Safe Abortion: Knowledge, Perception and Practices amongst Urban Poor Women in Vadodara, Gujarat

A Study by SAHAJ[1] & CommonHealth[2]

Background

For the past three decades, SAHAJ has been working for improvement of women's sexual reproductive health (SRH) in economically disadvantaged slums and slum-like localities (bastis) from Vadodara. It has trained a number of women from bastis as health workers who provide SRH information from a rights perspective to their fellow resident women and adolescent girls and through their interactions, it has mapped the community characteristics that influence their access to SRH information and services.

In 2018, SAHAJ undertook an exploratory study to document women's and adolescent girls' awareness about abortion legality, available abortion methods and services and contraception; their perception of safe abortion practices; their decision-making process and autonomy and experiences related to abortion services.

Methodology

Data regarding awareness, perceptions, autonomy and experiences were collected using qualitative methods. As the first step, eleven bastis were selected purposively to include the diverse representation of various communities residing in the city, which SAHAJ through its earlier intervention projects, knew to have distinct views, and attitudes towards SRH issues. These bastis were inhabited by long term migrants into the city, tribal communities, culturally rigid communities, religious minorities, underprivileged castes, residents with low or relatively higher literacy levels, better awareness of SRH issues or by communities with early marriage practices.

As the next step, for group discussions (GDs) women and adolescent girls representing different marital status and age groups such as 18–24 (unmarried), 18–35 (married), 36–45 (married) were selected from these bastis. A group of recently married (in the past two years) women too was included in the sample. A total of 13 GDs with 110 participants were conducted. Interviews were conducted with purposively selected 15 women from nine bastis who had undergone an abortion in the past 18 months. Interviews were conducted to get a deeper understanding of their experiences.

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1 *SAHAJ-Society for Health Alternatives was founded in 1984, with an idea of providing a supportive and facilitative environment for individuals interested in health and development work and in bringing about change in the lives of marginalized people.*

2 *Constituted in 2006, CommonHealth is a multi-state coalition of organizations and individuals advocating for better sexual and reproductive health.*

The GDs and interviews were conducted using pre-tested semi-structured tools by a SAHAJ field officer trained in conducting qualitative research and with an experience of working in the identified communities. Notes were made by the note taker – also a trained member of SAHAJ team. Case-stories were constructed based on the reports of interviews and discussions in the group discussions.

Data was collected over a period of two and a half months (1st February to 10th April 2018). The women were identified with help from anganwadi workers in areas where SAHAJ does not have an intervention project and with help of field workers who are local resident women in areas where SAHAJ has an intervention project. Data was collected after seeking verbal informed consent of these women. Those who were not comfortable with participation were not included in the study. Though the adolescent girls are members of SAHAJ's adolescents' groups formed under an intervention programme with explicit consent from the parents, consent for participation in the present study was sought from the girls.

Findings

There appeared to be confusion about legality of abortion. In GDs, many unmarried girls said that abortion is not legal and some that it is 'sometimes illegal'. However, they also said that *"abortion is a girl's right – if she wants an abortion then it is legal".* Participants of two women's groups unanimously said that abortion is legal and in one group they said that abortion after sex selection is illegal. Half of the interviewed women (7/15) said it is illegal. Some women, irrespective of their religious background said that abortion is a sin and that *'God does not look favourably on people who do it'.*

Women's criteria for good quality abortion care and reasons for choosing health care providers included, availability of in-patient facilities such as beds, nursing care, medicines, food and facility cleanliness and trust in the service provider, her/his perceived competence and attention to women's complaints / needs. Additionally, participants from some groups mentioned frequent and regular follow ups after the procedure and others stressed that it is important that *'nothing should be left behind in the uterus'* and there are no complications after the abortion such as bleeding, irregular menstruation, complicated subsequent pregnancies or infertility. Most of the women believed that abortion has adverse effects on women's health such as loss of appetite, weakness, anaemia, uterine ulcer and infections, increased susceptibility to illnesses/diseases and infertility.

Women showed high awareness about availability of abortion services and friends and family members were the main source of information. Some women got information only through personal experiences.

In areas where SAHAJ trained health workers work, women followed their advice to seek services from recognised centres. For some of the respondents, the choice of provider was influenced by family and friends. Most women talked about buying abortion pills from the medical shop either using old prescriptions from doctors or without them. According to them easy availability of pills has made abortion very accessible and it helps protect the woman's privacy as well. Some women said that they would first use pregnancy detection kit to ascertain pregnancy and then use pills for abortion. Few said that it is necessary to go to the doctor first and get the pills prescribed. Women from some groups shared that pills are not available at the government hospitals.

Participants were also aware of other methods used by health care providers. Curettage – commonly referred to as 'curetin or kreatin or kiryatin' was mentioned most often across the groups and women associated the term with 'cleaning the uterus'. Other methods mentioned were injection, intravenous fluid, insertion of medicine in the uterus, or if the gestation was high then inducing "labour" with medicines.

Three-fourth of the interviewed women had opted for private facilities suggested by friends and family members or where they knew the doctor or a staff member. Relatively easy accessibility of private hospitals was reported to be the main reason for opting for them. Possibility of medical abortion at home, without having to go to the doctor and without any investigations (which are believed to cause delays) was another reason for preference for private sector. Women also gave importance to perceived competence of provider, need for an accompanying person and satisfactory in-patient facilities. Women from the minority community especially preferred private facilities as they felt discriminated against and as anaesthesia or 'medicine to make woman unconscious' was not used at government hospitals. To quote one,

> ***"They are very suspicious about us. They look at us very strangely. We feel awkward…Lot of time is spent but less money is required."*** **(Basti 6 participant)**

All 15 interviewed women said that they had had a safe abortion. Ten of them had opted for medical abortion with three had purchased pills from the medical store without consulting the doctor. Five had undergone curettage, two at the government hospital.

In GD, participants talked about fear of social repercussions that influenced the actions of unmarried girls. Girls are worried about 'being responsible for dishonouring the family name' and scared of reactions from family members. This according to them was the main reason for girls with unwanted pregnancies leaving homes or even committing suicide. These sentiments were mentioned mainly in GDs with unmarried girls and women from the migrant community where awareness about SRH as well as status of women is low and cultural practices pose challenges for girls in making decision about marriage, partner or even employment.

Unmarried girls from the culturally rigid community said that girls directly approached a doctor, preferably from the private sector. Another group said that confidentiality is of prime importance while selecting a health care facility and hence an unmarried girl would not choose a doctor in the vicinity of her basti.

> ***"There are many tests (advised) in the government hospital, there are too many people around. The doctors are learners (students). Government hospitals also file a case if the girl is young (<18 years). The services in private hospitals are good."*** **(Basti 3, adolescent girl)**

Almost one-fifth of interviewed women expressed helplessness over making decisions about post-abortion contraception.

Conclusion

In terms of reasons for abortions, methods and providers preferred; the data from the present study are similar to those conducted across India over the past one decade. Most women still believe abortion to be illegal. While pills for abortion are preferred by women, these are not provided through the government tertiary hospital in the city. The women thus chose the private sector providers who provided the pills. Women's non-involvement in decisions about abortion and post-abortion contraceptive use and the low acceptance of contraceptives are indicative of the strong patriarchal community where women have low social status, poor access to resources and negligible decision-making power even about their own bodies.

The overall findings suggest partial retention of information received through interventions. The women who as adolescents were exposed to the SRH information were observed to be more aware and articulate about it. To ensure that women make better choices and access only safe abortion services, it is critical to address their poor awareness, systematically explore and document practices in public and private sector facilities and share all relevant information with them. It is important to note that SAHAJ health workers were mentioned to be the only source of information on abortion and women from their areas were more aware compared to others about legality of abortion. This highlights the importance of such interventions which need to be repeated or continued till a mass awareness is created through generations of women being made aware of the SRH issues.

Acknowledgements

Finalizing of tools:
SAHAJ team, Alka Barua

Community mobilization:
Neeta Panchal, Shakuntala Parmar & Alpana Nayi.

Data collection:
Bhavana Rajput.

Data documentation:
Alpana Nayi, Shakuntala Parmar, Smita Sonvane,
Rekha Makwana, Krishna Damor.

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***Special thanks to Dr. Alka Barua for valuable feedback.**

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