamper future fertility. On probing, some women respondents mentioned Emergency Contraception Pill (ECP) but believed that such pills are only consumed by 'unmarried' girls.

c) **Source of information:** Most of the women interviewed across centres claimed that they get their information about FP (Family Planning) methods from either an older female relative – an elder sister/sister-in-law/mother - or from a married friend. In situations where a few women had absolutely no contraceptive knowledge prior to their marriage, the husband was the one to introduce her to FP methods (usually condoms or at most, Oral Contraceptive Pills- OCP).

   **-**Thereafter, the doctor who carried out the woman's first delivery was reported to be the **first** source of **detailed information** on contraceptive options. In most of the instances they are found discussing these with their friends, family relative or some of them are told about the same by their doctors on their time of delivery.

*I check on the internet and I even discuss it with my sister. Five to six months back something happened, and I did not understand. I thought because of hormonal imbalance, I'm not getting periods on time, but after that, when I got it checked then, I got to know.- **Married,28 years, P2, User, Chetganj, Varanasi***

*My husband told me to take the pills, and he will not use the condom. He told me to get the pills from the doctor, so I started taking the pills. She said that there is one injection which should be taken in 3 years, so you can take it and apart from that you can put Copper T also. If you don't want to use Condom then you can take an injection or copper T also you can take, so for 3 years you will not get pregnant. Doctor Madam told me about these When we ladies were talking to each other, so I heard from them. I had gone to Anganwadi for my child's dose and over there ladies were talking to each other. - **Married, P2, MA User, Kalyani Nagar, Indore***

### 3.3.3 Contraceptives – Method-Wise Awareness

| METHOD | AWARENESS/SOURCE OF INFORMATION | POSITIVE PERCEPTION | NEGATIVE PERCEPTION |
|---|---|---|---|
| ***a)Condom*** | *Via Husband, friend, advertisements (predominantly post-marriage)* | *Easy and reliable, No side-effects* | *Issue of procurement & disposal, Bad quality, Risky, forget to use, Harmful to health* |

| | | | |
|---|---|---|---|
| ***b)Copper-T*** | *Via Doctor or Elder Women* | *Long term method, Depends on suiting the body* | *Fear of inserting a device, Complications like bleeding, discomfort, etc.* |
| ***c)Birth control pills*** | *Via Doctor, Peer group, Anganwadi* | *Cheap, Easy to consume* | *Fear of missing the dose, Lack of availability* |
| ***d)Injectables*** | *Via doctor and in rare cases word-of-mouth* | *Good to use after two children, Suits everyone differently but is good if suits* | *Fear from the needle, skepticism due to various myths and misconceptions regarding the ability to conceive after using injectables* |
| ***e)ECP*** | *Via Advertisements, word-of-mouth* | *No clear positives* | *Confusion with MA, Used by unmarried women, fear of being judged, excessive bleeding* |
| ***f)Traditional Method*** | *Via husband, friends* | *Easy, Reliable, Good success rate* | *Can't vouch for it always, mistakes happen* |

***Note to reader: The detailed understanding of awareness for each modern contraceptive method has been captured in Annexure IX of this report.***

**3.3.4 Understanding Contraception Timelines & Behaviour**

***This subsection analyses a women's decision making (depending on parity) on the choice of contraception and change in preference of a different method***

- **Usage and non-usage: Women with higher levels of education and greater access to technology, seemed to have a clear preference for modern methods of contraception**. Many of these women stated that opting for a long term method like sterilization could be a possible next step, and adopting contraceptive methods as an interim measure. Women who have received positive information about these methods are inclined to use them. The women who have received negative information about Condoms, Copper- T or find OCP use to be a hassle, end up adopting a traditional method after intercourse i.e. urinating or getting up immediately after intercourse, alongside periodic abstinence and the withdrawal method.

  *Women change methods because if one would not suit them and if there are a lot of disadvantages. So whatever new comes in the market we see that. That is why we change it. Suppose that I use Copper T and there is something better than I would use that.- **Married, P2, Peer Group, Chetganj, Varanasi***

- **Method of preference:** The most widely preferred method expressed by most of the women has been condoms and traditional methods like abstaining from intercourse on certain 'fertile' days of the month, or asking their husbands to use the withdrawal method. Women in interviews and groups

stated that the condom was seen as the least threatening and cumbersome to use. It also took the onus of managing fertility away from them. This was a welcome situation for women who stated that they were constantly burdened with work for the family and home. Across centres in cases when the husband was shy to procure condoms or he didn't like using them the women resorted to using traditional methods or birth control pills.

- In some cases, there had been a change of preference of contraceptive methods over the course of marriage. The change had been because one method didn't suit the couple or the woman wanted to experiment a different method. In some cases, women lamented how the OCP didn't suit their bodies (discussed side-effects) and ultimately there was a shift towards condoms. In such cases, they had to shift to another and in rare cases women (using condoms) have stuck to the method.
- In Indore predominantly, it was seen that there was consistency in the preferences of contraceptive methods over the timeline of marriage. The change has only been for a brief time 'to experiment' or 'try' a new method but they went back to the original method.
- MA came into the point of discussion where some women had consumed it while the others haven't. The majority of women advised Condoms/ Copper-T that should be the preferential method.

*Condom is best. Else we have to eat medicine every day and everything happens in the limit. Before when there were no kids so it used to not matter when we have intercourse. At that time it didn't matter and in this if you are having intercourse then we have to eat the medicine always.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Condom is good for me. Even though I took tablets but I think a condom is good. There is no risk as it remains outside.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*It is a good thing if one is using a condom. After marriage, if a lady gives birth to the child, then they feel satisfied. Ladies also start sharing and they ask to think about the next child after a certain gap. Suppose even after taking precautions if she conceives then she has to use any method to abort the child.* ***Married, 28 years, P2, User, Chetganj, Varanasi***

*There is fear always and condom is good to use.-* ***Married, 27 years, P2, User, Nanda Nagar, Indore***

*I will never suggest taking pills to avoid any side effects. If you forget to take medicine for one day then problems would be there. When you are having intercourse you are quite aware that time what protection you are using. You can say that forget to take medicine but never for condoms. -****Married, P2, MA user, Chetganj, Varanasi***

- In some cases, women in Varanasi have also expressed that Copper-T is a good method but the problem lies in the fact that it suits everyone differently. On the contrary, none of the women in Indore showed favourable/positive reactions for Copper-T. There seems to be a large set of inconsistencies related to the side effects of using it – primarily fear of inserting devices into the body.

*Copper-T climbs up the vagina, it's scary.* ***Married, P2, MA user, Chetganj, Varanasi***

- A small set of women in that centre also expressed relying on traditional methods as they are afraid of using hormonal methods because of their own prior experience, or hear-say about negative experiences, and the husband is not keen on procuring condoms, or disposal of a condom is difficult. In these cases, there is immense confidence in one's own ability to prevent pregnancies, and this

self-reliance is seen as a matter of luck, intelligence and a deep understanding between the husband and wife.

> *I know that after a period, if they have intercourse within eleven to twenty days, then she may conceive and apart from that before periods, if they have intercourse, then there are chances of pregnancy, so at that time, should be avoiding intercourse.**-Married, 28 years, P2, User, Chetganj, Varanasi***

- **Pattern of use:** The usage of contraceptive undergoes various shifts within the timeline of marriage. In cases where the possibility of conception was not entirely unanticipated, women appeared to have made a trade-off at the time of intercourse, giving in to either their own need or the husband's persistence to be intimate.

- In most cases, **no contraception method is used until the first pregnancy**. Only after the first child is born, are contraceptives considered for spacing. OCPs and Condoms emerged as the most preferred method to do so, by women across localities. Unless the woman has detailed information from a doctor, or extremely positive endorsement from a woman of her age, using copper-T or injections is largely feared, or seen as unsafe **after the first child** as it is perceived as having the potential to hamper future fertility. Some women continued to rely on **traditional methods** (douching, abstaining from intercourse on certain 'fertile' days of the month, or asking their husbands to use the withdrawal method, etc.) across their reproductive timeline claiming the success of the method and the ease to practice it. There were a few women who shifted from traditional methods (at P0) stage to other modern methods yet continued the complementary practice of traditional methods (extra precaution or in case of unavailability failure of modern contraceptive).
- There seems to be some consensus that these are permanent methods (long term) and are to be used once there is a sense of family completion i.e. after the second child:
  - In Varanasi, Copper-T came into conversations much more actively than in Indore where none of the respondents had a positive opinion about it.

> *It's best to go for copper two after having 2 children and then stay tension free for 3-5 tears. I had gone for the same.* ***-Married, 35 years, P2, User, Chetganj, Varanasi***

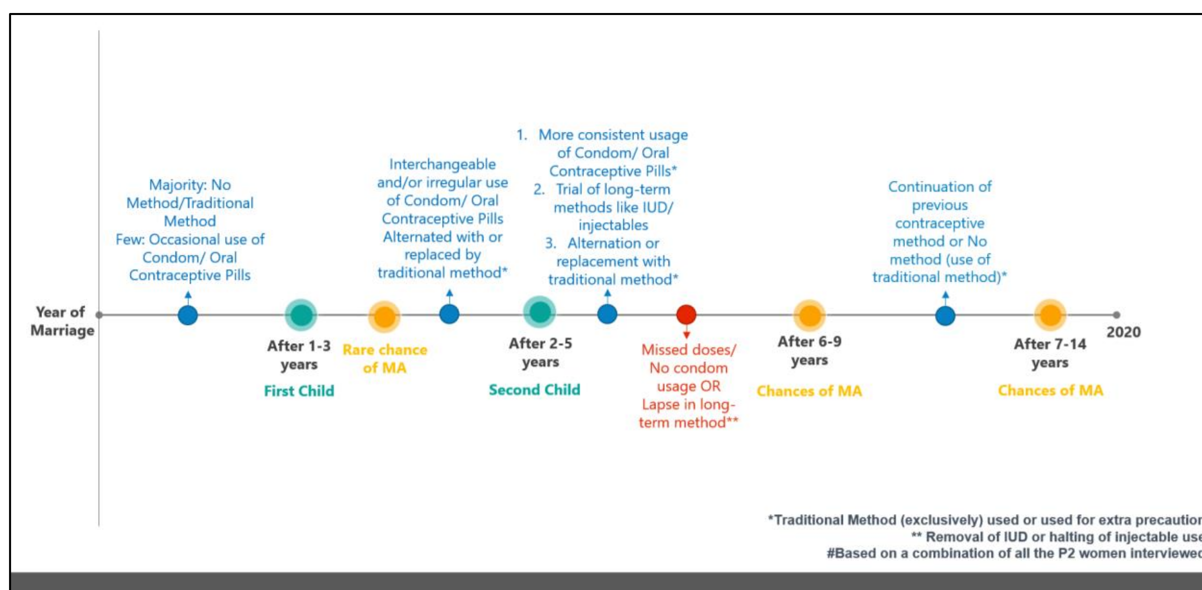



*Figure 1: Representative Contraceptive Timeline of a P2 or P2+ Women*

### 3.4 Abortion & MA – Knowledge

***This sub section focuses on the experiences of women who reported that they had had medical abortion and the account of their experiences.***

a) **Abortion vs. MA:** Abortion as a term was correlated by the respondents with 'surgery' or surgical methods of terminating pregnancy across centres. The association with pills was seen as ‘inducing a miscarriage’ or ‘spoiling the pregnancy,’ causing it to abort on its own. It appears that the absence of any instruments and the early stage at which MA is consumed, make it seem like a more natural, and less severe action than a surgical procedure requiring a provider’s intervention.
    - *D&C (Dilation and curettage) also came up during interactions as a procedure for abortion. Women expressed their fear, apprehensions and higher cost doctors charge for it. They believe that doctors still recommend this method in order to extract more money (around Rs.10,000).

b) **Virality of information: The introduction to MA for the woman takes place in the form of overhearing or in an unassuming, and most casual conversation** – either the women have heard about it from a friend/sister about their experience, or the husband's friend told the husband about such an experience and this was discussed between husband and wife, or she heard it in the form of gossip from the women she interacts with about a third person. This information is stored passively in the form of general knowledge until such a time arises when either the woman herself or someone she is close to faces an unplanned pregnancy.

c) **Legal Status of MA:** The most popular dilemma (amongst women and chemists) around medical abortion is that MA “is illegal” and there is a chance of misusing the tablets. Chemists in Indore also believed that these pills are ‘banned’ by the government/ ‘DM orders’ and are illegal to sell.

d) **Perception of being careless:** The research found a couple of women report that they had miscarried spontaneously and therefore had to take MA. Inconsistencies in timelines revealed that these women were likely using this version of events in order to seek validation from the husband or MIL who might want the woman to take forward the pregnancy.
    a. The fear of being judged for being careless (not using any contraceptive after 2 children) and then becoming laughing stock by other important stakeholders like in-laws (*sister-in-law, chemist, neighbors, etc*) leads to immediate consumption of MA pills.

**e) Parity of Women opting MA:** According to respondents, most of the women in Indore expressed that about 60-80 percent women consume MA. Out of this, the women who have no children range around 30-40 percent (while some said 0), women with one child range around 20-30 percent (those women might be working and need child gaping or for economic reasons) and the majority (80-90%) of the remaining segment constitutes women having two children. Contrary to Varanasi most of the women in Indore believed that at P0 stage women don’t consume MA as they fear complications might arise for their upcoming pregnancies.

   Depending on the parity of a woman, a woman who has one child would want to trust more on a doctor than a chemist. This tendency arises because they are less experienced and knowledge a woman holds at the P0 or P1 stage and looks for a legitimate source of information. At the P2 stage, the woman is more adept with prior knowledge and experience and finds a chemist to be more approachable and cost-effective.

f) **Most women see the maximum legitimacy in P2 women having abortions, given that they are likely to have achieved family completion.** According to most of the women interviewed, out of 100 women who have used MA, the largest chunk of women who consume MA pills were P2 women (an average of 60-70 women), because they do not want another child

(predominantly due to financial considerations). Women expressed that even at P1stage, women have started using MA because in today's cost of living, one child is quite enough in terms of expenditure. However, they added that P1 stage MA users account for a very small proportion. Many women accounted for unmarried women using MA but **did not see any merit in a newly married (At P0 stage) woman voluntarily undergoing an abortion using any method unless there was a health concern involved.** They also expressed how unmarried women have started consuming MA pills recklessly and added that they end up 'misusing' them and due the same reason chemists refuse to sell them.

*If 2 kids are there - one son and one daughter - they will go for abortion if pregnant. 70% women will be the ones having 2 children. The newly married couple would be around 50% you can say who take abortion pills.- Women in Peer Group, Chetganj, Varanasi*

g) **Prevalence of MA use: According to almost all women interviewed, they believe that the** average consumption of MA amongst married women, was between 8-10 out of every 10 women one might encounter. **There seems to be a unanimous agreement amongst respondents that the use of MA has become increasingly popular; it is easily accessible, and every woman knows at least one other woman who has consumed MA.**

### 3.5 Understanding MA Among P2 &P2+ Women

#### 3.5.1 Detection of pregnancy, it's circumstances

**a) Discovering an unplanned pregnancy:** In almost all cases in Varanasi and Indore, the women spoke of having detected pregnancies after missing the scheduled date for menstruation. Almost no woman cited a doubt based on intercourse – even when an existing contraceptive plan had been deviated from explicitly.

*We went to attend a marriage and I didn't have any birth control pills, so it happened.**- Married,32 years, P2, User, Indore***

- For women realization of something has gone wrong comes into picture when she misses her periods by 4-6 days. The fear of getting pregnant is not very high because experience has taught women that MA pills are available in the market in case she forgets to use a contraceptive (missed doses, lack of availability of condom) or if contraceptives fail to work (expired condom, the traditional method didn't work).

*Suppose period has to come on 10th and did not come then I will wait till 11th or 12th and then will go and check with the kit.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*So when I checked my kit, then I was pregnant, and 8 days were passed for that thing than I have shown to madam.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Yes, I had it when the condom had leaked. But I didn't waste any time this time. Like I was due to have periods on the 20th of the month so I took the tablet on 25th tor 26th. It's a trend in my body like if I am due on 20th I have it around 15th only. So it gets reduced from 15th to 10th. My menstrual cycle is in reducing order i.e. 5 days before.* ***-Married, 35 years, P2, User, LIG Colony, Indore***

**b) Dealing with an unplanned pregnancy:** Most women in Varanasi and Indore were comfortable procuring pregnancy test kits from the chemist – this is a function of the legitimacy of being a married, mother of two or more children. The woman either did not share this until she had confirmed the pregnancy or shared this information **only with her husband.**

*When my daughter was too small then I again got pregnant. I without telling our family we both husband and wife discussed and had abortion pills. I was just 10 days pregnant and I checked it with kit so then I went along with my husband to the medical store and bought the abortion pills.* ***-Married, P2, Peer Group, Cheganj, Varanasi***

*I had brought a pregnancy kit and checked it at home. Since the chemist store owner knows my husband and I told him that my stomach is paining so he said I will give you medicine but don't tell anyone about .-****Married, 34 years, P2, Repeat User, LIG Colony, Indore***

### 3.5.2 Trigger for MA and Decision-Making Process

***This subsection explores prior knowledge & perspective women have about MA.***

a) **Knowledge about MA:** The knowledge about MA remains **functional and basic,** and only becomes in-depth when another woman she is very close to is going through the process, or alternatively, when she faces an unplanned pregnancy herself. In cases where the women are repeat user (due to experience), she is better adept with knowledge and usage of MA pills.

*Abortion can be done by tablet. When it is not done after eating the tablets then go for abortion.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*This was all the first time I got to know about it (MA) when my doctor suggested me(when I was pregnant).* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Nowadays we know a lot of things. I have seen ads on TV. Friends who have used it also tell us about it One of the ladies in my relation had used it and told me that within the third night of having the tablet everything gets cleared. During one of the casual conversations she told me about this. That time nothing else was running in the mind other than this that we cannot have this child. The tension was high and we just wanted to get rid of this issue.* ***-Married, 26 years, P2, MA User, Mansab Nagar, Indore***

*We have heard about it from friends, husbands but not much aware of it.* ***Married, P2, Peer Group, Chetganj, Varanasi***

*b)* **Perspective on MA:** According to most women, usage of MA is permissible (legally) and a good option for termination of unwanted pregnancy, but only after a woman has had 2 kids i.e. completed her family. For some women, this completion can be achieved only after having at least one boy. Some of the women exclaimed that most working women have started consuming MA after having one child for gaping.

*No, this is there as no one wants to have the third baby after having the second baby. I guess it is 95% women who have if she has two children.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*When you don't want the pregnancy, you have to consume it, whatever goes on in your mind. We can't do anything else if I don't want any other child. Sometimes my mom askes to have one more child as I am grown up and self-dependent as well. Adi will get a brother. I said I don't want another anymore.* ***-Leena, 34 years, P2, Repeat User, LIG Colony, Indore***

### 3.6 Decision-making for MA

a) **Stakeholders Involved:** The first response from most of the woman is the fear of having to visit a doctor and have a 'surgical procedure.' **If a woman has heard of MA and even one successful example, this will necessarily be her first option to explore to terminate the pregnancy.** The decision making to use MA is mostly initiated by the woman and validated or approved by the husband. In some cases, if the husband was in favor of the woman having the child, women reported having protested and put up a fight in order to have the abortion.

   i. In a few cases, if the husband was expected or explicitly seen not to support the decision for abortion, the woman would resort to **seeking comfort and assistance from an external stakeholder** – either a woman of the same age, an older known woman, or a woman in her family whom she considers her confidante such as her mother, an elder sister or sister-in-law. Several women also talked about **home remedies** that they had tried, or heard of, to induce a miscarriage. These remedies included picking up something heavy, eating hot foods (like Amla juice, papaya,etc.)

   ii. However, there was an exception of a '**case of coercion'** where a woman wanted to conceive the child (third child) in order to have a girl. Being a mother of two boys the woman expressed wanting a third 'girl' child to fulfill all her unmet aspirations and dreams via her. But her husband didn't permit her because they already had two children as well as due to anxieties related to the safety of women in current times.

*First it is the husband and then all. Second is the sister or mother or friend. Whosoever we are close to.* ***-Married, P2, Peer Group, Chetganj, Varanasi***

*It is the decision of both people (husband and wife). You need to ask once from the husband.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*There was this sister of one of my friends. She was so mad that after she got married her MC stopped so she would have understood she is pregnant. She drank one full glass of Amla juice till her MC started. But till now she hasn't conceived a baby. She is so mad. You should never do this. It was her first baby she would have given birth to him she would have understood that.-* ***Married, 30 years, P2, User, Chetganj, Varanasi***

*The decision was taken by both of us. After checking we got to know that I am pregnant and now what to do and asked him should I visit the hospital so he said that she will take fees of Rs. 500 and nowadays madam doesn't give medicine because I have recommended many friends of mine to that place so she say there is no medicine. Better to bring from chemist***- Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Ginger and turmeric mixture can also be consumed by adding jaggery in water and boil and make kadha of it. Drink it hot in the morning abortion will happen.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*They had mentioned prepare Kadha and add more Ginger and Black pepper and that leads to miscarriage. They say if you eat hot and spicy things, then miscarriage happens I drank White vinegar.* ***– Married, 28 years, P2, User, Chetganj, Varanasi***

b) **Interaction with Peer Group:** In cases where the women in the neighborhood frequently interacted with each other they ended up sharing MA experiences generally using 'third person' stories. Information sharing in the form of general happenings or gossip was found to be more prevalent than seeking information for personal affairs.

*If there are ladies, then you talk freely to them about these things (MA).- **Married, P2, Peer Group, Chetganj, Indore***

*When we are chatting with everyone these things come in. Suppose if lady is sick and when we enquire about it then she says that such a thing happened and I took medicine for it. **Married, P2, Peer Group, Chetganj, Indore***

*Yes, if ladies are together then this is the topic of discussion. She bought from the medical, she took it of Rs. 700. **-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*We don't decide the time and day, but if we are sitting together, and that time if we had a talk on this topic that I was about to have a problem, but yet I didn't have a problem it is 2 days late. I want to go to the temple, but I don't have trust in a time when I will have a problem. So, if we pull that topic, then that time we can talk on this topic. **-Asha, 35 years, P2, Repeat User, Nanda Nagar, Indore***

c) **Negative vs. positive word of mouth:** Most of the women expressed that word of mouth about MA plays a pivotal role in choosing to consume the pills. The 'confidence' in the tone of a confidante reassures the women that it's a considerable option. On the other hand, negative word of mouth creates doubt and aspirations in the mind of the women even though she may go-ahead to consume MA. These doubts increase the 'risk factor' in her mind.

*My sister used it (MA), so I trust it.- **Married, P2, Peer Group, Chetganj, Indore***

*If women are facing this issue we tell them if it's good for her. We need to tell them that eat this, but we are not God to help you, we need to them about this. We can't give a guarantee on this. Normally it happens, but if it won't then, we need to tell the doctor. We need to take a risk. **-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

d) **Validation from others:** The women believe that positive experience sharing and discussion with a confidante acts as a support to build her confidence during the journey of MA. The tone of sharing information reflects her decision to use MA. This friend primes and positions an image of MA in the mind of the women. This information is first absorbed listening to third-person stories women share in peer groups. Later, when she is planning to use MA there is first information seeking (from a confidante) and then ultimately post consuming (via sharing her experience). There have been exceptions when friend/confidante have followed up regularly to ensure the well-being of the women.

*I would ask that whatever medicine (MA) you ate did it benefit you or not. If I have to eat it I would ask her if it is good or not. When my sister would eat it she would tell me. But if she needs to eat it she would ask for it. **Married, P2, Peer Group, Chetganj, Varanasi***

*Then I was tensed as we don't want that as it is tough to handle two children also. Then my friend told me that she is going to the mother's house and her mother knows about the tablet and I will bring it for you. I had periods because of that medicine.- **Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*I have the trust that she (my friend) will not tell anything wrong about this.* ***-Married, 35 years, P2,Repeat User, Nanda Nagar, Indore***

*I told my co-sister about it (MA). She said everyone is educated now and it is good to have two only. So I should go for MA –* ***Married,36 years, P2, MA User, Nanda Nagar, Indore***

*My friend told me she's had a successful experience with it, and I should go ahead with it. It's nothing very risky.* ***Married, 35 years, P2, User, Varanasi***

e) **Ease of use makes it a less serious, and accessible choice for abortion:** Most women respondents in Varanasi and Indore saw MA as 'only a medicine' that could help avoid the serious consequences of a pregnancy. It was referred to as 'trying it out' in order to avoid having to see a health practitioner altogether.

*Nobody comes to know about abortion and can do the abortion without anybody knowing it, in secrecy.* ***Married, P2, Peer Group, Chetganj, Varanasi***

*Eat the tablet and no one knows it. There is harm to the body due to pills abortion. It is good if it's done by eating a tablet. Else you need to take many injections.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*We can bring pills from chemist shop and eat it, so no one knows about it.-* ***Married, 28 years, P2, User, Chetganj ,Varanasi***

*I took medicine and she told me that I would get my period in two-three days. I had my period after two-three days. -****Married, P2, User, Subhash Nagar, Indore***

*Husband suggested me to go and visit the doctor considering if anything wrong happens but I took the risk and ate it secretly.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

**3.7 Planning MA Self-Use**

*a)* **Time gap b/w discovering pregnancy and of abortion:** Most women report having their most recent **termination in the first trimester of pregnancy** and the most commonly mentioned reason is family completion whilst for those who wanted more children, it was for spacing. The time gap between pregnancy and detection is usually more than a month. Most women find out after they have missed their periods or start having cravings that they recognize from a previous pregnancy.

*When the first child is not there you don't come to know about all this but when second child is there you come to know that 1 week is passed and start having doubt that pregnancy is there then doubt comes in mind, you come to know about it automatically.-* ***Married, P2, User, Chetganj, Varanasi***

*I waited for a maximum 8 or 10 days. We just wait for approximately 10 days and not more than that. Then the doctor gave me medicine.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*You start feeling nauseous and all and you just understand. The period also gets late. We know.-* ***Married, 35 years, P2, User, Nanda Nagar, Varanasi***

b) **Attitude towards healthcare provider: The doctor is seen as somebody who is more qualified than the chemist, and possesses detailed knowledge & expertise on dosage etc.** But to escape large fees (after a confidante primes the women) the decision is taken to procure the pills from the chemist itself without the doctor's consultation.

- It is **believed that the chemist will pass the right information as the woman is paying a large price for the pills** (more than MRP) to the chemist. In one instance, a woman got to know about MA via a confidante, she decides to consult the doctor but then ultimately takes her own decision by sending her husband to get the kit from the store.

*We will go together to the doctor if more time has lapsed.* ***-Married, P2, Peer Group, Varanasi***

*Suppose my periods are delayed by 1-2 days then will wait for 1-2 days then will have doubt in our mind and will bring the pills from the medical store.* ***Married, P2, Peer Group, Varanasi***

*It saves the fees of doctors because we have to pay Rs.500 and with medicine it costs Rs.2000.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*If we take medicine from any chemist then there can be any harm on the body and if the period doesn't come then what will we do and the main thing that we need to save the fees also. After taking medicine from trusted chemist we see. If the periods don't come then there was our doctor madam.* ***-Married, 34 years, P2, User, Indore***

c) **Depending on the parity of a woman, a woman who has one child would want to trust more on a doctor than a chemist**. However as soon as most women receive external validation by the society by having two children, she becomes confident enough to procure the medicine directly from the chemist.

d) **Procurement of MA:** In case of a supportive husband and if the gestation period is not too long, **the procurement is done mostly by the men** (respondents claim that he heard about MA from a friend or the woman (-wife) tells him about it as she's heard it from a friend or any other family member). In rare cases, where the woman felt her decision to terminate a pregnancy might be opposed, she went and purchased MA herself. Most respondents stated that the chemist, at the time of purchase, shared extensive instructions on the consumption of the medicine including dosage, frequency, expected symptoms, to be had with any item, etc., with the purchaser.

- **In some cases when the doctor prescribes the pill or when she is shy (using for the first time) that's when she expects the husband to get the pills.** The preferred doctor is a 'lady doctor' or 'gynaecologist' were female private practitioners practicing in their own private clinics. This doctor is generally the female doctor who has delivered a woman's first child. In most cases, if instructions to consume the pills are given by the doctor it was believed there is no need for the husband to ask the 'chemist' about the same. In cases, where the husband solely goes alone (without consulting the doctor) there is a belief in women that he will pass the right information (if given). In a few cases, the women preferred to read the information from the kit directly. In other cases where there has been a mutual decision taken by both of them yet the husband is not assertive in decision making the women

decides to procure it herself. After using it one time the women gain more knowledge and confidence to procure it herself later or once again.

*My husband had brought the kit and because of that I got to know that I am pregnant and then I did not understand what to do so I went to medical stores and I took medicine and after taking medicine it was cleared.- Married,**27 years, P2, MA user, Nanda Nagar Indore***

*If you are not able to go to the doctor anytime then you can go to the medical store. You tell him frankly then only he will understand and will give you the right medicine. Even after taking the medicine don't feel good then you go directly to the doctor but if you have time then you can wait for some time.- **Married, 28 years, P2, User, Varanasi***

*I told him that my period date was this but yet I didn't have my periods. So, do you have medicine for this as it was just 8-10 days extra. He replied, yes, you will get the medicine. I asked him to give the medicine, but I had some fear about will it affect, will I able to abort the baby. He said to me if you are having pregnancy, and you want to abort the child, so definitely this tablet will affect, and everything will be clear, or else it won't. If it doesn't get aborted, then you need to go to the doctor for a check-up. He clearly told everything. The price of that tablet was Rs. 550 which had 5 tablets. He told me I need to eat 2 tablets one day. I need to take the tablet with water. **-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*I directly said chemist I am not having my period, where it is been 10 days now and where it was going to come on 20th but it is more than that my period hasn't come and then he gave me the medicine. He gave me a kit which of very small tablets of white color **-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

- **The majority of the women opted to go to fixed chemists as the pills are considered to be 'banned' and not given easily without prescription**. In some cases the chemists ask multiple personal details and questions alongside asking for a copy of '**Adhaar card' as proof.** In one instance the chemist first provided an **Ayurvedic Syrup** (for abortion) but later the women went back again to procure MA pills (not given in kit but in small brown packets with handwritten information). MA pills are either oral or given in a combination of oral pills and pills to keep inside the vagina.

*There are 5 tablets are there. One tablet needs to put inside and one to consume it. No, 2 tablets need to keep inside. My sister had taken 5 tablets. **Married, 36 years, P2, Repeat User, Nanda Nagar, Indore***

*The government has made it so strict that we can't get an abortion pill. Yes, we people trust on chemist but still risk has to be taken.- **Married, 36 years, P2, Repeat User, Nanda Nagar, Indore***

*Yes there are lots of chemists who don't give the tablet. It is a risk as if something happens to us it will come on them and the tablet might be stopped to sell time. **-Married, 35 years, P2, Repeat User, Indore***

*I have taken medicine from him many times and I have trust in him and he knows my husband very closely because he have worked in the salesman line before and the chemist kept chocolate or*

*candy jars and mostly he used to take from him. He knows us very closely till date..* ***-Married, 32 years, P2, Repeat User, LIG Colony, Indore***

e) **Information on use and symptoms to expect:** The chemist's instructions across centres were then forwarded to women (which they completely trust, because they believe that the chemist is likely to know the product that he sells, thoroughly). Some women stated that they prefer going to the doctor (usually alone and in a few instances with her husband). There is supreme trust that has been given to the doctor and when she is consulted, the doctor herself gives the MA pills explaining the dosage and other details. In every case where the woman had consulted a doctor, the doctor had explained all the contraceptive methods for future use. On probing, it was revealed that these doctors are known to the woman, are non-judgmental, friendly, soft-spoken in their demeanor.

f) **Women preferred to go to the doctor with their husband or a female confidante (not alone).** There is supreme trust that has been given to the doctor and when she is consulted, the doctor herself gives the MA pills explaining the dosage and other details.

- In a few instances women mentioned in Indore, the doctor didn't even provide the knowledge about MA and instead asked the women to get an abortion (to earn more money). On asking for pills later, she gave the women the pills**. The price charged by the doctors is also much higher and is not provided in a kit format but as loose pills.** Some doctors even made the women had the first dose in their presence and gave instructions about how to consume the remaining doses.
- When it comes to MA Pills, **the women across centres felt that the stakeholder attached to procuring these pills will pass the judgment of not being able to handle her emotions and desires which leads to these unplanned pregnancies** or being scolded by the doctor of not using any method as a precaution.

*My husband was there along with me when went to the doctor and he got scolding as well as to why he gave abortion pills. You should do abortion instead of taking the pills.-* ***Married, P2, Peer Group, Varanasi***

g) **Frequency of Self-use:** In Indore, most of the women expressed that 30-40 percent of women self-consume these pills (via information-seeking through friends and confidants) and not going to the doctor. This knowledge comes from a 'user friend' who entails this trust. Self-consumption also saves on the cost of consulting the doctor and procuring pills from them at a triple charge.

### 3.8 The MA Experience

*a)* **The expectations of symptoms:** The symptoms expected by women are consistent with their actual experiences. Since they have gone through childbirth, and understand that a mass will be removed from their bodies, they consider it obvious that there will be bleeding after consuming MA. Most women stated that it was 'menstruation like bleeding, but heavier.'

*b)* **Symptoms after consumption:** On consumption, women express vastly different experiences from one another – there is no one consistent trajectory. This includes a variety of symptoms in combination - heavy bleeding, pain and blood loss, dizziness, nausea, weakness and feeling anaemic. If the pill is taken within the time period prescribed by the chemist or doctor, the result has been mostly successful. In a couple of cases, when MA was consumed too late into the pregnancy, the women had to ultimately resort to surgical abortion.

   a. Some women in Indore also expressed that they felt no pain whatsoever (unlike what they had expected) but just weakness and dizziness. Women who had used MA more

than once confirmed that there is no particular trajectory of symptoms and each MA experience can be vastly different in experiences.

*My stomach was paining and vomiting feeling was there but she (doctor) told not to do so. I was controlling vomit. Feeling giddy, restless feeling, sweating is also there.* ***Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*I feel like vomiting and feels mouth is bitter. Everything happens in 10 days and there are many thoughts.* ***Asha, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*It reacts differently for everybody. If it suits me then only I'll tell others to use. .-* ***Married, 28 years, P2, User, Varanasi***

c) **Husband's involvement:**

- In cases where the husband and wife were wholly aligned on terminating a pregnancy, they visited a known doctor for assistance, who then recommended MA to them. This was mostly in cases in Varanasi where the husband was wholly supportive and engaged in the process. In a few cases, the women heard about the pills through a confidante and expressed a desire to try MA to the husband, he still insisted on going to the doctor for confirmation. There were cases where the couple went to the doctor but didn't procure the pill from the doctor (they charge a higher amount for the pill ranging around Rs.800-Rs.2000) and instead bought it from a medical store.
- In Indore, it was seen that the husband (if supportive) is less engaged in the process of consultation with the doctor and options for termination of pregnancy. This is so because they believe that the women will be able to express and understand the doctor better in comparison to the husband. He just **accompanies her for support** and **if procurement is needed, he goes to procure it.** In the case of a non-supportive husband the woman doesn't expect him to accompany or to procure the kit. She feels that it's her duty to do everything by herself after getting the approval of the husband for abortion.
- The involvement of husbands in the MA journey only appears to remain till the procurement of MA takes place. Most women are hesitant to purchase MA on their own due to the anticipated embarrassment during interactions with male chemists, and so tend to request their husbands to make the purchase. Once the procurement is done, the woman largely goes through the consumption journey on her own. Upon probing, women stated that this was because men could not be expected to understand a process that concerned the female body. In some cases, a close female relative/friend who had known about the process was involved and consulted in case the woman was scared because of symptoms like bleeding, pain or dizziness. **Even in cases where nobody was consulted at the time of consuming MA, the woman tended to share it as an experience with a close female relative or friend afterward.** This was seen as an act of revalidation of her decision, and the experience of sharing what she had gone through.
  - The woman also doesn't want to involve her husband much in the process of consuming and follow-ups. Validation and approval is what is sought from him and hence requested for. Post that she thinks her husband cannot be involved as being a bread earner of the family. His main focus should continue to be on managing the financial situation of the family.

> *There was no involvement of him, nothing. I bought and did everything myself.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

> *No, I ate that secretly. told me afterward. He said as you have taken it then suffer now.* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*d)* **Potential to purchase MA themselves:** Many women across centres claimed that if MA pills had been sold by female chemists or at other accessible places where predominantly women congregate, they would readily have procured the drug themselves.

e) **Repeat use of MA:** Several respondents had used MA more than once. This had **not taken place in quick succession but over a number of years.** The stated opinion of women is that repeated consumption of MA is not good for the woman, but it does become an **accessible, convenient and reliable** option in their minds, **in case of another unplanned conception.** Therefore, repeated usage of MA is not problematic as long as the woman is not facing any complications. Even so, **after 2-3 times,** it is seen as potentially harming the body, and so is discouraged. For a woman, the benchmark of consuming the pills is the no. of times she has consumed it. For instance, a woman who had consumed it once believed only consuming it once is permissible or a woman who had consumed it twice believed consuming it twice is not a problem. They collectively know it's not good for her health but if a woman is pregnant and doesn't want a child, she is bound to take that pill again leading the on appointer increase in the saturation point.

### 3.9 Complications Involved with MA

a) **Expectations of complications:** Women seem to have an understanding that the MA experience differs from woman to woman depending on how one's body reacts to it. Those who had heard about it from a friend/ family member expressed that they've heard a mix of stories. After consumption, some had similar accounts and for others it was completely vice-versa. Since the symptoms are usually expected, the anticipation of complications varies based on subjective nuance – Some women perceive excessive pain as a potential for danger, whereas some women stated that bleeding that exceeded their standard menstrual cycle duration by more than a 2-3 days would be reason to feel scared. The greatest tangible threat shared by the women interviewed was that they would consume the medicine, and **nothing would happen i.e. the pregnancy would not terminate.** Women have mostly heard of such instances from other women. Only a few women cited that an incomplete abortion was a possibility and that if the pregnancy did not terminate completely, it would pose a potential threat to the woman's health. Even in this case, women were clear about the fact that they could seek assistance from a doctor. Very few women who were users of MA reported facing any complications.

> *Now if there are 6 ladies taking the abortion pills then everyone will face the side effects like some will have BP or diabetes or swelling in the womb. Nowadays any good medicine you take there are side effects of it we need to check if the medicine is of hard power or less power, that is also important in it. This abortion pill is a hard power medicine.-* ***Married, P2, Peer Group, Chetganj, Varanasi.***

b) **Complications are not defined:** The definition of complications was found to be very subjective for each woman. Even after hearing negative or positive experiences about MA women have felt differently. Repeat users have had different experiences when they first consumed it to when they consumed it later.

    a. A woman feels if a pill is consumed then it will definitely affect the body in some or the other way. But the complication is something that she expects like a long duration

of menstruation, unbearable pain, weakness which leads to women not wanting to work at home in this duration but has to work, vomiting, dizziness, etc. This is something that will happen and is not even stated until and unless asked in detail. Women in Indore, on average expressed heavy bleeding lasting for 4-5 days wherein they need to change multiple number of pads (4-5 per day). Most women on a scale of 10 expressed pain to range around 5-6 points, weakness approximately around 5-7 points and dizziness around 6-8 points. Most abortion-related cases reaching gynaecologists were treated as incomplete abortions.

*He had given one medicine and told me to come back again for a check-up after 4-5 days. After 3rd or 4th day only miscarriage happened. It is not like the normal bleeding, it is like the bleeding of the cuts in the flush. It was more. Every afternoon I used to wake up 2, in every 4 hours I use to change pad. I was using it twice, it was too much. I didn't feel like waking up. I had a lot of weakness because if there is this much blood loss one is bound to. I didn't feel like eating, not even milk or juice.-* ***Married, 30 years, P1, User, Chetganj, Varanasi.***

*Normally after 2-3 days pain stops but when bleeding continues then there is a doubt and wrong feelings come into the mind as the bleeding will never stop. If we face more problems like this we will go to the doctor-* ***Married, P2, Peer Group, Chetganj, Varanasi.***

*And while passing urine in the toilet sometimes thick bleeding also used to happen. I visited after 5 days to doctor and then she said that now you go in the washroom and just check that whether it is there or not so I said okay. So she had given me one pregnancy card to check but in that also one line was light and one was dark. So she said that somewhere one piece is reaming so again she had given me the medicine. It has silver foil packing.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*After taking the tablet I started feeling giddy and then in three tablets my bleeding started and then it was done. But the bleeding was heavier than the normal periods. I used 3 pads in a day I felt very weak.****-Married, 26 years, P2, MA User, Mansab Nagar, Indore***

*The stomach was paining very much and I had excessive latrine also and all this continued for 8 to 10 days. After that also some drops were coming and I was worried whether it is a big problem. I visited ma'am for that, so she told me that it is not a problem and all that happens. So, all that stopped gradually. .****-Married, 26 years, P2, MA User, Mansab Nagar, Indore***

c) **The biggest concern – Ending the pregnancy:** When asked about any fears or concerns they may have with regards to using MA, many women said that in the short time frame when the drug can be consumed, their sole concern was to 'get rid of' the pregnancy. In cases where the woman had not shared this with her husband or family members, the woman was comfortable dealing with side effects, as long as the abortion was initiated. At the time, the need to remove the pregnancy was much higher than considerations of side-effects or other detrimental effects. However, later on she realizes that by consuming MA pills you kill a life

*Even if there are so many doubts then she will not think about that but just take the abortion pills.* ***Married, P2, Peer Group, Varanasi***

| *You are killing a being at the end of the day.* ***Married, 35 years, P2, MA User, Subhash Nagar, Indore*** |
|---|

*d)* **The success of MA:** Most women of Varanasi and Indore stated that the stopping of bleeding after consuming MA was sufficient to indicate that they were no longer pregnant. However, to satisfy themselves, they reported either taking a pregnancy test or in most cases, visiting a doctor for an ultrasound to confirm that they had in fact been able to have a successful abortion.

| *Yeah I got the period on the next day in the evening and I told my husband to bring one more kit for checking.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore*** |
|---|

### 3.10 Understanding Contraceptive Timelines of MA Users

***This sub section aims to analyse the time when a woman consumes MA consumption in her reproductive timeline***

**Recent MA Users:** Women respondents who had had a medical abortion were asked about their contraception timelines (contraception they used/use from their marriage till consuming MA). On comparing their contraceptive timelines, the findings point to several trends: first, medical abortion users interchange between condoms and birth control pills through their reproductive timelines and more likely to cite most of the contraception options available in the market. No method or traditional method followers either have full confidence in the method and others also use it as an extra caution after using modern contraception. Second, medical abortion pills are used due to negligence or failure to follow modern contraceptive methods (lack of availability of condoms, skipped a dose of the birth control pill) or failure of a modern contraceptive method (expired condom/ breaking of condom). Most of the respondents were married at an early age (18-25 years) and they were still less likely to give birth to a child immediately after their marriage. Medical Abortion recent users were seen to maintain a minimum of 2-5 years or more of spacing between their first and second child. Given the findings irrespective of facing side effects, most of these women were satisfied with their medical abortions and it's subject to the ease of experience that she would or would not recommend it to others. Most of the recent women users reported continuing their old contraception method (preferably condoms or birth control pills) after their most recent abortion. However, it is important to remember that recent medical abortion users are not necessarily representative of all medical abortion users.

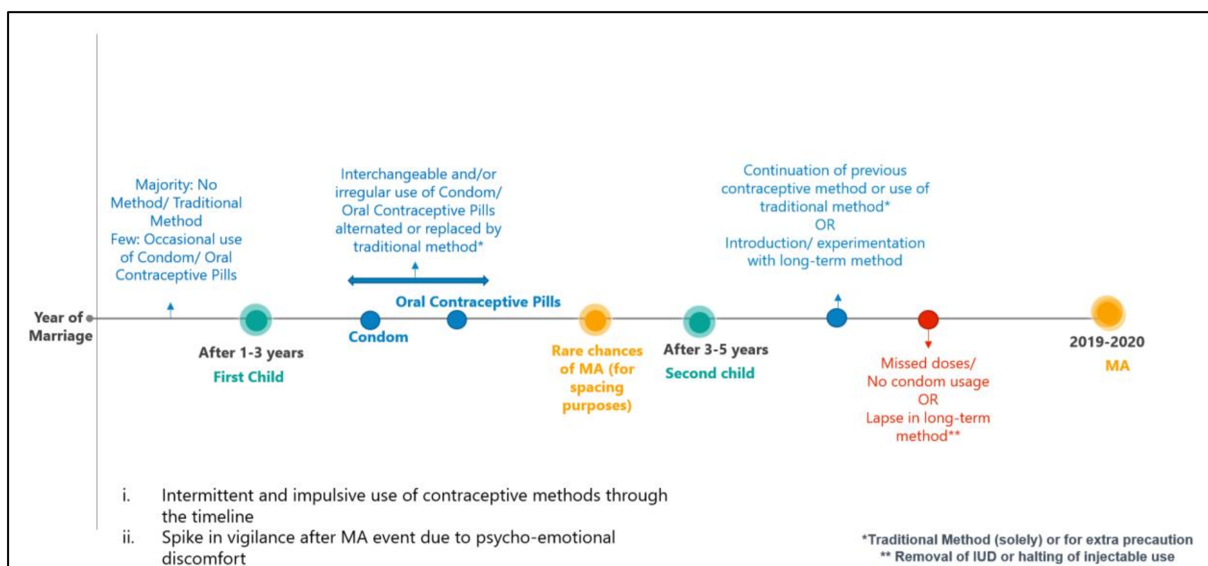



*Figure 2: Representative Timeline for a recent MA user*

**Repeat MA Users:** Women respondents who had had a medical abortion more than once were asked to give details about their contraception timelines (contraception they used/use from their marriage till

consuming MA). Interestingly, more repeat users were interviewed in Indore than in Varanasi. These women were specifically asked to give details about their more than one experience of consuming MA. Most of the respondents expressed that there is considerably less anxiety and fear when they consume MA pills for the second time. Even after repeated consumption, the experiences reported were varied (like a massive pain in the first experience to no pain in the second experience).Given the findings regarding complications, it seems that medical abortion users are not able to distinguish between side effects and complications and there is no standard definition of the same.

Any kind of contraception option that enters the timeline posts the birth of the first child. The starting of their contraceptive timelines reflect no usage of any method (traditional method in few cases) post their marriage and first childbirth as a result of the same. The vast majority of women users consume these pills after their second child. In a few instances, there is consumption before the second child for spacing (predominantly due to economic reasons). There seems to be no general pattern of when they consume these pills for the second time to the first. The time period of consuming MA for the first time to the second child range around 1to 10+ years.

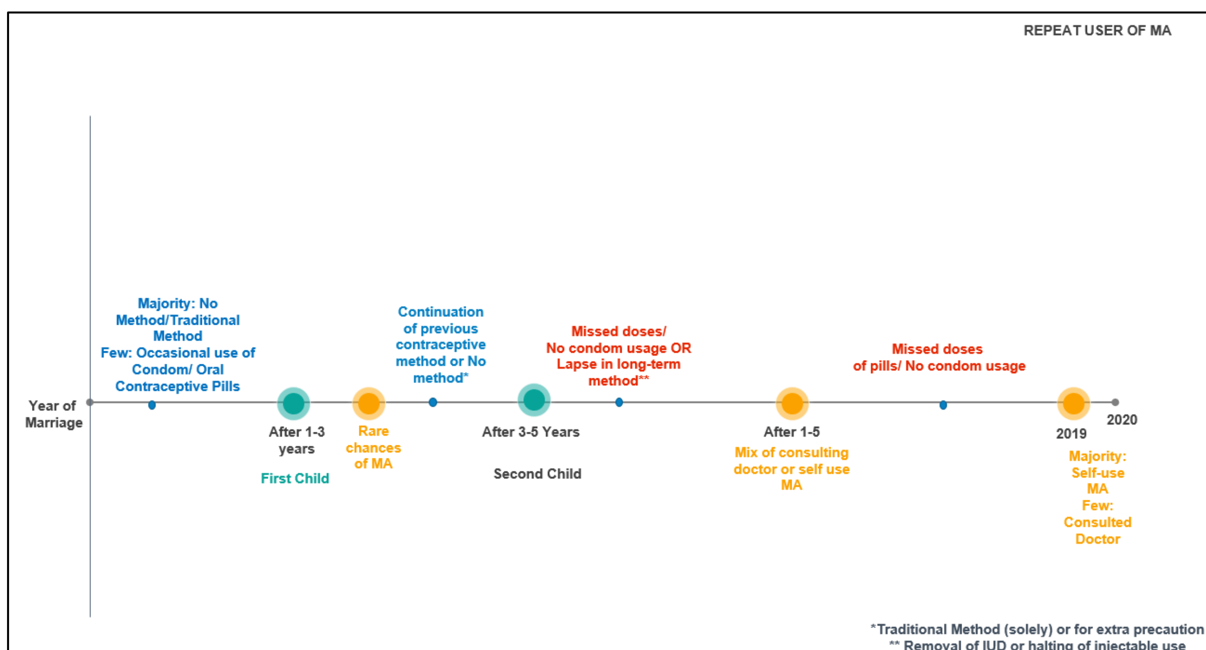



*Figure 3: Representative Timeline for Repeat MA User*

**Image 1: Some highlights from the fieldwork in Varanasi**

**Image 2: Some highlights from the fieldwork in Indore**

# CHAPTER 4 – CONCLUSION

## 4.1 Women suspend their emotions and stigma when deciding to carry out medical abortion

**The stigma is external:** Largely, women who are self-users of MA do not express any emotional distress with regards to the prevalent stigma around their decision to carry out medical abortion. The stigma is explicitly attributed to external influence from the immediate and extended ecosystem. If at all, the stigma associated with 'ending a life' is a belated sentiment, and does not impact the original need to terminate a pregnancy.

**Belief in fighting for her own need to terminate a pregnancy:** Women believe that there is limited understanding of the implications of an unplanned pregnancy on their physiological and psychological well-being.

**Urgency, convenience & discretion are crucial:** At the time of detecting the pregnancy (7-10 days after missing menstruation), the most urgent need is to find the quickest, most convenient and most discrete route to terminating a pregnancy before external influence stands a chance to change the decision.

**Self-proclaimed legitimacy:** The P2+ women believe that women with 2 or more children have the greatest legitimacy to terminate a pregnancy, owing to family completion (in adherence with societal norms around ideal family size).

## 4.2 The focus on informal touchpoints

**There is an explicit reliance on informal touchpoints including the spouse, and most importantly a trusted woman, of the same age or older, with either sufficient exposure and/or experience to MA by the woman, before taking the decision to carry out medical abortion.**

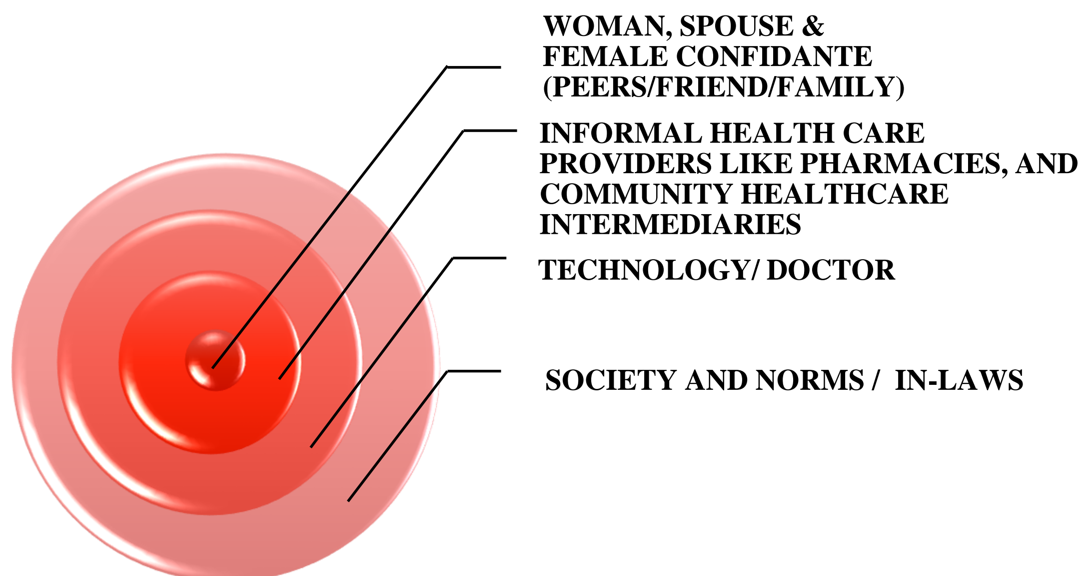



*Figure 4: The socio-ecological model undergoes a change when it comes to information seeking and inclusion of stakeholders in the decision to use medical abortion*

**Though there is access to both formal and informal touchpoints, the emphasis for a woman considering or undergoing MA remains on the latter.**

**Informal touchpoint in the home:**
**Husband:** A supportive husband (one who supports her in her decisions about herself and the family) is seen by most women as the gateway to fulfill their wants and needs because it is seen as legitimizing her actions. A husband's validation is considered extremely valuable for decisions like MA.
**Maternal home:** Most of the women express deep affection towards their maternal home – stating that the freedom in the maternal home cannot be compared to their current lives. The support of a 'father' has seen to be the biggest backbone in the lives. Through a parent's support these women could acquire education. Due to societal norms they got married at a considerably earlier age.
**Mother in-law:** A supportive MIL (mentioned rarely by women) is seen to be a pillar of support. She supports a woman in household tasks, taking care of children, passing advice, etc. This support translates into better knowledge and mobility of the women. Her agency to make decisions for herself is seen to be higher. A non-supportive MIL becomes a gatekeeper in a woman's life to take necessary decisions and acts as a hindrance to her overall agency in the household. Her expectations and demands on the woman add like an additional pressure she needs to live up to.

**Informal touchpoints outside the home:**
**Confidante-**

a) There is **one trusted and close 'confidant'** every woman has in her life. This confidant (friend, sister, neighbor, sister-in-law, mother, etc) is the 'one' open connection (apart from supportive husband) with whom a woman likes to share everything. In case it was something serious about MA, they would discuss it in person by visiting each other's home and the tone of the conversation is concerning and serious. This confidante becomes an anchor of support that gives women the confidence to take MA up and a belief if something (by chance) goes wrong this confidant would be there for the rescue.
b) In cases where **the women in the neighborhood frequently interacted with each other they ended up sharing MA experiences using 'third person' stories**. Information sharing is more active in groups than information seeking which is a personal affair. These instances are usually shared between normal daily conversations and also become a hub of gaining new additional information from fellow women. Older women usually are generally more 'trusted' and considered 'authentic' knowing they have gone through similar experiences before and hold better knowledge.
c) **An underground women's network:** There is a high level of dependency on informal women networks (friends, relatives) for information at all levels (in case of unwanted pregnancy, who to first approach for MA, discuss complications (if any) or who to approach if there is an issue following MA kit use).

**Pharmacy-**
**Preference for pharmacy over doctor:** The doctor in most cases, is seen as selling MA at an inflated cost, or being discouraging of terminating a pregnancy. Thus, the preference is to approach the pharmacy to gather information on consumption of MA. In some cases, women do approach their doctors owing to trust based on past experiences with pregnancy & delivery**.**
**Question about legality of MA:** There is a question in the minds of women about the legality of MA use. If the belief is that MA use is illegal, women tend to approach a spouse, known persons with whom there may be reason for credibility (known medical practitioner, known pharmacist, friend with previous experience etc.)

**Technology-**

**Technology as a verifying agent:** Whilst technology is used to proactively seek remedies for smaller ailments, in the case of MA, it is only seen as a mode of corroborating information gathered from other formal/informal touchpoints

### 4.3 The introduction to MA for the woman takes place in the form of overhearing or in an unassuming, and most casual conversation

Either the women have hear about it from a friend/sister about their experience, or the husband's friend told the husband about such an experience and this was discussed between husband and wife, or she heard it in the form of gossip from the women she interacts with about a third person. This information is stored passively in the form of general knowledge until such a time arises when either the woman herself or someone she is close to, faces an unplanned pregnancy. The varying platforms on which the information is shared, also dictates the specificity of the knowledge shared, ranging from passive assimilation of casually shared information to specific knowledge shared in response to a woman’s query about medical abortion. This can be depicted in the form of the pyramid below:

*Figure 5: Pyramid depicting the specificity of knowledge gathered on MA, based on the purpose and platform on which the information is shared.*

The platforms and occasions on which information about medical abortion is shared between women either one-to-one or in groups:

- **Advice offered** by an experienced woman to a woman facing an unplanned pregnancy, who is seeking help for a safe abortion method.
- **Voluntary sharing of own experiences** with contraceptive failure and/or unplanned pregnancies and experience with MA – to aid the woman for future reference.
- **Casual discussions** with female confidantes in the form of gossip, humourous conversations, or information sharing about a third person
- **Passive information** assimilation from older women in the maternal/marital home

*When we ladies sit and chat with neighbors or anyone so they also share things as such unwanted pregnancy happened with someone or with them. If my friends are there then we also share the things that I have this problem so she suggests solutions for that. .- **Married, P2, Peer Group, Chetganj, Varanasi***

*People will tell others that she is having problems but you don't share with her. So each one will share with others and will say don't tell this to anyone (laugh). Grapevine communication happens.- **Married, P2, Peer Group, Chetganj, Varanasi***

### 4.4 Severity of symptoms of the MA experience are not correlated with 'Complications'

- **Definition of Success:** The fear of having a half-successful MA is something women reported being scared of. Most women stated that the stopping of bleeding after consuming MA was sufficient to indicate that they were no longer pregnant. However, in some cases to satisfy themselves, they did report either taking a pregnancy test or in most cases, visiting a doctor for an ultrasound to confirm that they had in fact been able to have a successful abortion.
- **Understanding Symptoms:** There is a common confusion between the understanding of symptoms, side effects and complications. On consumption of MA pills women express vastly different experiences from one another – there is no one consistent trajectory (even for repeat users). The expectations of symptoms didn't necessarily turn out to be what they had expected in some cases. This includes a variety of symptoms in combination - heavy bleeding, pain and blood loss, dizziness, nausea, weakness and feeling anemic. Some women in Indore also expressed that they felt no pain whatsoever (unlike what they had expected) but just weakness and dizziness. For women who had consumed MA more than once had similar experiences both the times or completely different.
- **Inconsistent identification of complications:** The definition of complications is not fixated and very subjective for each woman. Even after hearing negative or positive experiences about MA women have felt differently. Repeat users have had different experiences when they first consumed it to when they consumed it later. Complication (confusion side effects) is something that she expects like a long duration of menses, unbearable pain, weakness which leads to women not wanting to work at home in this duration but has to work, vomiting, dizziness, etc. This is something that will happen and is not even stated until and unless asked in detail.
- **Actions after complication:** Prolonged bleeding and weakness was the most commonly reported issue. Usually the women dismiss complications (she already expects it) and bares it. In cases, when she's procured MA from the chemist she returns back to report the complications as the first option or in case she's procured pills from the doctor she consults back the doctor again. This is only a last resort situation and not something they do reflexively after facing a complication.

### 4.5 On the contraceptive-abortion continuum, Medical Abortion is closer to contraceptives than it is to abortion

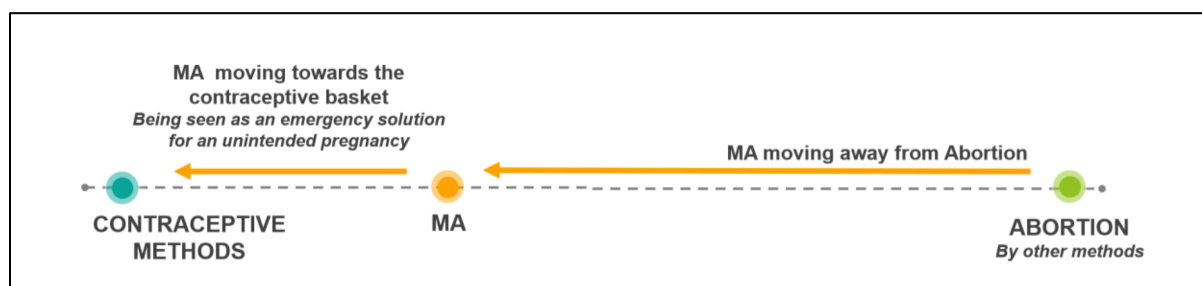



*Figure 6: This figure represents MA moving away from Abortion and entering the contraception basket as an option for limiting family size*

Medical abortion is referred to repeatedly as 'medicine' or a 'way to induce miscarriage.' The associations of women with MA being a method that needs to be administered very quickly after

detection of pregnancy, and as a way to prevent having a surgical abortion, are a testimony to the fact that MA is not seen as being congruous with 'abortion.' In the vernacular the word 'abortion' is used interchangeably with 'infanticide' and so MA is seen as a precursor that could prevent having to undergo a 'proper abortion.' Further, the process of MA is much more within the control of the woman, and therefore becomes the method she wants to use as a solution for an unintended pregnancy.

The following factors push MA away from abortion, and towards contraceptive methods on the continuum above:

- Lesser external intervention, so it can be kept a secret if required, especially from extended familial stakeholders who might discourage the act or prohibit it
- Greater control over the process since the woman can consume the medicine at will, and in a timely manner
- Lower possibility of being discouraged by external stakeholders too, since they tap into their grapevine for both information and access to MA.
- Discrete and simple to administer, and therefore less cumbersome since it does not require an invasive procedure, nor being hospitalized
- Less expensive to administer MA than to have a surgical procedure

### 4.6 Further Exploration

**The following recommendations capture further exploration that can add to the depth of insights garnered in this study in order to have a comprehensive understanding of the medical abortion experience for women in the country.**

1. **Exploration of the grapevine and inclusion of the same in implementation:** It would be advisable to explore informal sources of information that expose a woman to sporadic knowledge about medical abortion in order for future communication
2. **Determining if these attitudes are mirrored by P1, P0 women:** With insights about P2+ women in place, it must be explored if these attitudes and behaviors are being mirrored by P0 & P1 women as well
3. **Understanding the behavior and access for unmarried women:** For unmarried women, the societal taboo and stigma is exponential when it comes to sexual activity, contraceptives and abortion. Past studies have indicated substantial usage of medical abortion in this segment, and thus it would be ideal to explore the touchpoints and sources of information and procurement, as well as the experience for unmarried women.

# ANNEXURES

***ANNEXURE-I: REVISITING HYPOTHESIS FOR PHASE 1***

After conducting the simulation exercises (Phase 1) in both the centres we arrived at a set of hypotheses before conducting the second phase of the study i.e. ethnography. At the end of Phase 2, these hypotheses were either validated or invalidated based on findings.

| **Hypothesis formed after Simulation** | **Validated (YES/NO)** | **REASON** |
|---|---|---|
| 1. There is no stigma in the mind of the woman related to having an abortion by using MA | Yes | The stigma about MA is only 'external'(moral and legal stigma) i.e. via different stakeholders. 'Internally' there is no stigma in the mind of a women is seen as an accessible, easy to avail option available to them when any unwanted pregnancy arises. The 'urgency' of getting rid of the unwanted pregnancy is the pivotal thing and action point to them. |
| 2. The doubt of pregnancy (and discovery of symptoms) occurs approximately a week post missing the last expected menstruation in the woman’s cycle, not after potentially unprotected intercourse. | Yes | All of the women realize that they're pregnant post missing their menses 4-5 days (dates get extended and they start experiencing symptoms like previous pregnancies) because before that there is no sense of surety that unprotected sex/ failure of contraception will lead to a pregnancy.<br>Women recall that there have been instances when they had unprotected sex/ failure of contraception/no usage that lead to no pregnancy. It's a belief that traditional methods like urinating after intercourse (which they followed) become a safety net and there is no cause of worry. |
| 4. The woman procures the pregnancy kit before disclosing her anticipation of pregnancy to anyone | No | The woman first informs and discusses with her husband before procurement (she procures it either by herself/from doctor/via husband). She further needs validation from her 'confidante' before procurement as it tones down the risks in her mind and boosts her with the confidence she needs to go ahead and use MA. |

| | | |
|---|---|---|
| 5. The husband is not involved too much in the process of abortion – if he is included in the process at all. He is seen to play the role of an approver, then a participant. | Partially True | In the case of an unsupportive husband his role is restricted to the role of just an 'approver' by dumping the entire responsibility on the shoulder of the women. In one case of women in Indore, the husband didn't care to follow up or ask anything after a decision that they don't want to have this child and the women will consume MA pills. Everything had to be done by the women herself from procurement to dealing with the complications. The only source of his help was that he was 'known' to the chemist so the chemist readily gave her the medicine.<br><br>BUT in half the cases where the husband is supportive the role he has played is the role of an active participant who accompanies the women to the clinic, procures it (if the women ask him to), helps her during the days when she has consumed the pills it by ordering food from outside, pressing her back for relief and reassuring her with constant support. |
| 6. Women expect the husband to procure MA but also expect that he will relay incorrect information | No | In some cases when the doctor prescribes the pill or when she is shy (using for the first time) that's when she expects the husband to get the pills. If instructions are given by the doctor there is no need for the husband to ask the 'chemist' but even if he goes alone to procure there is a belief he will pass the right information (if given) else she will read it by herself.<br>In other cases where there has been a mutual decision taken by both of them yet the husband is not assertive in decision making the women decides to procure it herself. After using it one time the women gain knowledge |
| 7. At each stage, the woman expresses feeling the most trust for a close friend. She believes the friend is the one true person to speak in her genuine interest, with no vested interest of her own | Partially True | The women believe that positive experience sharing<br>and discussion with a friend acts as a support to build her confidence during the journey of MA. **But** this information sharing doesn't necessarily happen at all the stages. This mostly happens first with information seeking and then ultimately post consuming. There have been exceptions when friend/confidante |

| | | |
|---|---|---|
| | | have followed up regularly to ensure the well-being of the women. |
| 8. When deciding to use MA, the woman consults a close friend – possibly one who knows of or is herself, a woman who has experienced MA in the past | Yes | The woman who has experienced MA in the past herself acts as the biggest support system considering she's gone through it successfully and will not pass any wrong information. The tone of sharing information reflects her decision to use MA. This friend primes and positions the image of MA in the mind of the women. |
| 9. The chemist is seen by women to possess detailed knowledge & expertise about MA – often taking details on dosage etc. from him, over the doctor who may have prescribed it. | No | The doctor is seen as somebody over the chemist who possesses detailed knowledge & expertise on dosage etc. To escape large fees after a confidante primes the woman then the decision is taken to procure the pills from the chemist.<br>It is believed he will pass the right information as the women is paying a large sum of fee to the chemist yet doctor is seen as the ultimate right information provider. In one instance, women got to know about MA via a confidante, she decides to consult the doctor but then ultimately takes her own decision by sending her husband to procure the kit from the chemist. |
| 10. MA/abortion is seen to have a negative connotation and a stigma for every involved stakeholder, including providers | Partially True: No (for herself, friend and husband)<br><br>Yes (others) | MA/ abortion is not seen as a stigma to women who have already gone through it i.e. friend/confidante as she wants to support the women. The husband also sees it as a need of the hour situation without acting negatively towards it. The women herself don't see it as a stigma **but** there's still a fear of judgment and negative connotation in the minds of In-laws, providers (Ask for Aadhar card), doctors (might scold me) and other stakeholders involved in the process. |
| 11. The mother-in-law is expected to be against abortion, and therefore is left out of the conversation, unless she is a 'modern' MIL who supports her | Yes | The MIL even if supportive is left out of the conversation about MA<br>as the women feel there is no need to inform her only in the first place. This 'no-need' to |

| | | |
|---|---|---|
| son and daughter-in-law in limiting family size | | inform comes out of the fear that she may try to change or alter her decision. |
| 12. The women seem to spread their roots under the surface to connect with women whom they see as dealing with similar life situations. These women become confidantes who almost adhere to a code, by supporting one another, sharing stories, seeking advice, and being proactive about ensuring the woman's wellbeing. | Yes | These women believe it's their right to help any woman who comes to 'seek' information about MA from her if she's used it previously or heard about it via some other women. Sharing of information happens casually in groups in a humorous tone and manner whenever they come across or sit for banters in groups during their daily routine. |
| 13. There is a stark contrast between the detailed conversation a woman has with her female friend, versus the complete silence she maintains (normative dissonance) with other stakeholders, unless absolutely necessary | Yes | This stark contrast is because the women has complete 'trust' over this women and believes she will help her in any of the capacity she can. It is also because it's easier for women to understand women better over anyone else. Other conversations are more transactional in nature and lack the detailed emotional sharing. Historical trust with women in her life cements this openness and ability to share anything and everything. |
| 14. The feeling towards the abortion is not emotional or painful. In fact, the women see it as a pragmatic decision, one that takes on a strong sense of urgency as soon as the pregnancy is confirmed. Women see it as something that needs to be addressed swiftly and effectively | Yes | The sense of moral dilemma and reflection doesn't come at the time when women has decided to consume MA pills. She just wants a '*chutkaara'(riddance)* at that point in time and nothing else The feeling associated is logical and non-emotional.<br>Later on, she **might** start feeling moral about it. |
| 15. Fear of using MA is limited to a vague idea of potential harm a pill for abortion can cause. It is more focused on the completion of the abortion, rather than negative impacts on health through incorrect usage. | Yes | The woman just wants to 'get rid' of the pregnancy completely in urgency or in desperation keeping aside any set of complications that could come in hand with the consumption of the pills. There is a belief that negative impacts can be handled and dealt on later but right now the focus should be on the completion of the abortion. |
| 16. a)There is no set definition of complications post using MA. b)The women claim their experiences are varied, and that | a) Yes<br>b) Yes<br>c) Partially True | a) The definition of complications is not fixated and very subjective for each woman. b) Even after hearing negative or positive experiences about MA women have felt |

| | | |
|---|---|---|
| bleeding beyond the duration of the normal cycle of menstruation causes alarm,<br>c) and is followed by a conversation with the friend. | | differently. Repeat users have had different experiences when they first consumed it to when they consumed it later.<br>c)The conversation is not necessarily followed by a friend. It is followed by a conversation with the husband first if he's a supportive husband otherwise it is taken place with a friend directly. |
| 17. Women claim that they use technology to identify possible methods of abortion or to look up the name of the pill prescribed to them. | No | Women (Indore only) search about minor medicines for cough, cold etc. but they don’t search anything about MA or abortion. Information is received via a trustworthy source like a doctor/husband/friend/confidante. |
| 18. a)A woman is comfortable getting pregnancy kit /<br>b) but not pills for which she is dependent on her husband. | Yes | ***a)True*:** There is no sense of judgment attached if a married woman procures a pregnancy kit as it’s perceived as not something 'wrong' but rather as a means of 'good news'. The positioning of information via ads has enabled her to shed off the hesitation as it is perceived as something every married woman procures at some point in her life.<br><br>***b) Partially True*:** In half of the instances the women are not dependent on her husband as there is a mutual decision taken by both the partners. By the virtue of approval, she is considered to have a sense of her abilities knowledge to go and procure it herself from a fixed medical shop.<br>In other cases, the husband himself procures the MA as there is no judgment attached to the males on procurement in comparison to when the female procures it. |
| 19. The husband takes a step back when it comes to discussing MA with the doctor. Even the woman expects him to just accompany her as financial support. | Partially True | Husband (if supportive) takes a step back because they collectively believe that the women will be able to express and understand what the doctor says, better than the husband. He just accompanies her for support and if procurement is needed goes to procure it. In case of a non-supportive husband the woman doesn't expect him to accompany or to procure the kit. It's her own whole sole duty to do everything by herself by just having the approval of the husband to go ahead with abortion. |

## ANNEXURE-II: DETAILING OUT THE METHODOLOGY: PHASE ONE: ASSISTED SIMULATION

*This annexure provides a brief highlight on the methodology employed, and the hypotheses that were arrived at to be validated or invalidated in the subsequent phase of fieldwork. (The simulation exercise in Varanasi & Indore was conducted in December 2019.)*

**The Rationale:**

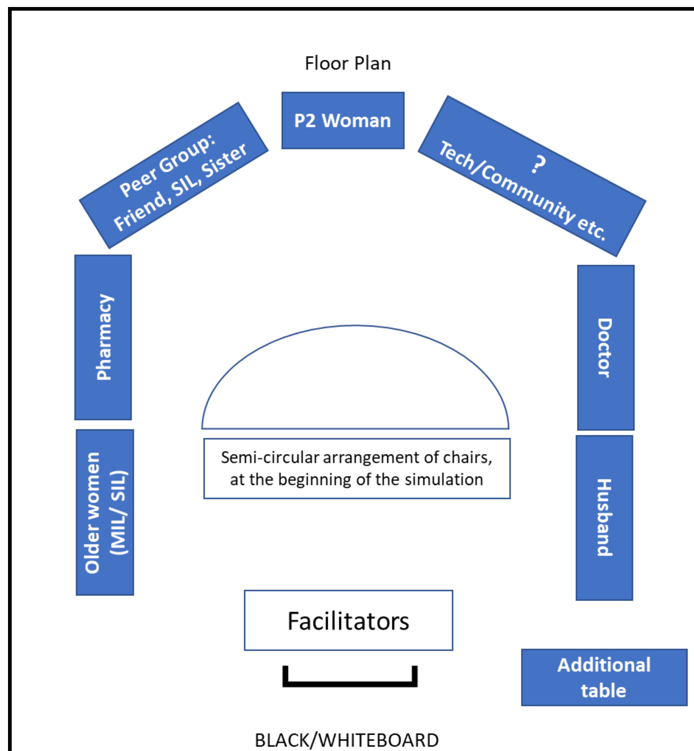
Assisted simulations were conducted in Varanasi and Indore (each in both the centres), traditionally employing the method of classroom teaching, by recreating a real-life scenario in a controlled environment to aid participants in understanding the possibilities leading to outcomes in a defined scenario. The key mechanisms that were involved were: **role-play, discussions and debates.**

- A simulation offered the comfort of departing from a real-life situation, offering anonymity as well as hypothetical action that had no bearing on the life of the respondent.
- The idea was to remove the respondent from their own context in which certain vulnerabilities and bias may have tainted their responses.
- Further, by creating a tactical course of action, a simulation presented a life-like situation but likely reduced the risk of emotional implications of a dramatic recreation in the minds of the beneficiary, leading to an honest portrayal of possible courses of action.
- Meanwhile, the role-play technique permitted respondents to explicitly state their point of view and feelings, without the fear of bias and judgment.

**Design of the Simulation:**

- A number of respondents were gathered in a closed room setting, for conducting role-play and debates which were action-oriented. It was conducted as a multi-layered exercise that posed different scenarios relating to the information gathering as well as decision-making on abortions & MA as a subset of fertility management.
- The simulation instrument was designed keeping the research objectives and questions in mind. It consisted of probable situations to identify the information-seeking and decision-making behavior. An overview of the process has been outlined below:
  - Respondents were gathered in a room and briefed on the subject matter to be discussed – relationships, intimacy, unwanted pregnancies, and abortion.
  - The room consisted of a number of tables with respondents representing various stakeholders in the woman's ecosystem, seated for interaction. Each table represented a different stakeholder – **husband/partner, influencers like older women, pharmacy, technology & media** amongst others along with a **blank table** for a touchpoint that may exist, but has not been named.
  - The respondents were given situations in the style of role-play and were asked to determine the course of action in terms of their own thoughts and feelings, followed by the married woman's interaction with any/all of the stakeholders, the reason for choosing that channel, the information she gains from each one, followed by her understanding and course of action.

**Simulation Set up:**




**The Process of Simulation:**

- A few days prior to the simulation, the team-initiated contact to pre-sensitize the respondents.
- The simulation session began with all respondents sitting in a group. The ice-breaker activity gave participants a chance to introduce themselves in a fun way. A number of random items were put into a tray, and the respondents had to choose one item, identify a quality that the object reflects in their personality, and then introduce themselves accordingly. Respondents shared about their lives, hobbies, and activities that they enjoy.
- The next activity was – 'scripting a movie'. As part of this exercise, participants were required to describe a central character 'Kavita'- who is similar to them.
- The next activity included a discussion on the 'Journey of Kavita', focusing on specific situations related to pregnancy, family planning and medical abortion. The activity included probes to recreate the scene between the woman and the relevant stakeholders in the form of role-play.
- **Incentivizing participation:** In order to incentivize participation, a bowl of candy/chocolate was kept at the centre of the room
- **Break:** If the moderator sensed a drop in energy, she considered taking a break in between the exercise – before the role-play exercise and offered the participants some refreshments and brief opportunities to interact with each other.
- **Yellow card:** To control respondents who might try to overshadow others and speak out of turn, the moderator introduced three yellow cards. When given to a respondent she had to refrain from speaking for 3-4 minutes.
- **Whistle:** Things at times became chaotic when women had many opinions to share. The moderator kept a whistle to blow to call the room to order – an action that was received with enthusiasm and laughter by respondents.

**PRE-SENSITIZATION:** Two days prior to the scheduled simulation, the research team (at least one member) initiated contact with the participants, over the phone. The idea was to warm them up to the concept of role-playing and to establish a personal connection with the research team. This

resulted in a positive predisposition at the time of the meeting for the activity. Before beginning the simulation, it was ensured that the researchers had the recruitment questionnaires from the field team. Through the course of the warm-up in the simulation, the research team pre-assigned teams of 2-3 women each, to be used to represent different stakeholders in the role-play activity.

**The flow of Simulation:**

The simulation exercise was started off with game-like introduction activities to build a rapport and comfort level with the facilitator. This was followed by a group activity that involved collective brainstorming to create the protagonist for a film. The participants were told to build a central character named 'Kavita' whose life would be similar to theirs – and then were guided to mutually arrive at a portrait if her personality, her personal and social life, her aspirations, fears, and the people she trusts. Thereafter, they were asked to participate in a role-play on behalf of this character, and some of the other touchpoints arrived at, in the course of the warm-up exercise.

**i. ROLE PLAY:** Respondents were assigned various situations and asked to draw up a course of action using the various touchpoints. Each touchpoint was represented by 2-3 women in the group, and they were requested to simulate potential conversations and thoughts for each one, at the time of interaction.

| Situation: | Probes: |
|---|---|
| Situation 1: A woman has 3 children, and does not want to have any more children. | *Why does she feel this way?*<br>*What does she do?*<br>*Whom does she talk to?*<br>*How does she go about achieving this?* |
| Situation 2: This woman has now become pregnant | *What does she think?*<br>*Whom does she talk to?*<br>*What does she do next?* |
| Situation 3: She decides she does not want to proceed with the pregnancy | *s her first thought?*<br>*can she talk to?*<br>*vhat happens?*<br>*ll are involved?*<br>*s she feeling?* |
| Situation 4: She has taken pills for an abortion | *How does she know of them?*<br>*Where does she get them from? Who brings it?*<br>*How does she consume it?*<br>*What happens to her mind, her body?*<br>*Then what happens?* |
| Situation 5: She is now facing complications | *How does she know of this?*<br>*What is happening to her body?*<br>*Whom does she talk to?*<br>*What does she do next?* |

**ii. DISCUSSION & DEBATE:** Once the situations had been played out, the women were brought together to have a debate about the actions and reactions of each representative touchpoint and why they thought it was correct or not. Questions asked included specific probes for everyone to validate or negate what was said in the course of the activity.

***ANNEXURE III: DETAILING OUT THE METHODOLOGY – PHASE TWO: ETHNOGRAPHY***

*The ethnography exercise in **Varanasi** was conducted **in December 2019 for a period of seven days**. After assessing the ethnography in Varanasi hypothesis were developed for Indore's ethnography. Ethnography in **Indore** was conducted in the second week of **January 2020.***

**Conceptual Framework**

Ethnography is an approach defined under the discipline of anthropology is about **understanding real people in their real-world or lived reality.** From focusing on *'what is the social behavior among married women?'* to *'How does the community interact with the network of influencers,'* an ethnographic intervention encompasses all.

In ethnography, the researcher had the opportunity to be able to immerse himself/herself in the target group's environment and to better determine their motivations and behaviors.

**The rationale**

For the process of investigation for this research, ethnographic tools were used as our basis to understand the context and the causal mechanisms and its boundaries by using a combination of methods to collect data from our study respondents in Varanasi and Indore.

**Universe:** For this research, the universe of the study were the communities in the city of Varanasi and Indore, where we were able to observe married women (users and non-users of MA) of varying parity, and their interactions with all the stakeholders identified in the first phase of the research.

In the course of the ethnographic exercise for a **period of 7 days, in both Indore and Varanasi,** the researchers immersed themselves in the community as an outsider and appointed a key informant from within the community in order to better elicit conversations and responses from selected members of the community.

In Phase 2, the team revisited the centres with the intention to delve deeper into the lives of some of the women researchers had met in the earlier phase (simulation), at the same time leveraging them as key informants in their communities, to snowball and meet with other women of similar profiles

**Tools & Iteration**

In order to understand how women – both, users & non-users of MA - interact with the various stakeholders who eventually have an impact on their behaviour and decision-making, it is necessary to take an iterative approach to this ethnographic exercise so as to accommodate new profiles of respondents which may emerge from what we learn from the exercise – be it influencers, or the women themselves. Further, the effort was focused on identifying how these interactions impact their agency, their incidental exposure to information, their information-seeking behaviour, and the socio-cultural values that drive their beliefs and decisions, which subsequently shape the MA experience. A number of tools were employed in order to interact with the various stakeholders in the community including - **Accompaniments, Observations, Mohalla Groups, Peer Groups, Dyads, Triads, One-on-One interviews.**

**The process**

a) *Contextualizing*
b) *Understanding the universe of the medical abortion users*
c) *Snowballing to identify other MA Users*
d) *Understanding the MA Users up close and personal*
e) *Understanding the symbiotic relationship between contraceptives and MA at a collective level*
f) *Mop up-close inspection of the various touchpoints*

**Study Setting of Ethnography**

**i. Centre I- Varanasi**

- The locations selected for the mapping and *mohalla* groups with *Godowlia Market Chauraha* as the central point, with the residence of our key informants in mind. These locations are: - ***Chetganj, Madanpura, Bengali Tola*** *and* ***Aurangabad***. The geographical distance between both these areas is 3-4 km with traveling time being 12-15 minutes.

**ii. Centre II- Indore**

- Similarly, the locations selected for the mapping and *mohalla* groups were based on the residence of our key informants in mind. These localities are - ***Subhash Nagar, Nanda Nagar, Khajrana, Badi Bamori***. The geographical distance between both these areas is 4-5 km with traveling time being 15-30 minutes.

**Overview of Activities**

a) Physical and social mapping with key informants
b) Mohalla groups with key informants and their social circle:
c) In-depth interviews with users and non-users of medical abortion recruited through key informants and recruiters
d) Peer groups with users and non-users of medical abortion

| ACTIVITY | DETAILS |
|---|---|
| **Identification of key informant** | Identify women in the group to be engaged as key informants. Speak with them to set up an arrangement for the week of ethnography with a clear understanding of:<br>1. Incentive for time<br>2. Assistance with mapping<br>3. Accompaniment for part of transect walk<br>4. Introduction to own peer group, and extended community members<br>5. Arranging for meetings, if required |
| **Synthesis of findings from simulation & modification of instruments** | Evaluate insights from simulation and apply to ethnography |
| **Identification of women who have had an experience with MA in the past** | Field team pre-recruited women in the chosen locality |
| **Physical map** | Create a physical map of the locality to highlight key landmarks – residential areas, commercial areas, educational institutions, health centres, industry, recreational spaces, etc. |
| **Exploration & introduction: with key informant** | Life map – Along with the key informant, discuss and create a **life social map to** superimpose the places where the target group goes, whom they meet, topics of discussion, activities, dos, and don'ts, etc.<br>*Objective includes:*<br>● Understanding the woman's mobility and independence<br>● Ecosystem for health<br>● Ecosystem for information |
| **Exploration with key informant and people she is introducing the team to** | Visiting key places of interest where the TG is likely to congregate, to be introduced to other women and her peer group.<br>*Objective includes:*<br>Perspective for health and information for women who are in different life stages |

| | |
|---|---|
| **Home visits and discussion with women who have undergone MA**<br>**&**<br>**In-depth interviews with MA users** | Home visits to the homes of women who are contraceptive and/or MA users – primary conversation is with the woman, along with brief discussions with other members present<br>*Objective includes:*<br>● Understanding family dynamics – stakeholders, dynamics, roles, etc.<br>● Her health-seeking behaviour<br>● Expansion or contraction of the health ecosystem at different life stages<br>● Mental frames they are using for contraceptives, MA, emergency contraceptives |
| **Peer Groups** | Collective perspective – An in-depth group discussion to gather a collective perspective on:<br>Family Planning, fertility, family planning, contraceptives, abortions in the community, preferences of women, ability to take decisions, relative risk perception, perspective on MA, etc. |
| **Deep dive** | Accompaniments to all key touchpoints, pharmacy, shop, boutique - to witness interactions and to communicate with external influencers |

**Detailed Description of Ethnography Activities**

a) **Physical and Social Mapping**

- The ethnography phase of this study began with a physical mapping exercise with our Key Informants (KI), identified from the previous phase. This was followed by a social mapping exercise and a *mohalla* group with the extended social circle of the key informant to discuss information access, mobility, lifestyle and preferences, and health-seeking behavior of women in the community.
- The **physical mapping** of the localities with key informants was indicative of their high awareness of all key resources around their *mohalla* or locality, going up to the popular central marketplace i.e. the *Godowlia market (Varanasi)* and *Rajwada (Indore)*. The women interviewed were able to deliver comprehensive maps highlighting key routes surrounding their community, and various popular landmarks, and community resources and touchpoints including schools, hospitals, religious sites/monuments, restaurants, chemist shops, sports equipment shops, municipal buildings, grocery stores, etc.
- The **social mapping** was carried out in *mohalla* groups with women from the neighborhood, in an informal setting. The exercise enabled the identification of places that women visit in and around the community. This was a precursor to establishing various places in the community where women congregate and interact with one another. Shopping at the nearby market emerged as the predominant point of social engagement amongst women across *mohallas,* along with temples, as well as local grocery stores. Also, beauty parlous, schools of their children, municipal building, clinics/hospitals, neighborhood tea stalls, restaurants, vegetable vendors, etc. were cited as places where women socially interact with one other.

b) **Mohalla Groups:** Mohalla Groups were conducted across both the centres with the help of key informants. These took place with 3-9 participants, depending on the size of the KI's social circle. The social mapping was completed with all these participants who helped us identify the

key areas where women meet and interact, followed by an understanding of the lifestyle and preferences of women living in these localities.

c) **In-depth interviews (including Home Visits):** This exercise was culminated in a series of interviews with pre-identified as well as incidentally discovered (snowballing) of **self-users and non-users of MA** within the target demographic, to arrive at a detailed understanding of their subjective experiences. Some IDIs were conducted as home visits to the homes of women who were contraceptive and/or MA users – primary conversation is with the woman, along with brief discussions with other members present.

d) **Peer Groups:** Peer groups were conducted to get an in-depth group understanding and collective perspective on family planning, contraceptives and medical abortion. These groups constituted exclusively MA users, MA non-users and a mix of both.

**Observations:** Observations were carried out in some of the places where women usually meet and interact. They were both health-based, and non-health-based locations. With the help of the key informants and the women with whom contact has been established, the researchers conducted accompaniments to observe and conduct interactions with external influencers or touchpoints like retailers, pharmacists in the community. The interactions were either observed or carried out as a mystery client by the researchers themselves.

### *ANNEXURE IV: LIMITATIONS OF THE STUDY*

Some of these limitations are outlined below:

a) **Subject Matter Bias:** In the effort to be empathetic and sensitive, and to ensure that sensibilities are not compromised, it is not uncommon for researchers to take on an overtly cautious approach towards a study on the topic of abortions. Therefore, a pre-emptively cautious tonality and attitude are taken on in the course of interacting with respondents. In the past, it has been found that the actual decision to use MA itself was objective and instantaneous. It is perhaps not compulsory to place the burden of sensitivity upon respondents in order to approach the topic with a certain intensity, and instead might be advisable to normalize the concept of abortions and MA in the conversation to yield true responses. Due to the personal nature of the research subject, we approached the respondents with extreme sensitivity. However, it was found that the respondents were comfortable and at ease to discuss contraception and MA among peers with whom they felt safe and/or anonymous.

b) **Recruitment feasibility and ethical norms:** Limited sample definitions also rendered recruitment difficult to accomplish, given that women themselves, husbands, in-laws, and even medical and non-medical providers approach the issue with great caution; therefore resulted in the need to probe a target audience that was difficult to identify, and stood to be put at risk in the course of the recruitment process. Research recruitment was conducted in a sensitive manner. The research fieldwork followed all ethical processes and protocols and each respondent signed a consent form before participation in the research.

c) **Extensive contact with simulation respondents between two phases:** Given the social taboo that surrounds the topic of abortion, it was necessary to maintain contact with the Simulation respondents, to be able to collaborate with them as key informants who could use the grapevine to connect the research team with women of similar profiles.

d) **Need for multiple interactions with individual respondents due to subject matter sensitivity:** Though the ethnography phase accounts for a thorough exploration of the network of touchpoints a woman has access to when seeking to terminate an unplanned pregnancy, there was an explicit need to maintain sensitivity. This resulted in the research team has to visit and revisit respondents to discuss personal details in isolation, but to also observe the respondent in

their home environment, and to accompany them whilst they interacted with external touchpoints.

e) **Identification of recent MA users:** One of the challenges of using ethnography was that whilst users of medical abortion could be identified using snowballing in the key informant's locality, it was difficult to filter recent users from users in the past. For this reason, a small sample of recent users of medical abortion was purposively recruited from the same localities where ethnography was being carried out.
f) **Reliance on key informants:** Simulation participants were relied upon as the key informants to help in snowballing of the sample to find more women who were users of MA. However, the team had to rely on the knowledge and inclination of these women to be able to execute fieldwork. The subject matter sensitivity resulted in the team's dependence on the informants. Owing to the nature of the subject, the team was also unable to use operations expertise to recruit respondents directly.
g) **Physical strain and sample uncertainty:** The teams for ethnography were faced with uncertainty owing to the unpredictability of first, identification and then, the willingness of a user of medical abortion to participate in multiple individual or group activities. This resulted in an exhaustive process of navigating multiple localities within a larger area, with physical strain often kicking in.
h) **Community backlash:** Specifically, in localities that saw women with significantly lesser ability/agency/confidence to be mobile, and where the woman was seen to have relatively lower agency in terms of decision-making; the team faced backlash and aggression from family and community members. This was a hazard brought about by the need for the research team to revisit the same locations in order to engage women in multiple groups and individual settings.
i) **Vicarious trauma:** With a total of close to 60 in-depth interviews with users of medical abortion, the team was exposed to multiple accounts that indicated trauma, violation of consent, physical and emotional abuse amongst several others. This resulted in the experience of trauma and severe emotional distress amongst team members. Ongoing counseling was offered to team members affected within the team to sustain stability in terms of ability to investigate. Further team members were advised to seek professional counseling if required depending on their experiences and respective states of mind.

### *ANNEXURE V: INSIGHTS FROM SIMULATION-PHASE-I*

The following inferences were drawn on the basis of the Role Play that the women did during the simulation exercise. Most of these inferences were validated in Phase 2- Ethnography and hence we are sharing these as an annexure.

**a) The woman's sense of self**

***A woman's description of herself is based on her immediate ecosystem i.e. her family and children. She is intent on investing effort into 'proving her worth' and 'holding the family together' on the basis of the validation she seeks from her family.***

Across both centres, the woman's initial description of herself linked to the role she plays in the family. In an activity that required them to introduce themselves using the qualities of inanimate objects:

- Items like staplers, tape, etc. were used to describe inherent qualities of being able to 'fix problems' for family members, or to 'hold the family together.'
- Meanwhile, items like bangles, nail paint, etc. were used to describe a more **visible and tangible presence of herself** in the home – things that make her noticeable in the home and allude to her physical beauty and fondness for dressing up for the benefit of the household, particularly the husband. Here, this was a combination of her personal choices and her feeling of being noticed by members of her family.

- In rare cases, a woman picked up a pen or pencil to demonstrate her keen interest in giving her children good quality education
- In Indore in particular, several women picked up bangles for their physical appeal, and the fact that they are a key signifier of the 'married woman' – her presence can not only be seen but can be heard clearly in the home, a sign of happiness in the home.

*I have chosen a tape, which is used to join broken and torn things. I have the quality that I join relations and I give time to that so then remains joined.- **Respondent, Simulation, Varanasi***

*I have taken Fevikwik, it used to stick things. It can be used to stick relations and all those things. I also keep everyone together.- **Respondent, Simulation, Indore***

*Nail paint, I like cosmetics as I am beautician so I like all this makeup and all.- **Respondent, Simulation, Varanasi***

*I have taken bangles like the way bangles clink, the same way I am. When I'm at home the environment is more fun. Wherever there are fights I solve them with my happy mood. **Respondent, Simulation, Indore***

*I also picked up bangles. First of all I like bangles and they clink very nicely. It is a sign for my husband. Because of this people know that I am in the house and that I am coming. **Respondent, Simulation, Indore***

**b) Creating the protagonist –**

*When women were asked to create a version of themselves suited to a character in a film or a television serial, women created a blend of a traditional and modern woman – a very aspirational combination of a daughter-in-law, a wife, a mother – who has very specific interests.*

They all envisioned Kavita to **own a smartphone** – with brands like Vivo, Samsung and Mi mentioned explicitly. Interests on the smartphone included – watching videos on YouTube, using WhatsApp and Facebook, watching missed episodes of Tv serials, etc. Kavita was stated to have no more than 2 children, and in most cases was older than most of them had been when they conceived their children.

*Her age is 25 years, and she is married for five years. Yes, she has one child is of two years, and the other one is three or four years old. She is a housewife and is willing to work. She likes shopping. She likes watching movies. She also likes to go to the kitty parties and parlor. She likes to travel with her children and husband. Yes, a joint family will work. She has support from her in-laws. She is willing to work ahead. **- Respondents, Simulation, Indore***

*She likes to go to the park and she likes to eat food with her children. She loves to feed them food and teach them. She also likes to spend time with her husband. She likes to go to the temple. She also likes to watch TV and attend the Ganga aarti. **-Respondents, Simulation, Varanasi***

*All these things she does on mobile generally. She orders food and researches too. She is on job, so she doesn't get much time to watch TV. She watches the main things only on her smartphone. - **Respondents, Simulation, Indore***

*MI will be in their budget.- **Respondent, Simulation, Varanasi***

**c) Aspirations, Fears, Trust –**

**Aspirations-**

***After the birth of two children, her initial aspirations are focused on her children, with a stated feeling of achieving fulfillment through them, that they were not able to achieve for themselves***

The woman primarily associated her **aspirations** with **seeking validation for her role in the family**. Being a good mother, a trusted wife and daughter-in-law, wanting to see her children grow, spending quality time with family members. Personal aspirations revolve around for fulfilling her interests like going out, purchasing items, assuring a successful future for her children having a job, pursuing individual interests and being self-reliant

*There are infinite wishes. I aspire that I should get that much money that our family should work properly, and we should also live properly. -**Respondent, Simulation, Varanasi***

*We should be dependent on ourselves. We should be able to do something so that we can earn something for the children and husband. -**Respondent, Simulation, Varanasi***

*She wants children should grow up and study. They should become something. They should reach on a good post. The things which we are not able to do that should be done by our children.**- Respondent, Simulation, Indore***

*She wants to do something on her own.- **Respondent, Simulation, Indore***

**Fears-**

***A woman's fears and aspirations were found to be aimed at seeking validation from the family, and being 'missed when she's gone'***

**Fear** focused on three key things:

- **Being reprimanded by the family** (in-laws or husband) for doing something that is perceived as being 'incorrect' – The woman does not want to be seen as making any 'mistakes' or being 'doubted' by or rousing suspicion amongst the family. The overall feeling was that her actions should not hurt or upset any of her family members.
- **The wellbeing of children** – The fear that children will grow up to be disobedient, or not be able to achieve the success that they have envisioned for their children. Another fear was also about the safety of children in a growingly dangerous world.
- **Fear for her own wellbeing in terms of health** - In one of the simulations, the fear of unplanned pregnancy was expressed clearly as a predominant fear

*She has fear for family's health, and she should not have the third baby.-**Respondent, Simulation, Indore***

*She should not make any mistakes. She should not make any mistake because of which someone is harmed, or someone feels bad**. -Respondent, Simulation, Varanasi***

*It should not happen that unknowingly, I did some bad for someone. Later, when I realize that I did wrong with them, then we have to regret it. **-Respondent, Simulation, Varanasi***

*Her children should grow up well; they should not choose the wrong path. She is worried that her children should not get spoilt**. -Respondent, Simulation, Indore***

*Husband's fear. If she wants to go somewhere there is a fear. If she wants to talk about anything, then she has fear that it should not be perceived in the wrong way. If she wants to somewhere, then she has fear if she is late because at home she will have in-laws.**-Respondent, Simulation, Indore***

**Trust-**

***Trust is directed first at herself, in that she wants to be able to make informed and responsible decisions for herself as well as for her family***.

**The idea of trust has many manifestations**:

- *Trust in herself was stated as the most important kind of trust* – to be able to take independent decisions, without being questioned
- Trusting relationships with her partner and family, to be seen as doing the right thing, to not be doubted
- Trust and dependence on her family to care for her and to share her feelings.
- Trust and confidence on friends to be able to share her deepest feelings and emotions, without being judged and receiving advice that would be in her interest

*She has trust in her family, children and husband. She has trust in her maternal family also. -**Married,P2, Simulation, Varanasi***

*She has trust in herself. -**Married,P2, Simulation, Varanasi***

*Even if your husband is supportive, if you make a little mistake, he will say something to you. But your friend will give you.**- Married, P2, Simulation, Varanasi***

*The most important thing we should have is our husband's support.- Respondent, Simulation, Indore*

*She trusts her friend. She trusts her sister. We can't tell everything to my mother and husband, but we can explain everything to our sister. We can share our things.- **Respondent, Simulation, Varanasi***

d) **Approach to relationships or 'characters' –** The following characters were quoted as having roles to play in the lives of women:

- **Family**: husband, parents-in-law, brother/sister-in-law
- **Maternal home**: mother and sister
- **Intermittent touchpoints**: neighborhood shopkeeper, plumber, electrician, family doctor etc.
- **Friend circle**: Through kitties, at the parlor, children's friends' mothers, neighbors, etc.

We meet friends at a parlor when we go. We have friends at kitty parties.***- Respondent, Simulation, Indore***

**The Role Play**

i. **Family planning & contraceptives:**

***All women seem to have significant knowledge about methods of contraceptives – but it was found to be inconsistent. It was found that the first family planning advice offered to the woman was to adopt a method of contraception. This had led to the decision to use contraception. However, while there was some agency to influence the method choice of contraception, role play did not provide evidence of the ability to decide independently.***

- Most portrayals in the roles of various stakeholders saw the woman receiving varied advice from her mother-in-law, husband, doctor and friend. In most cases the woman said that she

would consult only her doctor or her husband regarding family planning methods. All women seemed to have significant but inconsistent knowledge about methods of. In the role of the providers, they were seen to offer specific but disparate advice about the benefits and possible risks involved in the usage of various methods.

- The first advice offered by any stakeholder was for the woman *to adopt a method of contraception* – followed by the woman in the protagonist's role having an argument with the husband to use condoms.
- At this stage, OCPs, IUCDs, Injectables and Sterilization were in the consideration set. In both centres, explicit negative effects of various contraception methods emerged including inconvenience in usage and physical harm/discomfort to the woman's body.
- In one case, through the role-play it emerged that the husband had brought OCPs for the woman and she had refused to take them because they made her feel dizzy, whilst in the other case, it was revealed that a traditional method of withdrawal/calendar method was being followed.
- It emerged that the final decision to use contraceptive methods involved the agency of choice, but not the ability to take the decision independently, without the consent of at least the husband, if not also the mother-in-law.

*MIL: I will take some medicines or I will prefer to use copper T so that it will help me to maintain my safety and my kid's safety also.- **Respondent, Simulation, Varanasi***

*Kavita to doctor: That I can manage, I will bring my husband with me next time and you also explain it to him and I am ready for the injection.- **Respondent, Simulation, Varanasi***

*You can use a condom after that she can use multi-load but don't let her use needle and all, first you know all the details by your doctor. Suppose if you want to get one another kid meanwhile then you can remove it. Use of needle can be dangerous so don't do anything without doctors advice and if you don't want another kid then you can also do operation or vasectomy procedure. - **Respondent, Simulation, Varanasi***

*Kavita to husband: If we have two small kids, there is no need to think about having one more. I don't want a third child for that we will have to do family planning. **- Respondent, Simulation, Indore***

*Husband: You can have some medicine.*
*Kavita: I cannot have any medicine I feel giddy.*
*Husband: We can use a condom or show it to the doctor.- **Respondent, Simulation, Indore***

*MIL: During our time, we had four to five children now I want you to have three. I want a boy.- **Respondent, Simulation, Indore***

**ii. Doubting an unplanned pregnancy**

- In both centres, the situation automatically progressed to that of doubting an unplanned pregnancy, as that was seen to be the key reason to bring up the conversation with many stakeholders. This situation saw the woman experiencing symptoms like nausea, a strong sense of smell, and/or having missed her period as signs of a possible pregnancy. In both centres, a week was given as the time past her due date for menstruation, as cause for alarm.

- This automatically put emergency contraception out of the consideration set, even though women portraying the chemist, or a friend recommended it as a possible way of avoiding a pregnancy.
- The woman, thereafter, was seen to go to the chemist to purchase a pregnancy test kit from the chemist by herself. In one centre, this chemist was known to the protagonist and therefore passed on the information to the husband without telling her.
- There was a portrayal of a fight between the husband and wife, first because the woman blamed the unplanned pregnancy on his irresponsibility, and then regarding her intention to keep the pregnancy a secret. Meanwhile, the woman was of the opinion that there was no cause for alarm without confirming the situation.

*While working she can feel all the pregnancy symptoms like weakness, smell. Her period has been delayed by one week. She will take a test. Then she will go to the husband. **-Respondent, Simulation, Varanasi***

*If you have missed your date, you get a feeling of being pregnant. **- Respondent, Simulation, Indore***

*The time wasted might have been more than a week. **- Respondent, Simulation, Indore***

*Kavita to MIL: We will have to think about our expenses as we go ahead. I don't know how it was during your time but I will have to take care of the child. I will have to see through the education and my husband does not earn so much. **- Respondent, Simulation, Indore***

**iii. Negotiating the decision for abortion**

- The initial stated response for course of action as portrayed by the women was to tell the husband and then to go to a doctor.
- Upon being asked if this was expected behavior from the woman in the situation, women stated that telling the husband would depend on her suspicion that he may ask her to carry the pregnancy to term.
- The husband in both cases was in agreement when involved in the decision. The woman portraying the husband was seen to check with a friend whose wife he knew to have undergone an abortion.
- In Varanasi, an ideal 'modern' mother-in-law was portrayed, as being supportive of the woman's decision to terminate her pregnancy. Upon asking what would happen if the abortion was opposed by the husband and mother-in-law, the woman said that she would not tell anyone about it. The woman was seen to try and consult with an older sister-in-law, only to be reprimanded for wanting to terminate the pregnancy.
- In Indore too, the woman said that she would not trust anyone to be completely supportive, and would go to the doctor on her own, or go directly to the pharmacist for a solution.
- In both cases, everyone except the close friend was shown to be either skeptical or vehemently against the idea of having an abortion.

*She already has children she does not have want to have one more. If the mother in law comes to know, she will tell me to give birth. The husband will also say the same thing and I don't want that. Should I tell the doctor directly? I do not understand what to do. **-Respondent, Simulation, Varanasi***

*Kavita: I do not want a child I even spoke to mummy. She also told me to do what is good for you. I don't want a child but I wanted to ask you once what do you want because it is your right.* ***- Respondent, Simulation, Varanasi***

*If the mother in law knows the daughter in law is pregnant, she will tell her to give birth. The parents are not involved in this discussion; it is the husband and wife. When the topic is over between the husband and wife, she goes to talk to her friend.* ***- Respondent, Simulation, Indore***

**iv. Choosing and carrying out MA**

- The mother-in-law in both centres was seen to be one who would oppose the woman's decision to carry out an abortion – with several reasons to explain the incident of abortion to her - including having consumed 'hot foods,' a fruit/food item that is known to induce miscarriage or the lifting of heavy objects.
- The information on MA was sought in both centres from a close friend 'who had experienced MA before.' This was supplemented by consultation with the doctor, the husband's friend, and the pharmacist.
- The woman expressed a sense of fear of having an incomplete abortion, and the possible impact the drug might have on her body. Once again, this fear was placated by the woman in the role of her close friend/sister, who told her that even if it was not complete, eventually a doctor would be able to help her.
- The chemist was found to be the one who explained the dosage and consumption of MA, even in a case where the doctor had reluctantly prescribed it to the woman

*Kavita to Doctor: Namaste ma'am! You know that I am pregnant because you have checked me earlier. I wanted to come with my husband but suddenly everyone started saying that we should not have the 3rd child. Ma'am you know that both of my kids have been caesarean. I don't want more kids and I have heard about medicine. I have one friend who has used this medicine and she was not satisfied by that, that's why there is a bit of a doubt in my mind about the medicine, and my husband, mother-in-law, father-in-law, my mom, my sister in law, no one wants that I should abort this child. I want to know this from you that is the medicine safe, and then I will use the medicine only.* ***-Respondent, Simulation, Varanasi***

*Chemist: What happened?*
*Husband: We had gone to her home but she is stubborn that she doesn't want the child.*
*Chemist: Is it positive?*
*Husband: She wants to get an abortion. She is not listening to me.*
*Chemist: Tell her do not get an abortion. I have medicine give it to her and tell me after she has it. This is a medicine give it to your wife for 5 days and after 5 days the abortion will happen. If it does not happen after that and there is a problem, you can consult the doctor.-****Respondent, Simulation, Varanasi***

*She will go to the medical store or I will take my friend and go to the doctor.* ***- Respondent, Simulation, Indore***

*Chemist to husband: Take this medicine the medical person said that it will clear all there will be no problem caused. There is no need to go to madam now. If its been 15days or one month have been passed then it was necessary to go to her but now if you take this medicine then it will get clear.*
*This means there are 4 pills small ones. Two are big ones, so these 2 pills which are small and one big you have to eat together means there is a slot of 3-3 and you have to take it for 3 days. -* ***Respondent, Simulation, Indore***

**v. Dealing with complications**

- In the process of administering MA, all other stakeholders took a backseat, whilst the woman cross-checked with her friend about expecting bleeding, nausea and some pain.
- Consistently, the panic set in if the bleeding duration exceeded the normal duration of menstruation, or if the bleeding was taking place in clots. At this point, the woman was compelled to share this state with her friend, and then her husband. In spite of discord between the husband and wife, the woman stated that she had no choice as he would be the one to support her financially and physically if she were to become ill as a side effect of using MA.

*After five days, her periods occur. Normally for us, it comes for four to five days. But I am bleeding for a week now, so I have a doubt in my mind. -****Respondent, Simulation, Varanasi***

*There is a small amount of swelling in the body. There is a pain in the stomach and loss of excess blood which you get to see in parts so by that. You feel that why is this happening and I should meet the doctor and I would talk to my parents. So there are many such doubts in her mind. .-****Respondent, Simulation, Varanasi***

*There would be continuous bleeding, feeling unconscious. If the bleeding does not stop so I would feel that it is too much. There is blood coming out of it so there is also that tension what if it remains inside then what would happen. -* ***Respondent, Simulation, Indore***

*If the bleeding does not stop till seven days and happens more than that, you need to visit the doctor once. -* ***Respondent, Simulation, Indore***

***ANNEXURE-VI: DETAILED UNDERSTANDING OF THE STUDY CENTRES FOR PHASE 2***

**Community Profile (Varanasi & Indore)**

A small spectrum of demographic profiles appeared to emerge across the locations visited in te second phase of the study.

- **Chetganj (Varanasi)** appeared to have a higher socioeconomic profile of residents overall, with rented and self-owned houses- one room or more, and a kitchen. In some cases, the family lived in even two floors. The area constituted a mix of working and non-working women, a combination of joint and nuclear family structures, and it was here that the greatest number of families supporting the employment of the daughter-in-law were found. The community structure was reported to be dominated by Hindus of all castes and economic strata. Employment in the area spanned individual business owners, shop owners, and jobs in local organizations.
- In **Aurangabad (Varanasi),** the socioeconomic class appeared to be lower than Chetganj, with rented and self-owned houses, having one room or more, with a maximum of two-three floors maximum. The respondents stated that the locality housed a mix of Hindu and Muslim Households. Here women stated that the shops were mostly owned by Muslims who do a lot 'weaving/machine' work.

- **Khajrana (Indore)** appeared to have majority of Muslim respondents and the socio-economic class appeared to be lower to Subhash Nagar and Nanda Nagar. The respondents stated that the locality housed a mix of Hindu and Muslim Households. Homes are 'pucca'/ 'cemented', bare-brick, closer together, single floors or two-story at most, single bedroom homes. There was a mix of nuclear and joint families in the area living mostly in their self-owned houses together or next to each other.
- In **Bengali Tola, Madanpura** and surrounding localities, women claimed that the community constituted a large proportion (more than half) of migrants living as renters in the homes of local homeowners, resulting in a lot of social interaction across strata. Entire families were seen sharing one room or two at most. Most buildings in this area are located close together, having 2-3 floors – with owners renting rooms to multiple migrant families. The women claimed these migrants belong to Bihar, the South of India (Tamil Nadu) etc., as well as exclusive enclaves of Muslims indicating a mix of all communities.

***ANNEXURE VII: FROM ETHNOGRAPHY - UNDERSTANDING THE P2/P2+ WOMAN & HER UNIVERSE BETTER***

*This annexure examines the life of a P2 & P2+ woman, in terms of her sense of self, her lifestyle and preferences alongside her internal and external relationships.*

**a)Her Routine**

***A woman's maximum time is spent attending to her family and their needs.***

***Most women reported having to maintain regular schedules and regimented lives, built around their families.***

They said that they begin their day early in the morning and prepare food for husbands, children and any other family members. Once the husband and children have left for their day, the women claimed to have some free time. They said that they spent this time to relax, rest, entertain and connect with friends & family. When the children return in the afternoon, they get back to providing food and helping them with studying, and completing their household chores, before their husbands return in the evening. Across centres watching videos of recipes, dance steps, chatting with friends and relatives or watching serials on TV/phone or just taking a nap while the home is empty, was considered acceptable utilization of free time. '*Dhoop sekhna*'/ 'basking in the sun' (during winter season) with women in the family and neighbors also has dedicated time in their daily routine and was mentioned as an enjoyable activity.

*I wake up in the morning. Then I wake my kids up and make breakfast. Then send the kids to school and make lunch. Then after taking bath I do prayers. After bathing and doing prayers, I make breakfast for my husband and mother-in-law. Then when I am free in the afternoon I rest for some time and while resting I watch movies. Then I watch serial in the evening-* ***Married, 30 years, P2,MA User Chetganj, Varanasi***

*I get up in the morning and do all household chores. I take a shower, do puja and all then make some breakfast, husband and children leave the house at 9:00. I use the phone in free time then. -****Babli Devi,35 years, P2, Non- User, Chetganj Varanasi***

*So I wake up at 6:00 in the morning. I collect the drinking water and I do daily rituals like brushing teeth, taking bath, freshen up and everything. So once that is completed I do my prayers, I clean up kitchen prepare tea. Then I wake the kids up and I prepare the lunch for them I make them bath that I do it for both of them. I prepare their dress and everything. I serve them "Curd-paratha", Tea-Bread and then once kids go to school then I prepare lunch for my husband. He takes lunch with him. Sometimes he takes lunch and sometimes not. It depends as he also likes to have food outside. And also there is some household work which I do till 12:00. I finish all my household work till 12:00. I get free*

*that time only. And then I listen to songs or I sleep for some time and I watch TV as well it depends.* ***Married, 34 years, P2 Repeat MA User, Nanda Nagar, Indore***

*I like to sleep when I am free.-* ***Married, Mohalla Group, Chetganj, Varanasi***

**b) Interests, Hobbies, and Passions**

***Most women prefer to spend their solo time by sleeping for a short duration when nobody is home or browsing the net on a smartphone if they own one.***

**Spending 'free' time:** When asked about 'free' time the women said that they spent it resting or sleeping uninterrupted for a short duration when nobody was home. They explained that they work all day at home. When nobody is at home, they prefer to unwind and get some rest. The most common response in addition to this was the fact that they spend their solo time browsing a smartphone if they own one. This includes talking, chatting, playing games, and watching videos. The respondents mentioned several hobbies. Interests shared by women range from cooking various kinds of food, talking on the phone, 'chatting' with their friends/family, dancing, traveling within the city, and for some, traveling outside the city. In addition, a few also mentioned an affinity for reading and reciting poetry. In Indore most of the women expressed similar interests, hobbies and passions. The few interests that stood out were listening to music on phone/TV/Caravan, spending time on *Tik-Tok app*, going to have evening snacks.

*I use my phone. I see videos on YouTube otherwise my son uses it.-* ***Married, 30 years, P1 User Chetganj, Varanasi***

*I do tailoring work. I get free till 4 o'clock so then I go to market.-M****arried,30 years, P2, MA User,Chetganj,Varanasi***

*When I get free in the morning after preparing the Tiffin for children, husband and after doing all the work I use the mobile till I have to go to the bath, the water is heating up, so I use the mobile for a little time, I check the WhatsApp messages on it and reply it to everyone. -* ***Married, P2 , MA User, Subhash Nagar, Indore***

*I love listening songs. Whenever I am doing any work I simultaneously love listening songs on my mobile. I listen online as well as I have "Radio Mirchi" and I also have 5,000 pre-downloaded songs in a tape.* ***Married,34 years, P2 repeat User, Nanda Nagar, Indore***

**c) Purchase Behavior and Brand Preference**

***Purchase habits of women are dependent upon price, distance of purchase and their mobility. Women clearly have a brand preference but lack 'name recall value'. The purchase of fringe items (non-necessity) is limited and occasional.***

*i.* **Dependent on distance and mobility:** Preferences of products and places of purchase for most women across communities was reported to be characterized by the ease of access to the point of purchase, and their individual levels of mobility.

*ii.* **Walking distance for smaller needs:** Most women stated that they purchase smaller grocery items from a nearby store, whilst in most cases the entire month's ration would be purchased from a single store. In some cases, especially in *Chetganj(Varanasi)*, the women made these purchases themselves.

*From nearby wholesale shops and by chance when I get time then I buy from Big Bazaar as well. On Wednesday, there is Big Bazaar there sale so that's when I shop from there.* ***– Married, P2 user, Chetganj,Varanasi***

*iii.* **Price consciousness reigns supreme:** Quantity and variety of purchase of items for themselves, their families and their homes are driven by cost-effectiveness, and the ability to spend money. Most women in both the centres mentioned the fact that things have become very expensive, and that they have to be careful with their purchases. There was also an observable sense of pride in being able to demonstrate frugal purchase behavior, and in finding the best deals from sellers.

*I go if there are any offers. My son Krishna sees the offers of Big Bazaar and he tells me about it. If there is an offer in which if you shop for worth Rs. 750, you will get Rs. 150 off, So I availed that and saved Rs. 150 that way.-* ***Married,30 years, P2, User, Chetganj, Varanasi***

*There is a place called Godowlia or Big Bazaar as if I have to purchase something. It is in Sigra. Jackets, Kurti, Dresses, tops, these things and then the shoes.* ***-30 years, P1, User, Chetganj, Varanasi***

*iv.* **No specific brand preferences (except smartphones) Vs Specific Brand Preferences:** Women in Varanasi, while aware of multi-branded shopping outlets like malls, preferred open markets over single-branded goods. For instance, the *Gadoliya* crossing market is considered a one-stop market for everything from clothes and makeup to groceries, medicines, childcare needs etc. In Indore, Rajwada market is considered the most important market to go out with family, friends and neighbors to meet their shopping needs. But apart from smartphones women **do have brand preferences** and are **brand-conscious** in terms of the brand of their TV *(Samsung),* a sanitary napkin *(Stayfree or Whisper*), shampoo etc.

*v.* **High consumption of cosmetics, but limited brand recall and knowledge:** Sporadically, a few brand names were mentioned – For example, makeup brands like 'Oriflame','Lakme', 'Vaseline' or 'Nivea' came up occasionally (*mentioned by the women to demonstrate their knowledge on the subject)* but predominantly, they claimed that it was the simply the product that would appeal to their taste, and not the brand. But it clearly reflected the affinity they start having towards a particular brand after experiencing the quality of the product. Without any realizations or acknowledgments of the brand tenets they get converted into loyal customers.

*There is eyeliner of Blue Heaven. I have taken better brands then it but it doesn't suits on eyes.-* ***Married, Mohalla Group, Nanda Nagar, Indore***

*I use Vaseline or Ponds also but sometimes.-* ***Married, Mohalla Group, Nanda Nagar, Indore***

*vi.* **Sanitary products:** As for sanitary napkins in Varanasi, the women recognize their choice of product by colour (green, orange or blue) than by brand name. **Even though these women have considerable levels of individual mobility, sanitary products were generally purchased by their husbands.** On the contrary, women in Indore prefer to buy sanitary napkins on the **basis of their brand names** like '*Whisper'/ 'Stayfree'* rather than based on their color. They hold better knowledge about brand names and what they like or do not like. Sanitary products were generally **purchased by women** and not their husbands from malls, chemists and general stores. Intimate hygiene products like 'V wash' etc. are only used in case of an infection.

*We tell him (shopkeeper) the name that gives us Whisper or Stayfree.* ***Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*I go to the purchase pad and all. I ask him to give pad and they understand and give it to me. No, we don't talk because they know us and we are their daily consumer. I mean, we purchase stuff of ten days or 15 days or for a month at the same time. He knows we require this much ration every month or so. As all of them understand this is  and that is why they don't ask.* ***– Married, 28 years, P2 Woman, Non User, Chetganj, Varanasi***

*I buy sanitary napkin from grocery store or else from the general store and if there is lady is there so we ask her which one is good and if gents are there so I just tell them to give Whisper.* ***Married, P2, MA User, Subhash Nagar, Indore***

*I use it for three to four days, there are limited pads in a Whisper pack, it is very good.I buy it a large quantity from Ranipura. I have bought one dozen packs from there, so due to that I get low rates.  It also ensures I will also have it in my stock.* ***-27 years, P2, User, Nanda Nagar, Indore***

*I buy it from the medical. Nowadays it is normal so I buy it by myself. I use Stayfree Secure. First my husband used to bring and now I am bringing it. Sometimes while he is returning home I call him and tell him so he buys it from a chemist  nearby his office.* ***- P2 Woman, User, Kalyani Nagar, Indore***

**d)Technology Access & Usage**

***Almost all of the women own and know how to use a smartphone and are assisted by children (or husbands) to learn how to operate it. The 'voice assistant' feature has made navigation easier and faster. Apart from Google, Youtube and Tik-tok, applications are also used  for social networking, e-commerce and food ordering.***

Most of the women across centres own personal smartphones that have been purchased by their husbands, with the exception of a few who have purchased phones on EMIs.  The phone usage is not restricted to just themselves and extends to their children as well. In several cases, the knowledge and ability to try and use new applications were reported to come through slightly older children (aged 8 and above).

- In both centres, the most common brands of phones that emerged were *Mi, Oppo* and *Samsung*.
- The usage of technology in Varanasi was mostly occurring using the 'voice assistant' feature which they use to search videos on YouTube, or for search results on Google.  YouTube is the one app that every single woman uses. The majority of the searches were for food recipes, design styles for suits/blouses, dance steps, cartoons *(Doremon*) for children, and design inspiration for children's school projects – all carried out using the voice assistant feature or in rare cases via typing. In Indore, there's an equal set of women that use the 'voice-assistant' and 'typing' to search things on Google/ YouTube. Interestingly some of the women in peer groups also mentioned that they use Google to find out about home remedies and to check the details of some of the medicines prescribed by the doctor. The majority of the women use technology to get information related to child education, possible areas to explore their hobbies and work she does, food recipes.

*If there are difficult words then we use voice command and if it is easy then we type also.* ***Married, Mohalla Group, Nanda Nagar, Indore***

- There seems to be a relatively smaller number of women in Varanasi who use Google to access and gain information about anything in particular. Those who do, generally look for information related to videos they are looking for, or about medicines, any topic they want to know more about, places to eat nearby, shopping places, etc.
- Every woman of Varanasi and Indore is active on WhatsApp and they predominantly use it to send 'good morning' messages or to share pictures/video/forwards etc. They have also started using it to upload statuses. Most of the women have a Facebook account (upload pictures and statuses) and if they don't use it, then their husbands or their children are active on it.

*Food-related or whatever that I find interesting. I scroll down and watch videos of food dishes. You can type it or you can directly say it in the mic that you want to know how to cook paneer dishes. I don't see just one dish I watch at least 2-3 dishes videos and then I make one from that. I have made a lot of things.* ***– Married, 35 yrs P2 Repeat user Varanasi***

*Yes. It's my personal phone. My husband bought that for me I watch videos. There is Facebook, WhatsApp, and whatever chatting things are there that I do. I post my photos rarely but I post my kids pictures more often. On YouTube mostly I browse cooking stuff..* ***-Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***

*I use WhatsApp, YouTube, and Google. It helps me to educate children, like if they do not understand anything then I search on Google and explain it to them. I like to teach my children.* ***Married, 28 years, P2, MA User, Chetganj, Varanasi***

*Yes, I know how YouTube works. I watch cooking videos and all on YouTube. If I can't write English or find it difficult at that time I record it (voice assistant). If we are writing something like a name after writing half we can see the full name (google prompts). So, we just need to click on it.* ***-Married, 34 years, P2, Repeat MA User, LIG Colony, Indore***

**Applications Usage**

*i.* **Video consumption:** Apps like *JioTv* and *Hotstar* are widely prevalent to catch up on missed episodes of TV shows and with the perk of watching them at a time convenient to them. Interestingly one of the respondents in a Mohalla Group in Indore mentioned about *Netflix and Prime* as a medium of video consumption. The majority of the women are still confined to using YouTube, Hotstar and Jio Tv.

*My son also runs the Jio TV app. There is an app called Hotstar where I watch my serials.-****Married, Mohalla Group,Chetganj, Varanasi***

*I check things on YouTube for healthy breakfast and all. Mostly I check out Shilpa Shetty's videos of making these all recipes. She always has something healthy to tell like Oats and all I have learnt it from there only.****- Married, 34 years, P2 Woman, Repeat MA User, Nanda Nagar, Indore***

*I just open the YouTube and we can say or it comes automatically.* ***-Married,35 years, P2 Non User, Chetganj, Varanasi***

*ii.* **E-Commerce:** *Amazon, Flipkart, Snapdeal, ShopClues* and other shopping apps (*First cry* also came up) are installed but are used mostly by the husbands of women living in Varanasi or in some cases by their children for making purchases like watch, lipstick, phone etc. In some cases, the women claimed they ordered themselves, with the 'cash on delivery' option. *Amazon*

and *Flipkart* were the only apps mentioned repeatedly by the women respondents of Indore. These apps were predominantly used to buy household items and electrical appliances (ordered by both the women and their husbands) and not to buy clothes. There is a lack of trust in these apps in terms of the color or quality of clothes they will receive. Due to the same apprehension they prefer to buy clothes from the market directly.

*We use Shopping apps like Amazon, etc. Sometimes for me and Babu (child) my husband does the online shopping because he doesn't have time. My husband just asks me to select from his phone. He has got an account, mine has no account.- **Married, 30 years, P1 woman, MA User, Chetganj, Varanasi***

*My child ordered a Milton Company water bottle online from Amazon .- **Married,30 years, P2 Woman, MA User, Chetganj,Varanasi***

*I haven't recently ordered online anything yet because I don't trust online things. Once I had ordered Kurta through Amazon. It came in a very small size. Since then I prefer going to store for checking things on my own to buy.- Married, **34 years, P2 Woman, Repeat MA User, Nanda Nagar, Indore***

*iii.* **Payment apps:** There was no usage of payment apps in Varanasi. In one case, a woman expressed her husband had Google Pay but he doesn't use it anymore. There was also a limited understanding of payment apps amongst the women. In Indore, payment apps like Paytm and Phone pe are all used by the husbands. Some of the women expressed their desire to learn how to use these apps for their own convenience and knowledge.

*He has Paytm and all, he pays the bills and recharges the mobile also. **Married,30 years, P2 Woman, MA User, Chetganj, Varanasi***

*iv.* **Food delivery:** *Swiggy/Zomato* tends to be used occasionally by the husband or children to order Burger/Pizza – food that is not typically prepared at home. Most of the women in Indore were aware of *Swiggy and Zomato*. A few also mentioned about *Uber Eats*. Some of the women use *Swiggy* **independently** or with the help of their child (8years or above) to order food. Most of the women are still dependent on their husbands to use the apps to order food for the family at home.

*I order mostly from Swiggy. Before it was Uber. Now it is Swiggy. **Married, Mohalla Group, Nanda Nagar, Indore***

*I have downloaded it but I don't use it. My nephew uses it. Both Zomato and Swiggy. **Married, 35 years, P2 Woman, Repeat User, Varanasi***

*Zomato is there which my husband uses. He prefers to eat pizza so we order that only. No, husband orders from it. We order from Rajesh Sweet House, food is good there. Its quality is good. – Married, **P2, User, Chetganj, Varanasi***

*Yeah, I order for Dosa and all from apps.- **Married, 28 years, P2, Non-MA User, Chetganj, Varanasi***

*v.* **Other applications:** The usage of applications for gaming like *Candy Crush*, or *Google Maps* for navigation, *Ola* for long-distance travel, photo editing apps, *Tik-Tok* for entertainment and *E-Rail* for live train tracking were mentioned across the groups in Varanasi. In Indore specifically, *Google Maps* emerged as a popular application for navigation. Women used

*Google maps* to go to nearby places and find out routes to the locations. Earlier, playing the popular 'Snakes' game on a keypad phone was something women showed a fondness towards.

*My daughter uses TikTok also and she makes videos on it and shows how many likes she got she has made an id with my name.**-Married, P2, Mohalla Group, Varanasi***

*Yes, my daughter studies from this itself. If she wants to take something from Google, then she uses it. My sons, he keeps on watching anything.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Children have now downloaded TikTok so I watch that to have a little fun.-* ***Married, P2 Woman, Subhash Nagar, Indore***

*Like all my sisters and my mother are there in the group in one group and there is a different group of aunties and then another family group is different. I like to do WhatsApp.* ***Married, P2, Mohalla Group, Varanasi***

*We wish a good morning to all on WhatsApp. I watch, like and share on Facebook.* ***Married, P2, Mohalla Group, Varanasi***

***ANNEXURE- VIII: HEALTH AND NON-HEALTH PROVIDER TOUCHPOINTS BASED UPON THE OBSERVATIONS/ACCOMPANIMENTS***

Observations were carried out in some of the places where women usually meet and interact. They were both health-based, and non-health-based locations. In some observations, researchers took the role of participants themselves to understand the dynamics better. In other cases, the researchers' role was of the researcher (an objective outsider) itself. These interactions were later matched to check the consistency or variance of observations that women have spoken about in their IDIs. It is essential to note that women in Varanasi refused to accompany the researcher for accompaniments to nearby medical shops, general stores, etc. and only a few women from Mohalla Group in Indore accompanied the researcher to nearby general stores, saree shops etc. but not to chemists.

**Varanasi Observations-**

- **Government hospitals (Researcher as participant) -** Two popular hospitals namely *Marwari Hospital* and *Hindu Sewa Sadhan Chikitsalya*. Both the hospitals are two-story buildings with all kind of facilities available inside like small rooms for each kind of doctor. General ward, private rooms etc. There is a 24-hour chemist shop inside both the hospitals.
- The 'parcha' (consultation fee receipt) for consultation is for Rs.10 and the room no. where the doctor sits is mentioned. This paper is then taken to the respective doctor. There are 2-3 'lady'/female doctors that's it in both the hospitals. All the doctors have one compounder who sits next to them for taking weight and filing up a regular register. The waiting area is outside the room where the doctor sits and is jam-packed. Doctors are well-educated are soft-spoken and give appropriate time to each of the patients. The only drawback is that they sit for a certain number of hours in the hospital like (morning -5 hours) and the rest of the time only emergency doctors are available. In some cases, they mentioned married/unmarried above the prescription and also advise for appropriate tests that should be taken to understand the ailment better. The facilities and the doctors both are above satisfactory otherwise. The hospitals are located at a central location. One hospital had a small temple-like place with a pandit sitting there to conduct rituals.
- **Private Clinic-** Private clinics are located in all *mohallas*. **Akanksha Jain's** clinic propped up in many IDIs and hence was visited. The clinic is situated at the main road and is always full

of patients waiting (minimum waiting is approximately 30 minutes to one hour). Inside there is a waiting area, a counter where the prescription is made (for Rs.200), another counter for medicines and the main room where the doctor sits. The main room also has a waiting area for patients up to 5 and there is no divide between this area and where the doctor sits (basically these in-line waiting patients can hear all the conversions between the doctor and the patient). There is no one-on-one privacy the patient has with the doctor. Posters of Dimpa and 'sex determination being a crime' were pasted across the waiting room.

- Dr. Akanksha Jain is a middle-aged well qualified, soft-spoken and non-judgmental doctor who gives the apt amount of time to understand the patient and their grievances well. There is a sense of comfort which she establishes with the patient that leads to open communication. The doctor also prescribes a set of tests that can be taken to understand the ailment or condition of the patient better.
- **Medical Shops:** Most of the medical shops happened to provide the MA kit with all set of instructions that need to be followed during and after consumption. The providers were all middle-aged men and one of them even offered to click a picture of the kit we plan it to procure later on. For those who didn't offer it either said they don't provide it/it's illegal/another shop recommended. There was a sense of inconsistency in a few shops that women mentioned offer MA pills and, on our inquiry, refused to give it to us.
- **Abortion Centre (Researcher as a researcher) Mukti Abortion Centre:** is also located in a market area. There was a huge patient waiting room with a dividing door that separates the doctor's room into the waiting area. On inquiry, the doctor was busy in OT and even asked about the credentials of the researcher to make a conversation. It is believed that the doctor wasn't willing to speak to the researchers and trying to ignore them altogether. There were large boards with the kind of services offered and the abortion charges (Up to 2 months- 400,3 months-1200, 4 months- 3500 and 5months-4000)
- **Parlor:** Small one-room sized parlors are located within these *mohallas*. They provide services to all age groups of women ranging from students, middle-aged women to old women. There is a sense of free-flowing of conversation about MA and other things in these safe spaces. One owner even opened up about her MA experience and also discussed how other women openly talk about it over here. It is believed that the sense of comfort the owner provides also is correlated to the kind of conversations that happen over there.
- **Mobile Shop:** A young (estimated the mid-late 20s) aged boy was sitting in a small counter as mobile shop visit. He provided information about all the trending smartphones (Samsung is the most selling followed by Oppo and Mi) and the identity proofs that are needed to purchase one. EMI options are available in most of the shops and women tend to buy nice trendy colors available.
- **Private School:** Bright English Private school situated on the Chetganj main road is one of the most popular schools of the area. The principal gave a tour around the school and explained how all sections in terms of economic class opt for their school (they even have students studying for free/subsidized fee). The monthly fee of the school ranges around Rs 800-1000. Most of the mothers in Chetganj area spoke highly of the school and on observation it appeared to be a good school with full facilities and amenities available to the students.

**Indore Observations-**

- **Medical Shops:** After doing 6-7 chemist observations both as participants and researchers, the consistent finding came out to be that MA pills are 'banned' by the government because they are being 'misused'. '*DM sir ke orders hai'.* These chemists also recommend the women to go to the doctor as she might help her better (will give pills or write a prescription). Those who are

offering the kits were charging a higher price (Rs.550 for an Rs.409 pack) and those who are not selling are selling an alternate ayurvedic medicine for the same.

- **Parlors:** Small one-room sized parlors are located within these *mohallas*. These parlors also sell sanitary napkins, beauty products and undergarments. They provide services to all age groups of women ranging from students, middle-age women to old women. Women are really conscious about their beauty and want to be up to date with time.
- **Private Clinics:** Private clinics are located in the middle of residential areas. Saroj Nursing Home propped up in many IDIs and hence was visited. The clinic is situated in a residential area. Inside there is a waiting area, a counter where the prescription is made (for Rs.200), inside there is a shop for medicines and a doctor's cabin. The waiting area is spacious and up to 10 patients can wait in the room. There is complete one-on-one privacy the patient has with the doctor. Posters of *Dronis (*Dronis 20 Tablet is a combination medicine used for oral contraception (prevention of pregnancy). It is also used for the treatment of acne vulgaris in women who desire oral contraception) are placed in the doctors, cabin and a side curtain area where doctor checks the patient. The doctor is patient, soft-spoken and attends the patient with full patience. All of the nurses wore pink uniforms and communicated with ease.
- Dr. Kalpana Jain middle-aged well qualified, friendly and non-judgmental doctor who gives apt amount of time to understand the patient and their grievances well. There is a sense of comfort which she establishes with the patient that leads to open communication. The consultation charges are Rs.400 which she herself collects from the patient directly. The clinic is small and there is a large waiting area (which is always full). Husbands generally waited outside and they prefer buying medicines from the shop next door to the clinic. After purchasing the medicines some of the women even go back to the doctor's compounder to get them verified and know about the doses. One of the patients also asked a researcher the fees of the doctor while they were leaving the clinic. There is a no standard fee board inside the clinic but a print of certificate that says that the doctor is certified to recommend MA.
- **Undergarments Shop:** All of the undergarments shops in Indore had male staff. They were attentive to all the customer needs and didn't have any apprehensions. The women customers were easily sharing the colour, sizes, designs etc they wanted to purchase. The researchers were acting as participants while visiting these shops and were attended very well by the salesman.

***ANNEXURE IX: DETAILED UNDERSTANDING OF CONTRACEPTIVE AWARENESS AMONGST P2 WOMEN FROM PHASE - 2***

a) **Condoms:** Most women in Indore & Varanasi had a preference for condoms as they are **easy and reliable**. Some had their apprehensions that it is harmful to the women's body, issue of procurement, issue of disposal, forgetting at times, embarrassment of purchase and use, etc. Husbands are the only ones to procure them. There are days when either of the parties decides not to use it. There were also instances when some women told that now it's shown in TV ads as well. There were fears regarding the chances of the condom breaking or bad quality of condoms not working out.

*I feel condoms are the best method so that females will not get any disease due to it. There are no side effects of it.* ***Married, 30 years, P1, MA User, Chetganj, Varanasi***

*I was afraid that if something from it (condom) goes inside my body, then it will permanently stop my pregnancy. It might tear so that may get me pregnant.- Married,* ***P2, MA User, Subhash Nagar, Indore***

*I have heard about it but have never used it. It is because my husband feels that who would bring it and throw it. The biggest worry is where to throw it.* ***Married, P2, Peer Group, Chetganj, Varanasi***

*We were only using a condom. We didn't face any problem. I used to have some hesitation that something might happen. No. he used to not feel that. I was the one who used to feel that.- Married,* ***P2, MA User, Kalyani Nagar, Indore***

*We have used a condom. Apart from that I've never had a tablet or any other medicine. Till today we use it. I have seen it in movies, also my friends' marriage happened before me. she didn't tell anything. I saw this in movies etc. When people started talking about it, then mother-in-law said it's been a long time.-* ***Married, 30 years, P1, MA User, Chetganj, Varanasi***

b) **Copper-T:** Copper-T or what women in Varanasi 'Freedom' ( name of the brand) is another popular contraception method women in Varanasi opt for, but this is only after they've had the second child. There was a mixed set of responses as it suited some women while others faced a set of complications like bleeding, discomfort, etc. The respondents said that in case it suits, it should be preferred. Doctors even recommend this and so do other elder women/ friends like MIL, Bhabhi (sister-in-law), Didi (elder sister), friend, etc. None of the women respondents in Indore showed an affliction towards opting/positive opinion for Copper-T. There seems to be a large set of inconsistencies related to the side effects of using it – primarily fear of inserting devices into the body or negative experiences of other women opting for it.

*Copper T is also used. It has a validity of four to five years. One of my friends used it, but one's body shape change, the body becomes wide and the body becomes loose. I told her why you don't remove it, I told her she looks weird and fat, but she is comfortable with it, that is she never removes.-* ***Married, 35 years, P2, User, Subhash Nagar, Indore***

*I have heard about it recently. My sister used it for 3 or 4 years. My friend told me that it results in blood loss and weakness. So I didn't use it. She heard from her mother that there are problems with Copper-T. She had a fear and so she suggested me not to do it. Her husband told her to do it.-* ***Married, P2, MA User, Mansab Nagar, Indore***

*In government hospitals it is called Copper T and in private it is called Multiload. My sister in law daughter used it. It suits some people and it does not suit some. Some of them remove it and some of them use it. If you use it you either put on weight or lose weight.-****Married,35 years, P2, Non User, Chetganj, Varanasi***

*When my first child became six years old, my mother brought medicine because I didn't want to have another child at that time. Now, I use the Copper T .-****Married, P2, Peer Group, Chetganj, Varanasi***

c) **Oral Contraceptive Pills (OCP):** Predominantly used for spacing between children, many women expressed skipping the '*big black tablet'*. There were mixed set of responses as respondents claimed that it has worked for some and didn't work for others. There seems to be not any massive reliability on these pills. Women have mostly heard about them from elder women who have been using/used and is inexpensive as well.

Oral Contraceptive pills are not essentially being used for spacing but as a preferred contraceptive method by women. Generally, they are preferred in cases where the men were too shy to procure a condom, due to fear of it tearing or lack of consensus between the husband and wife. Tablets like Mala-D is interchangeably used with Mala-N. There were some women who complained about the quality of Mala-D and Mala-N. One woman respondent also showed a bottle of a birth control pill named 'DUOLUTON L' which she believed is of superior quality (in terms of effect, lower side effects and overall success) to Mala-D. The only worry mentioned consistently by OCP users was the 'fear of missing the dose' or 'lack of availability' in cases when they don't have access to the pills.

*As there are 21 tablets inside it and seven tablets are given in black color type. They are dark brown colored. They say don't eat it. They say you should eat it during periods so we don't eat it.* ***Married, P2, Peer Group, Chetganj, Varanasi***

*There are other contraceptive methods like Mala D today and all that. Nowadays, ladies are very much intelligent. It is not like they do not have information about it. Everybody knows about contraceptives methods. Those who do not think much about it I cannot say about that people.* ***- Married,28 years, P2, User, Chetganj, Varanasi***

*Mother told me about Mala D but I felt it is not good. Suppose I forget to take the medicine then so all that fear I had every time.-* ***Married, P2, MA User, Chetganj, Varanasi***

*To have a gap between children. I have heard about Mala D. They show it on TV. My uncle's younger daughter- in- law took me to the doctor and she also used to eat. She consults the doctor and then has the tablet.* ***-Married,30 years, P2, User, Chetganj, Varanasi***

*You have to eat it every day and it will have 21 tablets for 21 days. Then there are the 7 black tablets to ensure periods start. I took only 2 leaflets not more than that because I used to feel giddy and it wasn't suiting my body. I used tablets between 2006 to 2010 then I shifted to condom.-* ***Married, 26 years, P2 User, Mansab Nagar, Indore***

*Ads used to come on TV 'Mala- D Garbh Nirodhak Goli' and there were many other brands also, but I don't remember their names. Mala- D was more popular at that time. If we went to the doctor, she prescribed some other pills. -****Married, P2, User, Subhash Nagar, Indore***

d) **Injectables:** The knowledge of injections gained by women is mostly from the doctor and in rare cases via word-of-mouth. The women across centres thought that it was a good option but there was some level of scepticism involved with opting it as a contraceptive method. This scepticism is due to various myths and misconceptions regarding the ability to conceive after using injectables. A few women stated that the normative fear from the needle demotivates them to opt for this method. There seems to be a prevalent fear that the effect of an injection cannot be reversed if need arises and can therefore lead to fertility issues.

*If the injection doesn't suit her, then it can't be undone immediately.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*There is an injection for not having a baby. My aunt used it after having her first baby. Yes, her periods became irregular. Condom is better. Injections it is very harmful.- **Married, P2, MA User, Mansab Nagar, Indore***

*I have heard about the 6 months injection. One of my relatives used the injection and it was successful and she told me about it.-Married, **26 years, P2, User, Mansab Nagar Indore***

*I thought about it but I was afraid of what happens if it fails or has negative effects on the body and it's a needle.**-Married, P2, User, Subhash Nagar, Indore***

*I have heard about them taking injection. An injection in which you can have a gap between two kids for one or three years. When I had gone for an abortion my doctor told me about this injection. My mother's sister's daughter in law had taken an injection and because of that she died. **-Married, 30 years,P2, User, Chetganj, Varanasi***

*I have heard about Antara injection, and it suits some, and it doesn't suit some ladies. Some get periods even after using it. It suits some so it is fine, but if it doesn't suit you then don't. **-Married, 28 years, P2, User, Chetganj, Varanasi***

*Yes, I used to take injection for a long time. Rachna Madam prescribed it to me. I took injection for 6 months due to that my body started swelling. I used to have sour burps. Still I continued it for 3-4 years as I had to take it every 6 months. **-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

*Nowadays there are a lot of options for family planning but injection one is best for me but when I consulted the doctor she told me that there are problems due to injections that MC stops due to it and then ladies create problems. Due to it so the doctor suggested not to use injection but go for Copper T. I said no I am scared of Copper T. **-Married, P2, Peer Group, Chetganj, Varanasi***

e) **Emergency Contraceptive Pills (ECP):** The ECP does not make it to a woman's consideration set at all across centres. In the process of asking about a woman doubting an unplanned pregnancy, the discovery of the pregnancy itself was seen to be made after 1 week of missing menstruation, thereby eliminating the 72-hour window altogether. Though some women did bring up the ECP, they were unsure of its use and tended to confuse it with MA (abortion pill). There's also a belief amongst women that ECPs cause extreme bleeding and are predominantly consumed by unmarried women. There was a case of exception where a woman had a negative experience with ECP and showed a clear preference towards opting for MA instead.

*Heard somewhere 72 hours tablet is there you need to take that this type of medicine is given. On that it is written that you have to take for three days. **-Married,35 years, P2, Non-user, Chetganj, Varanasi***

*There was an ad on TV at that time and I guess that is banned as of now and that was just shown once or twice (MA). Unwanted 72.abortion kit is also available in the market to use.**-Married, 35 years, P2, Repeat User, Chetganj, Varanasi***

*My sister was having one child and she did not want another baby so her husband bought I-pill medicine from medical store and gave her. He said that consume this tablet with milk and within 24 hours abortion happens.* ***-Married,35 years, P2, Non-user, Chetganj, Varanasi***

*I didn't take anything. If I need it I will take it, otherwise we will see. If I take I-Pill, there is a lot of bleeding. I took it once when he forgot using a condom. I won't ever.* ***-Married, 34 years, P2, Repeat User, LIG Colony, Indore***

f) **Others:** Some women reported relying solely on **traditional methods** (douching, abstaining from intercourse on certain 'fertile' days of the month, or asking their husbands to use the withdrawal method, etc.) to prevent pregnancy. For a few women using modern contraceptives, using a traditional method as a back-up or relying on a traditional method if a modern contraceptive is unavailable/expired/ not used acts as a safety net to prevent a pregnancy. There seems to be a

*After you have sex then you can go to the bathroom immediately. Yes, earlier people used to keep gap between children like that only. All women have tried it but nobody will tell about it.-* ***Married, P2, Peer Group, Chetganj, Varanasi***

*Yes, we are going to the washroom anyhow. No, nothing happened I used to go normally. After it I go in the washroom and wash it.-****Married, 35 years, P2, Repeat User, Nanda Nagar, Indore***