MARIE STOPES INTERNATIONAL

MEDICAL ABORTION IN INDIA: A MODEL FOR THE REST OF THE WORLD?

RESEARCH & ANALYSIS: 2

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Acronyms

CORT	Centre for Operations Research & Training, India
ICPD	International Conference on Population Development
IUD	Intrauterine Device
MSI	Marie Stopes International
MA	Medical Abortion
MBBS	Bachelor in Medicine and Bachelor in Surgery
MTP	Medical Termination of Pregnancy
NGO	Non Government Organisation
OCP	Oral Contraceptive Pill
PHS	Population Health Services
WHO	World Health Organization

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Executive summary

Unsafe abortion continues to be one of the major causes of maternal deaths. Complications from unsafe abortions lead to the hospitalisation of more than five million women a year around the world.[1]

In the past, safe abortion services were mainly restricted to clinical settings in urban areas with available skilled healthcare workers and specialised equipment. Access was often limited to a minority of women who could afford and locate services. However, the introduction of medical abortion involving the use of abortion-inducing medication instead of surgical intervention has radically changed the situation over the last 20 years. Medical abortion is an inexpensive, simple to use and acceptable method of terminating unwanted pregnancies with the potential to revolutionise access to safe abortion.

Marie Stopes International (MSI) is a leading global provider of reproductive health services, supplying high quality services to more than five million clients in over 40 countries in 2007. In 2008, MSI provided approximately 450,000 safe surgical abortions as part of a spectrum of integrated services, making it one of the largest non-profit providers of safe surgical abortions worldwide. The introduction of medical abortion was welcomed by MSI as an opportunity for more women to access low-cost, safe abortion.

Some countries have been slow to register and make available the two drugs most commonly used in medical abortion, mifepristone and misoprostol, despite strong evidence that medical abortion is safe and effective.[2-7] MSI is committed to exploring new and feasible ways to increase access to these potentially life-saving drugs, both within its own clinics and via other healthcare providers.

The biomedical dimensions of the regimen mifepristone and misoprostol are well documented. However, the impact of access to medical abortion via both traditional hospitals and clinics and less traditional channels such as pharmacies and community health workers is not so well understood. Of all the countries that have increased access to medical abortion, India stands out as a country in which women (and men) can more easily access the drugs.[8] The government has actively encouraged increased access to safe abortion services and use of medical abortion is widespread. What remains to be investigated is how people access medical abortion and how men, women and healthcare providers have responded to the introduction of it, as well as how medical abortion fits into the provision of broader reproductive health care, including post-abortion family planning.

In response to these questions, MSI undertook a study to examine the views of women, men and healthcare providers. The aim was to understand the implications of India's out-of-clinic provision of medical abortion and to draw lessons for other countries that wish to scale up access to medical abortion.

Methodology

In 2008, MSI undertook a cross-sectional randomised household survey in two Indian states, Gujarat and Jharkhand. In total, 811 women and 403 of their husbands were interviewed about a range of issues related to abortion, including attitudes towards and experiences of abortion. To increase the number of interviewees who had had a medical abortion, 33 women were purposively selected through snowballing techniques and interviewed using the same questionnaire as the other women. Finally, 88 pharmacists and 87 healthcare practitioners were purposively selected and interviewed about their attitudes and experiences in providing medical abortion services.

Key findings

Knowledge and attitudes

The vast majority of women and men in both Indian states support the use of abortion. However, levels of knowledge differ between men and women and between the two states. Important gendered differences included:

- approximately two-thirds of women and 85% of men erroneously thought that abortion was illegal
- overall, men are somewhat more liberal than women in their views about abortion, with more than 95% of men supporting abortion for a range of reasons.

Generally, women and men were more accepting of abortion in Gujarat than their counterparts in Jharkhand. Despite these differences between the

states, more than nine out of ten men and women thought that abortion is acceptable in a range of different scenarios. These state differences were replicated for attitudes towards abortion. For example:

- 50% of men in Gujarat strongly disagreed that abortion leads to major negative side effects compared with only 15% of men in Jharkhand (similar pattern for women)
- women in Jharkhand who had had an abortion were 2.7 times more likely to report that abortions lead to major negative side effects than women who had not had an abortion. In Gujarat, the opposite pattern occurred: women who had had an abortion were about half (0.46) times as likely to say that abortions were dangerous
- more women in Gujarat (71% vs. 48% in Jharkhand) strongly agreed that they could talk confidentially to their doctor about terminating an unintended pregnancy (similar pattern for men).

Women, men and healthcare providers were generally very supportive of medical abortion:

- 65% of women and 57% of men thought that medical abortion should be promoted more widely to communities
- 71% of women and 74% of men considered medical abortion either very effective or somewhat effective.

Women who were supportive of medical abortion had a number of reasons for being so, including the lower price of medical abortion, the simplicity of the procedure and the fact that a clinical procedure is not needed.

Perceived social support for abortion

The importance of the husband in deciding whether or not a woman should have an abortion was a recurring theme in the findings. In addition, perceived social support was higher in Gujarat than Jharkhand:

- 32% of women in Gujarat and 40% in Jharkhand stated that only the man can decide whether or not a woman should have an abortion
- 69% of women in Gujarat and 50% in Jharkhand said they thought their friends and family would support them if they used abortion services.

Comparison of attitudes to abortion within married couples showed that husband and wife agreed with one another in only 55% of cases regarding whether or not the wife would be supported by her husband if she wanted an abortion.

Perceptions about abortion providers

Overall, both women and men expect quality services and rate privacy, provider skill, distance and cost as important factors when choosing an abortion provider.

- in Jharkhand, women who had had an abortion placed less importance on privacy (one percent vs. seven per cent said privacy was not important). In Gujarat, women who had had an abortion placed less importance on cost (67% vs. 52%).

In terms of availability, women and men all report that abortion services are generally available nearby.

Provider experiences and attitudes

About eight in ten healthcare providers viewed medical abortion as effective. Even more said it should be promoted in the community.

- 78% of pharmacists and 85% of practitioners considered medical abortion to be somewhat or very effective.

Overall, pharmacists offered less information and advice to medical abortion clients than healthcare practitioners, and there was a greater variety in the advice that they gave, especially regarding regimens. This suggests gaps in pharmacists' knowledge of medical abortion.

Cost of medical abortion

Obtaining medical abortion pills from pharmacies is cheaper than going through practitioners. Pharmacists estimate costs below 600 rupees ($12) in comparison with up to 3000 rupees ($60) amongst practitioners.

Specific medical abortion experiences

Of the 45 women who had had a medical abortion, a majority were positive about their experience:

- 80% were satisfied with medical abortion
- 56% would recommend medical abortion.

Nearly one-third of the women had obtained the pills directly from a pharmacy, with nearly all of them (96%) receiving instructions. Just over half the women failed to return for follow-up advice.

A large proportion of women reported complications following their abortion: 40% of surgical abortion users and nearly 66% of medical abortion users. However, on closer inspection it appears that these women did not actually suffer from complications but rather from some of the known and expected physical effects of an abortion. Nonetheless, the findings reveal a perceived concern about these effects that perhaps were not well explained to the clients when receiving the pills.

Compared with medical abortion users, women who had had a surgical abortion were more than twice as likely to have been hospitalised as a result of the abortion, suggesting that major complications associated with medical abortion were relatively uncommon.

Post-abortion family planning

Post-abortion family planning is an important aspect of abortion-related counselling and reduces the likelihood of repeated unintended pregnancies.[9] Worryingly, post-abortion contraception use was not very high in either state and was particularly low for women who had had a medical abortion:

- 56% of surgical abortion users took up contraception following their abortion, compared with only 46% of medical abortion users
- of those women who took up post-abortion family planning, 53% of surgical abortion users took up long-acting and permanent methods compared with only 25% of medical abortion users
- 43% of medical abortion users who did not take up contraception following their abortions cited lack of information as the reason (compared with only 12% of surgical abortion users).

Four women reported that they were forced to be sterilised as a pre-condition of having a surgical abortion, which is a matter of grave concern.

Conclusions and recommendations

Main conclusions

Medical abortion in the two states is easily accessible, popular and associated with fewer serious complications than surgical abortion - even in the context of low levels of knowledge and training. India's model of liberalised access to medical abortion has, on the whole, gained high levels of acceptability from both women and men (demand side) and healthcare providers (supply side).

Although the law does not allow for pharmacists to provide medical abortion drugs without prescription, it is apparent that over-the-counter sales without prescriptions are fairly widespread. Clearly, over-the-counter sales can be associated with some potentially negative consequences, such as inaccurate medical abortion regime prescriptions, lower rates of post-abortion family planning uptake and less medical abortion counselling. However, many of these issues could easily be addressed through training to increase the knowledge and skills levels of pharmacists. Rather, the overarching lesson is that, in spite of these challenges, out-of-clinic provision of medical abortion has succeeded in making medical abortion more accessible.

Our research suggests that, in order to reach public health goals and improve reproductive health and choices, access to and awareness of medical abortion should be increased dramatically, including in out-of-clinic settings. Reasons include:

- high social, community and clinical support to increase access to medical abortion
- high client satisfaction and high success rates
- cost effectiveness, with medical abortion up to five times less expensive than surgical alternatives
- less serious and fewer complications and reduced need for costly hospitalisation compared to surgical procedures
- women using "backstreet" clinical settings are open to exploitation, for example, in terms of the price charged and forced sterilisation as a determinant for surgery.

India's model of liberalised access to medical abortion is a lesson to the many other countries that struggle with high rates of unsafe abortion and the consequent unacceptably high levels of maternal morbidity and mortality.

Main recommendations

Access to medical abortion needs to be urgently scaled up through as many cost-effective and simple approaches as possible. Key recommendations to improve access to medical abortion include:

- rolling out the provision of medical abortion into urban slums, rural and under-served areas through out-of-clinic settings such as pharmacies and via mid-level healthcare professionals
- providing basic training to providers of medical abortion on the regimen, correct prescription, side effects, post-abortion family planning, counselling and follow-up
- educating women and men about their reproductive health rights and family planning in general; and specifically about the legality and availability of mifepristone and misoprostol for safe abortion
- ensuring medical abortion pills that meet the highest standards of quality and efficacy.

Photograph: G.M.B. Akash / Panos Pictures

Chapter One: Background

Unsafe abortion continues to be one of the major causes of maternal deaths. Complications from unsafe abortions lead to the hospitalisation of more than five million women a year around the world. An unsafe abortion represents one of the greatest indicators of inequity between rich and poor women: in rich countries, up to eight percent of abortions are unsafe compared with more than 95% in Latin America and Africa and 60% in Asia.[1]

Access to safe and affordable abortion services is hampered by restrictive legal environments and weak underlying health infrastructure. Traditionally, the provision of safe abortion services has required the training of specialised medical staff as well as relatively expensive equipment. However, since 1988, a new and easier alternative has existed in the form of medical abortion.[4] Medical abortion involves taking two drugs known as mifepristone and misoprostol. When taken within the first nine weeks of pregnancy, these drugs are associated with a 98% success rate.[2, 3, 10] (See Box 1 for more information on misoprostol and mifepristone.)

Despite the proven effectiveness of medical abortion, only a minority of countries (35) have registered mifepristone.[1] Misoprostol is more widely available, as it is registered in numerous countries for non-abortion-related purposes. However, within those countries that have registered medical abortion drugs, uptake has been high. Over three million women were estimated to have taken the drugs successfully by 1999.[14]

Marie Stopes International (MSI) is a leading global provider of reproductive health services, supplying high quality services to more than five million clients in over 40 counties in 2007. MSI provides access to safe abortion services as part of a spectrum of integrated services. The introduction of medical abortion was therefore welcomed by MSI as an opportunity for more women to access safe abortion in a simple, low-cost and client-oriented manner.

MSI is committed to exploring new and feasible ways to increase access to these potentially life-saving drugs. MSI's research in the United Kingdom shows that women would prefer more flexibility in where they take medical abortion drugs, with many preferring the comfort of their own home to a clinic setting. Anecdotal evidence suggests that medical abortion drugs are now freely available as both legally registered drugs and on the black market in many countries, including large swathes of Africa, Latin America and Asia. It is important to understand how these new approaches have increased access to medical abortion and what the effects are.

Box 1: mifepristone and misoprostol

The term "medical abortion" refers to pregnancy termination with abortion-inducing medications in the place of surgical intervention.

By the 1980s, medical abortion had become a safe and effective alternative for pregnancy termination in the first trimester. This was made possible with the availability of prostaglandins in the 1970s and of anti-progesterones in the 1980s.

Various drugs and combinations have been used for first trimester abortion. The most widely researched drugs and combinations are prostaglandins (PGs) alone, mifepristone alone, methotrexate alone, mifepristone with prostaglandins and methotrexate with prostaglandins. The combined use of mifepristone and misoprostol has become the standard medical regimen for early medical abortion recommended by the World Health Organization (WHO).[11]

Mifepristone is an antiprogestin that is licensed for pregnancy termination in many countries. Taken orally during pregnancy, mifepristone blocks progesterone receptors, making the endometrium unable to sustain a growing embryo. Mifepristone also triggers an increase in prostaglandin levels and dilates the cervix, facilitating abortion.[12]

Prostaglandins soften the cervix and cause uterine contractions. They are administered orally or vaginally to ripen the cervix before surgical or medical termination of pregnancy.[13] The most commonly used prostaglandin is misoprostol (administered orally or vaginally), a prostaglandin analogue originally developed to prevent and treat gastric ulcers.

The reported complete abortion rate for misoprostol alone varies between 61% for single use and 93% for repeat doses.

Given the lack of understanding of how medical abortion is being used outside of the clinical setting, MSI undertook research into the attitudes and experiences of women and their husbands and healthcare providers in two states of India - a country where medical abortion drugs are widely available and some level of provider training has taken place. The aim was to see how accepted the Indian model of medical abortion has become.

1.1 Medical abortion in India: historical and legal context

Although abortion is illegal in many developing countries, abortion in India is legal. Official figures suggest that approximately one million abortions are performed each year in India,[15] although various studies suggest there are actually six times as many abortions.[16] The biomedical dimensions of the regimen mifepristone and misoprostol are well documented (see Box 1). However, what is less understood is the impact of access to medical abortion via both traditional hospitals and clinics and less traditional channels such as pharmacies and community health workers. India is an important country to analyse because of its relatively liberal approach to medical abortion and the ease with which women and men can buy the drugs outside of the clinical setting.[8] It should be noted that it is still illegal in India to acquire medical abortion drugs without a prescription, although studies suggest that over-the-counter sales of the drugs is common practice.[8, 17]

In 1971, the Indian Government liberalised its abortion laws significantly by adopting the Medical Termination of Pregnancy (MTP) Act. Until then, the Indian penal code only permitted abortion if it was required to save the life of the woman. Anyone caught performing an illegal abortion was liable to three years imprisonment and a fine. Women terminating their pregnancy faced up to seven years in prison and a fine. Whilst this did not deter many women from seeking a termination, it did mean abortions were often carried out by unskilled practitioners in unsafe conditions. The resulting high maternal mortality rate prompted the government-appointed Shah Committee to recommend legalising abortion in 1966 to encourage women to seek terminations in legal and safe settings.[18]

The MTP Act allows any government-run hospital or certified private facility in India to perform abortions up until 20 weeks of pregnancy. Under the original Act, an abortion could only be performed by an obstetrician-gynaecologist or another medical practitioner who has undergone sufficient training and has been certified.

In 2002 and 2003, the Indian Parliament passed the Medical Termination of Pregnancy (Amendment) Act and the amended Rules and Regulations to strengthen the MTP Act and improve the availability of abortion services. Most significantly, the amended MTP Rules sanctioned medical abortion. They allow an obstetrician-gynaecologist or another certified medical practitioner to provide mifepristone and misoprostol in a clinic setting until the seventh week of pregnancy. Furthermore, they can provide medical abortion in any clinic, not necessarily one certified under the 1971 MTP Act, provided that they have access to a certified site with capacity to perform a surgical abortion, should the need arise.

In 2002, the Drugs Controller of India duly approved a license for mifepristone; misoprostol had already been available in India to treat gastric ulcers. Upon doing so, the Controller recommended the use of 600mg of mifepristone coupled with 400 µg of misoprostol orally, albeit only in the first 49 days of pregnancy. Since then, a National Consortium of medical experts developed consensus protocols and guidelines[i] suggesting a lower dose of 200mg of mifepristone (in line with WHO recommendations).

In developing countries, the combination of mifepristone and misoprostol has proved highly successful at terminating pregnancies, with an average success rate of 95%.[12] This success rate has been replicated in a number of studies in India. For example, one study in 2000 found that 96-98% of medical abortions in three different settings - a research hospital, a family planning clinic and a rural healthcare clinic - were successful.[19] This finding was repeated in several other studies.[20]

Few women report any serious side effects of medical abortion. Mundle et al.[20] studied the medical abortions of 149 women in a government-run primary health centre in a village in the Nagpur district, Maharashtra in India. No woman involved in the study reported any serious complications. All women reported bleeding - 8.6 days on average - but this is expected

[i] See http://www.aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/report/2_1_7.html.

and was reported by many women as similar to or less than that experienced during a normal menstrual cycle. Three-quarters of the women involved in the study mentioned nausea and 65% reported abdominal cramping for three days on average. However, women reported low levels of pain.

The side effects reported in this study largely reflect the prevalence and severity of side effects reported in other studies from India.[21] For example, a review of 239 medical abortions between April 2002 and February 2003 by Parivar Seva Sanstha, a registered non government organisation (NGO) in India, found that whilst women complained of nausea, abdominal cramps, bleeding and vomiting after taking misoprostol, very few women required medication. The same study found that, after taking misoprostol, 89% of women had vaginal bleeding and 84% had abdominal pain, the majority of which was moderate or mild.[22]

In addition to the few side effects associated with medical abortion, in several studies Indian women have identified a number of other positive features. For example, almost half of the women involved in the study by Mundle et al. liked the ease and speed of medical abortion, whilst a fifth appreciated that the abortion was done in an outpatient setting and/or that no anaesthesia was required.[20] This is reflected in a number of other studies.[7, 23, 22] In fact, the perceived ease and availability of medical abortion led women in some studies to prefer medical abortion because it was compatible with their lifestyle, duties or tasks.[21] A number of women also view medical abortion as less painful than surgery.[21] The Indian NGO Parivar Seva Sanstha found that some women preferred medical abortion because they were afraid of surgery or pain.[22]

Participants from focus group discussions in one study also felt that medical abortion provides greater privacy (especially if multiple doctor visits were not required). They also thought that it would be of great use when secrecy was important, especially for unmarried women.[17]

Notably though, some studies have found that women who chose surgical abortion cited many of the same reasons for doing so; such as its convenience and being faster, easier, simpler and compatible with their lifestyle.[7]

Given the supportive policy environment and extensive evidence in support of medical abortion, demand for the procedure has grown quickly in India. However, government implementation of the MTP Act has been slower and as the following section shows, services on the ground do not always conform to national legislation or guidelines.

1.2 Access to medical abortion in India

Implementation of the MTP Act has been slow and geographically uneven. For example, the Act stipulates that all public sector facilities from primary health care level upwards must provide abortion services. However, according to Khan et al., by 2001 just a quarter of primary health centres in Uttar Pradesh provided abortion services.[24] Furthermore, only one of the four reviewed states provided abortion services in more than half of the public health facilities. These primary health centres commonly cite as barriers the absence of a provider trained in surgical methods or the lack of equipment and/or infrastructure required to provide surgical abortion services, including water and electricity.

This limited availability of surgical abortion should mean that medical abortion provides a key option for many Indian women seeking to terminate their pregnancy. However, because providers must at least have access to a certified site with the capacity to perform a surgical abortion, the availability of medical abortion is also limited. This restriction may have contributed to a mushrooming of over-the-counter sales of mifepristone and misoprostol in response to increasing demand and willingness to pay.[8]

Surgical abortion is more expensive than medical abortion and it is therefore typically educated, married women from an urban middle-income family rather than lower income women who access surgical abortion.[15] Given that not all public facilities are yet offering medical abortion services, it is poorer women who are more likely to resort to unsafe abortions or over-the-counter purchases because they cannot afford the higher costs associated with surgical abortion.

Under the MTP (Amendment) Act, pharmacists are only supposed to sell mifepristone and misoprostol by prescription. However, sales of the pills without prescription are widely reported. In one study, three chemists admitted to some over-the-counter sales.[8] In another study, most chemists interviewed reported that the

majority of clients that requested tablets for medical abortion did not have a prescription.[17]

Chemists emerge from various studies as the primary source of mifepristone and misoprostol for many women because these drugs are not widely available in public sector health services.[8, 17] For example, a study of medical abortion in 2005 in an area of northern Tamil Nadu found most chemists in the district stocked mifepristone or misoprostol, whilst only larger clinics and private hospitals typically had their own stocks. As a result, doctors in smaller, public facilities often sent patients to buy the pills from a chemist.[8] Where local pharmacies do not exist, pills for medical abortion are often available at local grocery shops.[17]

In some cases, pharmacists have replaced doctors altogether, advising clients about which drugs to take for medical abortion and how to take them. What is not clear is how effective and acceptable this model has become.

Although it is not legal for pharmacists to provide medical abortion pills without a prescription, the reality is that this is a fairly common occurrence in India. Not only has this happened in response to low government provision but also in response to women wanting to demedicalise the procedure. In one study by Mundle et al., 19% of women who had had a medical abortion indicated they would prefer home administration of misoprostol in the future.[20] Another study found that, whilst 87% of medical abortion users preferred taking the drugs in hospital under supervision, the rest felt that medical abortion was convenient and could be taken at home.[25]

In 1997, a study concluded that women could safely and effectively use mifepristone and misoprostol with less medical supervision than was typically recommended.[26] The study collected data from 799 medical abortions in six urban health centres in China, Cuba and India between 1991 and 1993. It found that women could correctly determine pregnancy in nearly all cases and that the majority of women could correctly calculate whether or not the duration of their pregnancy was short enough for medical abortion to be possible. It also found that no woman incorrectly thought her abortion was complete during the course of a medical abortion.

Liberalising the protocols on how medical abortion is administered would improve privacy and reduce many of the difficulties women face in addressing their sexual and reproductive health needs. However, further evidence about the impact and efficacy of taking mifepristone and misoprostol outside a clinic setting is essential. For example, will women be able to access adequate care in an emergency? It is also unclear whether women correctly follow the appropriate medical abortion regimen outside clinics.

With these gaps in knowledge in mind, MSI undertook a study of attitudes and practices with respect to medical abortion. Unlike some of the studies described above, MSI's study included a randomised household survey of both women and their husbands (allowing for a comparison within couples), as well as a survey of pharmacists and practitioners.

Chapter Two: Methodology

This chapter outlines the methodology of this study as well as the background characteristics of the men, women and healthcare providers.

The aim of the study was to assess the attitudes towards and experiences of medical abortion by the two main constituencies: women and their husbands (demand side) and providers (supply side). The study included three populations:

1) 811 women and 403 husbands sampled in a household survey.

2) 87 purposively sampled pharmacies and 86 purposively sampled practitioners.

3) 33 purposively sampled women who had had a medical abortion.

2.1 Research questions

The research questions fell into three main lines of enquiry:

1) Attitudes towards abortion and medical abortion in particular (Chapter Three):

a. To what extent are women and their husbands supportive of medical abortion?

b. Who makes decisions regarding abortion?

2) Attitudes and experiences of medical abortion providers (Chapter Four)

a. In what way do pharmacies and practitioners supply medical abortion to women?

b. Are pharmacies and practitioners supportive of increased access to medical abortion? Why?

3) Experiences of medical abortion (Chapter Five)

a. How do women describe their experiences of medical abortion and surgical abortion?

b. What types of complications do women report after medical abortion?

c. What are the levels of satisfaction with medical abortion?

2.2 Study setting

The study was undertaken in two very different states of India: Gujarat and Jharkhand. Although these states represent some of India's diversity, the results cannot be extrapolated to the country as a whole from two states alone. Gujarat was chosen due to reports of high levels of medical abortion use[ii] and Jharkhand was chosen for programmatic reasons as this is the main area in which MSI's Partner in India - Population Health Services (PHS) - operates.

As the map on Page 15 shows, Gujarat is located in the west and Jharkhand in the eastern part of the country. The population of Gujarat is relatively rich: only 7.2% live in the lowest wealth quintile compared with 49.6% in Jharkhand. The Gujarat population is also more educated: Gujarat has a female literacy rate of 58.6% compared with only 39.4% in Jharkhand (Census 2001).

2.3 Study design

The study design was a cross-sectional survey implemented through a randomised sample of households and through purposively selected healthcare providers and women who had had a medical abortion. MSI only surveyed urban settings because we understood that medical abortion was not widely available in rural areas.[17] Four cities were chosen in each state, based on which were the most urbanised and geographically dispersed. In Jharkhand, these cities were: Ranchi, Hazaribagh, Bokaro and Dhanbad. In Gujarat, the cities were: Ahmedabad, Vadodara, Rajkot and Surat.

2.3.1 Household survey design and sampling

In each of the cities, five enumeration areas were identified based on dispersed geographical locations with approximately 200 households per area. In each area, the first household was drawn randomly. Each further household was then selected by walking to the fifth house along from the last house sampled. Households were considered eligible to participate in the survey if they contained married women under the age of 35. Only one eligible woman per household was included. When the selected household did not have an eligible woman, the next household in the enumeration area was approached. In every second interviewed household, the husband was also interviewed. Repeat visits were undertaken to increase the likelihood that eligible husbands and wives were interviewed.

2.3.2 Purposively sampled healthcare providers

Within each enumeration area, two pharmacists and two health clinics were identified through snowballing techniques - both by asking providers about other providers and by asking women interviewed through the household survey about abortion service providers. As the sample was purposively selected, the results are not representative of all healthcare providers, and over-sample healthcare professionals who provide abortion-related services.

2.3.3 Purposively sampled medical abortion users

In addition to the household survey, women who had had a medical abortion were purposively sampled due to concerns that a household survey was not well suited to identifying sufficient numbers of women who had used medical abortion.[iii] A two-pronged approach was taken to identify medical abortion users. First, the abortion providers surveyed were asked to refer researchers to women who had recently used their services for medical abortion. Second, a snowballing technique was used in which women who had reported having had a medical abortion in the household survey were asked if they knew anybody else who had had a medical abortion. By following this approach, an additional 33 women who had had a medical abortion were identified and interviewed. Respondents answered the same questionnaire as those who were sampled through the household survey.

2.4 Data collection instruments

Based on the overarching research questions, a questionnaire was developed, pre-tested and translated into local languages. The questionnaire for women included sections on demographic and socio-economic characteristics, attitudes towards medical abortion and experiences of medical abortion. The questionnaires for husbands included the same topics, but excluded experiences of abortion. A separate questionnaire was designed for the healthcare providers with sections on background characteristics, attitudes towards medical abortion and approaches to providing medical abortion. Copies of the questionnaires are available upon request.

Figure 1 Map of India and study area

[ii] Personal communication between CORT and local research groups.

[iii] Given the taboo surrounding abortion, many women are still likely to under-report an abortion.

2.5 Fieldwork

The fieldwork was contracted out by MSI to the local research company CORT India (Centre for Operations Research & Training). CORT was responsible for designing and implementing the sample strategy, training the fieldworkers, implementing the study and compiling the results into an initial dataset. The fieldwork took place between April and September 2008. For both the household survey and the survey of the purposively sampled medical abortion users, female researchers interviewed the women and male researchers interviewed the husbands.

2.6 Data analysis

Data were coded and entered by data analysts at CORT India. Both CORT and the Research and Metrics Team at MSI undertook data editing and data cleaning. The data were then analysed using the data analysis software STATA by MSI's Research and Metrics Team.

The analysis is presented in three separate chapters. For the chapter on attitudes (Chapter Three), the data from the women and husbands recruited through the household survey were analysed. The women who were purposively selected medical abortion users are not included in this section. The analysis compared women from the two different states, and also compared those women who reported never having had an abortion with those who had had a surgical or medical abortion. Analysis was also conducted between couples within households. Differences were first tested using Chi squared tests and then for selected outcomes, more in-depth analysis was undertaken using logistic regression. Husbands' responses were also analysed separately, examining differences between states and between husbands who reported their wives had had an abortion with those who did not report wives' abortions.

The data on providers were analysed separately and are presented in Chapter Four.

The chapter on experiences of medical abortion (Chapter Five) included the women from the household survey who had had a medical abortion and the women who were purposively selected. Because the medical abortion sample includes the purposively selected women, the women who have had a medical abortion are not representative of the general population in the way that the other women are, and so firm comparisons between women who have had and have not had a medical abortion cannot be made.

Table 1 Do reports of abortion by women and their husbands match up?

	Husband reports abortion			
Woman reports attempting abortion	Yes Number	No Number	Total Number	Total %
No	6	304	310	82.9
Yes	47	17	64	17.1
Total	53	321	374	100

2.6.1 Discrepancies between husbands' and wives' accounts of abortion

In six cases (highlighted in Table 1 below), women reported that they had not had an abortion when their husbands said that they had. Five of the women said they had had a miscarriage, and one reported continuing with an unwanted pregnancy. In all six cases, the husbands said their wives had had surgery with anaesthesia, that the pregnancy had terminated successfully, and that there were no complications. Given that the men provided numerous details of the abortion such as cost and provider, it seems likely that the wives had undergone an induced abortion at some point. They may also have had a miscarriage on a separate occasion or simply prefer to describe their induced abortion as spontaneous. Given that it is unlikely the men would have invented so many details about their wives' abortions, these women have been added to the "had abortion" group for the purposes of this report. Because they did not give details about their abortion experiences, however, they are not included in the chapter on abortion experiences.

In 17 cases, women reported having attempted to terminate an unwanted pregnancy while their husbands said they had not had an abortion. Two of these women report attempting but failing to have an abortion, which helps to explain the apparent discrepancy in these cases; their husbands are added to the "had abortion" group for the attitudes chapter. Of the remaining 15 women, none said they had hidden the abortion from their husbands. Indeed, five said their husbands had decided to terminate the pregnancy and an additional three said they did

not know how much it had cost because their husband had paid. As with the men, the women reporting abortion reported numerous details about their experience, and it seems likely that they did indeed undergo the procedures they describe.

Four women in Gujarat reported they had attempted to terminate an unwanted pregnancy but had not succeeded. They are included among the women categorised as having had an abortion.

2.7 Background characteristics

This section provides a brief overview of the women, husbands and healthcare providers included in this study. Most of the women and all of their husbands were recruited through the household survey. Women who were purposively sampled are reported upon separately in the tables.

2.7.1 Women

In Table 2, we show background demographic characteristics of the women from the household survey by state. The women came from eight cities, four in Gujarat and four in Jharkhand. Approximately 100 women were sampled per city. The women in Gujarat were somewhat older than those in Jharkhand - 68% versus 60% of women were in the age group 25-34 and four percent vs. 13% in the age group 35-45 for the two states respectively.

Women in Gujarat had fewer children - 15% had three or more, compared with 36% of the women from Jharkhand.

Proportionally more women in Gujarat than Jharkhand report having had an abortion. The Gujarati city of Vadodara accounts for 22% of the total women who report having an abortion. The other cities account for roughly 10% each (not shown).

Table 2 Demographic characteristics of women, by state, with purposively sampled women also shown for information

	Gujarat %	Jharkhand %	Total No.	Recruited purposively No.	%
State					
Gujarat	100	0	410	7	21
Jharkhand	0	100	401	26	79
Total	100	100	811	33	100
Women's age					
16-24	28	27.3	223	13	39.4
25-34	68.1	60	517	19	57.6
35-45	3.9	12.8	67	1	3
Total	100	100	807	33	100
Parity					
0	11.5	8.2	80	3	9.1
1	31.4	22.7	219	9	27.3
2	41.5	32.7	300	14	42.4
3	10.8	19.2	121	1	3
4	3.9	9.5	54	1	3
5	0.5	5.2	23	3	9.1
6+	0.2	2.5	11	2	6.1
Total	100	100	808	33	100
Had abortion?					
No abortion attempt	78.2	86.5	627	0	0
Non-medical abortion only	19.1	12.7	121	0	0
Medical abortion at least once	2.7	0.8	13	33	100
Total	100	100	761	33	100

The women from each state also differed in terms of their socioeconomic characteristics. The women sampled in Gujarat had somewhat higher levels of schooling, with only 11% having no schooling, compared with 23% of the women sampled in Jharkhand. Although most women said they did not get paid in cash or in kind, the proportion of those who did not get paid was highest in Jharkhand - 95% versus 87% in Gujarat. In the Gujarat sample, 97% of women reported a Hindu head of household. In Jharkhand the figure was lower - 85%. Correspondingly more women in Jharkhand reported having a Muslim head of household - 15% vs. 3% in Gujarat.

Table 3 Socioeconomic characteristics of the women, by state, with purposively sampled women also shown for information

	Gujarat %	Jharkhand %	Total No.	Recruited purposively No.	Recruited purposively %
Years of schooling completed					
Zero	11.1	22.7	136	3	9.1
1-5	6.9	8	60	4	12.1
6-10	50.1	47.1	393	13	39.4
11+	31.9	22.2	219	13	39.4
Total	100	100	808	33	100
Pay per month (rupees)					
100-500 ($2-$10)	2.9	1.5	18	2	6.1
501-999 ($10-$20)	2.9	0.2	13	0	0
1000-1399 ($20-$28)	2.7	1.2	16	1	3
1400-2499 ($28-$50)	2.2	1	13	2	6.1
2500-32000 ($50-$640)	2.2	0.7	12	3	9.1
Does not get paid in cash or kind	87	95.3	736	25	75.8
Total	100	100	808	33	100
Type of work					
Service	2.7	2	19	6	18.2
Daily labour/Bidi maker	5.9	0.5	26	0	0
Skilled labour	1.7	1	11	1	3
Contract labour/peeling garlic	0	0.2	1	1	3
small business/tailoring work, selling vegetables	1	0.5	6	0	0
Self-employed	0.5	0.5	4	0	0
Cook	1.2	0	5	0	0
Does not get paid in cash or kind	87	95.3	736	25	75.8
Total	100	100	808	33	100
Religion of head of household					
Hindu	97.1	84.5	734	25	75.8
Muslim	2.7	14.7	70	8	24.2
Jain	0.2	0.5	3	0	0
Sikh	0	0.2	1	0	0
Total	100	100	808	33	100

2.7.2 Women: background characteristics associated with self-reported abortions

As can be seen in Table 4, women in Gujarat reported more terminations of pregnancy than those in Jharkhand. However, within each state, there were other characteristics that were also associated with higher reports of terminations. In Gujarat, 34% of all the abortions reported came from Vadodara, and 25% from Ahmedabad. Far fewer came from Surat (15%) and Rajkot (18%). In Jharkhand, the cities were not significantly different in terms of proportions of women reporting abortion.

In Jharkhand, years of schooling completed was significantly related to whether or not women reported abortion. Women with little schooling reported the lowest number of abortions and women with the most schooling reported the most. In Gujarat the association was not significant, but women with no education reported proportionally fewer (approximately half as many) abortions than those with education.

Table 4 Relationship between education level and women's report of having had an abortion

	Gujarat		Jharkhand	
	Had abortion %	Total No.	Had abortion %	Total No.
Years of schooling completed				
Zero	11.4	44	7	86
1-5	28	25	3.1	32
6-10	21.6	185	17.2	186
11+	27	122	19.8	81
Total	22.6	376	14.3	385
	Pearson chi2(3) = 5.0734 Pr = 0.167		*Pearson chi2(3) = 10.2784 Pr = 0.016*	

Photograph: Stuart Freedman / Panos Pictures

2.7.3 Husbands

Through the household survey, a subset of husbands was recruited in every second house where a woman was interviewed. Husbands' background characteristics are shown in Table 5. Approximately 50 husbands were recruited from each of the eight cities.

The husbands' characteristics varied by state, as in the case of the women. The men sampled in Gujarat were younger than in Jharkhand (61% vs. 49% aged 25-34 and 32% vs. 45% aged 35-60, respectively). Proportionally fewer husbands in Gujarat had no schooling (1% vs. 9% in Jharkhand). Probably related to this is the finding that more men in Gujarat were in the highest pay bracket. Approximately the same proportion of men in both states had wives who had had abortions.

Table 5 Background characteristics of husbands, by state

	Gujarat %	Jharkhand %	Total No.
State			
Gujarat	100	0	202
Jharkhand	0	100	201
Total	100	100	403
Husband's age			
16-24	6.9	7	28
25-34	60.9	47.8	219
35-60	32.2	45.3	156
Total	100	100	403
Husband: years of schooling completed			
Zero	1	9	20
1-5	11.4	6	35
6-10	54.5	43.3	197
11+	33.2	41.8	151
Total	100	100	403
Husband's pay per month (rupees)			
501-999	0	1	2
1000-1399	1	2	6
1400-2499	15.2	24.6	79
2500-32000	83.8	72.4	310
Total	100	100	397
Wife had abortion?			
Yes	15.4	11.4	53
No	84.6	88.6	343
Total	100	100	396

Table 6 Relationship between husband's education level and whether or not wife had an abortion

	Gujarat		Jharkhand	
	Wife had abortion %	Total No.	Wife had abortion %	Total No.
Husband: years of schooling completed				
Zero	0	2	5.6	18
1-5	13	23	8.3	12
6-10	10.7	103	5.7	87
11+	23.9	67	19	84
Total	15.4	195	11.4	201
	Pearson chi2(3) = 5.9271 Pr = 0.115		Pearson chi2(3) = 8.3094 Pr = 0.040	

In Jharkhand, the husbands' education levels were associated with whether or not their wives had had an abortion. As with the women, higher education levels among husbands were also associated with higher levels of abortion. The association was not significant in Gujarat.

2.7.4 Background characteristics of practitioners and pharmacists

The providers were first asked about their personal background and qualifications. The results are summarised in Table 7 below. Of the pharmacists interviewed, 26% did not have a degree in pharmacy. Of the practitioners interviewed, 18% reported neither MBBS (Bachelor of Surgery and Medicine) nor a qualification in Obstetrics/Gynaecology. The providers in Jharkhand were typically older than those in Gujarat, and the practitioners were generally older than the pharmacists. The pharmacists reported dealing with more family planning clients per week - 46% said they had over 30 clients per week, compared with six percent of the practitioners.

Table 7 Pharmacist and practitioner background characteristics, by state

	Pharmacists				Practitioners		
	Gujarat %	Jharkhand %	Total %		Gujarat %	Jharkhand %	Total %
Age				Age			
20-29	31.8	16.3	24.1	20-29	4.4	0.0	2.3
30-39	36.4	30.2	33.3	30-39	40.0	12.2	26.7
40-49	25.0	32.6	28.7	40-49	31.1	31.7	31.4
50+	6.8	20.9	13.8	50+	24.4	56.1	39.5
Total	100	100	100	Total	100	100	100
Total (N)	44	43	87	Total (N)	45	41	86
Do you have a degree in pharmacy?				What is your professional qualification?			
Yes	75.6	72.1	73.9	MBBS	6.7	31.0	18.4
No	24.4	27.9	26.1	DGO/Gynaec	75.6	50.0	63.2
				Others	17.8	19	18.4
Total	100	100	100	Total	100	100	100
Total (N)	45	43	88	Total (N)	45	42	87
Family planning customers per week				Family planning clients per week			
None	0.0	4.7	2.3	None	0.0	0.0	0.0
1-4	0.0	7.0	3.4	1-4	29.5	7.1	18.6
5-10	13.6	18.6	16.1	5-10	40.9	35.7	38.4
11-30	36.4	30.2	33.3	11-30	27.3	47.6	37.2
31-99	40.9	30.2	35.6	31-99	2.3	7.1	4.7
100+	9.1	9.3	9.2	100+	0.0	2.4	1.2
Total	100	100	100	Total	100	100	100
Total (N)	44	43	87	Total (N)	44	42	86

Chapter Three: Attitudes to abortion

In this chapter, we examine women's and men's knowledge about and attitudes to abortion.

Because the interviewees were sampled from two different states, and because their responses were very different according to the state they came from, we have presented most findings according to whether the respondents were from Jharkhand or Gujarat. In addition, because ideas about abortion are likely to change if the woman herself has had an abortion, we decided to examine women who had had an abortion and those who had not had an abortion as two separate groups. For some analyses, we also found that men differed, depending on whether they reported their wives had had abortions or not, and so again we present the results separately.

3.1 Women's knowledge about and attitudes to abortion, by whether or not they have had an abortion

There was no difference between the two states in terms of women's knowledge of the legal status of abortion. Approximately two-thirds of women said abortion was illegal, and one-quarter said it was legal. In Gujarat, more of the women who themselves had had an abortion said that it was legal (36% vs. 22% of women who had not had an abortion). In Jharkhand, there was no difference between women who had had abortions and those who had not. In both states, over half of the women who had had an abortion said that abortion was illegal.

For the men, there was no difference according to whether or not their wives had an abortion. Very few thought abortion was legal - approximately 15% in both states.

3.1.1 Attitudes: when is abortion acceptable?

Attitudes to abortion and when it is acceptable were significantly different in Gujarat and Jharkhand for all of the scenarios presented to the women. Generally, the majority of women were in favour of abortion in the various scenarios: if the health of the woman is in danger; if the woman does not want another child; is unmarried; is pregnant as a result of rape; or there is a strong chance of a defect in the baby. In all of these cases, more women in Gujarat than Jharkhand said they agreed with abortion under these circumstances. More women in Jharkhand than Gujarat, however, agreed that abortion should be allowed in the case of contraceptive failure (93% vs. 88%) and if the foetus is female (13% vs. 10%) or male (12% vs. 1%), or over 20 weeks old (23% vs. 7%).

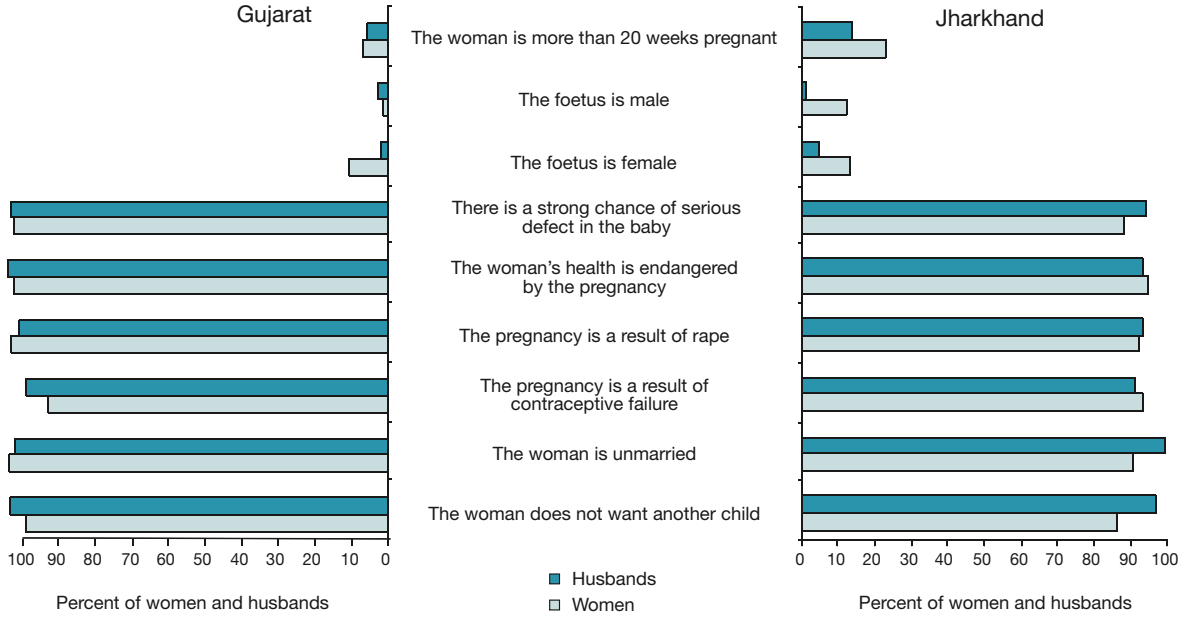
Among the women in Gujarat, there was also a significant difference in attitude between women who had had an abortion and those who had not in terms of their attitude to abortion in the case of contraceptive failure: 96% of women who had had an abortion themselves were in favour compared with a somewhat lower figure of 87% of women who had not had an abortion (not shown). For the other scenarios, and for the women in Jharkhand, there were no significant differences between those who had experienced abortion and those who had not. For the men, there was no difference by abortion status of their wives.

Table 8 Knowledge of the legal status of abortion, by state and for the women, by whether or not they had experienced an abortion

	Gujarat women			Jharkhand women			Gujarat	Jharkhand
	No abortion attempt	Had abortion	Total	No abortion attempt	Had abortion	Total	Husbands (all)	Husbands (all)
As far as you know is abortion legal or illegal*							%	%
Legal	22.0	36.5	25.3	24.5	29.1	25.2	14.4	16.4
Illegal	69.1	52.9	65.4	64.2	56.4	63.1	80.0	81.6
Do not know	8.9	10.6	9.3	11.2	14.5	11.7	5.6	2.0
Total	100	100	100	100	100	100	100	100
Total (N)	291	85	376	330	55	385	195	201

*Significant difference in Gujarat by abortion status ($p<0.05$)

Figure 2: Percentage of women and husbands agreeing that abortion should be allowed under different circumstances, by state

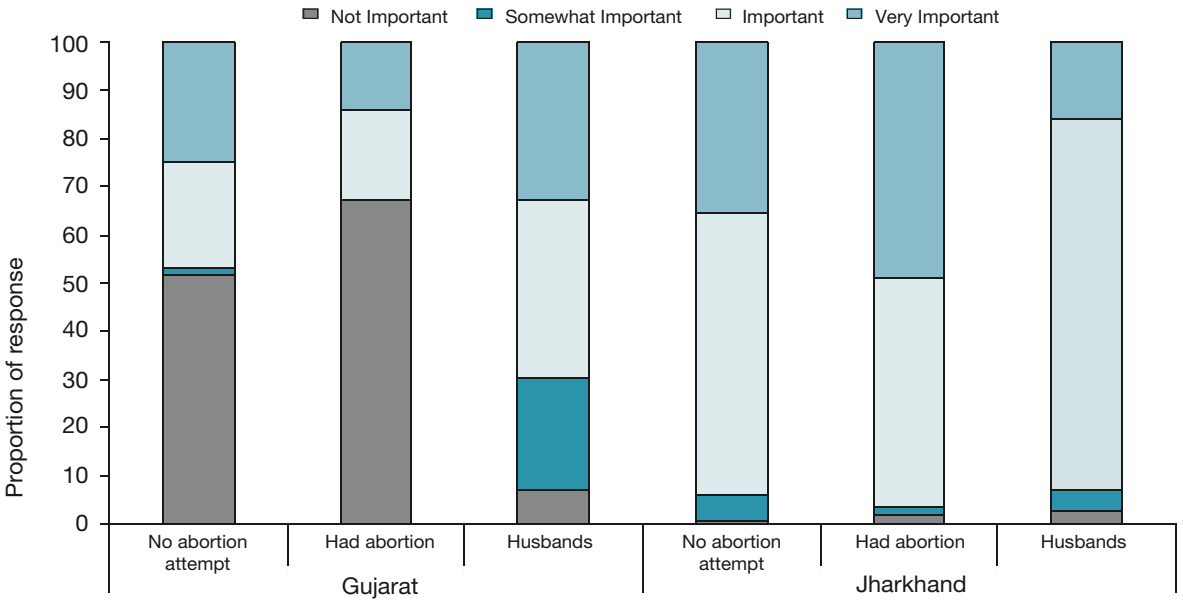


Over 90%, and in most cases over 95% of the men supported the idea that a woman should be allowed to have an abortion in almost all of the scenarios.
The only exceptions were for sex selection, which over 95% of the men opposed, and in the case of a pregnancy over 20 weeks, where only about 10% of men said that women should still be allowed to have an abortion.

Overall, the men were somewhat more liberal than the women, but the vast majority - around 90% - of both men and women supported the idea that women should be allowed to have abortions in a range of different circumstances. More women supported the idea of women being allowed abortion for sex selection.

Photograph: Robert Wallis / Panos Pictures

Figure 3 Women and men's responses about how important costs are when selecting a provider for abortion



3.1.2 Important characteristics of abortion providers

Women were asked what factors they thought were important in the selection of a provider for abortion. In Jharkhand, women generally thought almost all the factors mentioned were important and very few (under three percent) said any of the following were "not important": having a female provider, cost of the abortion, provider skill, equipped facility, legal provider. The only place where some said a factor was not important was "distance from home", which was cited as not important by approximately one-third of the women.

In Gujarat, most women agreed that provider skill, a legal provider, and an equipped facility were important. Very few women cited these as "not important". There was a range of responses to the other factors, including cost of the abortion, importance of a female provider, privacy, distance from home, and husband's consent not being required, with women's responses spread from "not important" to "very important".

In most cases, there are no measureable differences in attitude between women who had had an abortion and those who had not. There are only two exceptions to this: in Jharkhand, women who had had an abortion placed less importance on privacy (one percent vs. seven percent said privacy was not important ($N=385$, $p < 0.05$). In Gujarat, women who had had an abortion placed less importance on cost (67% vs. 52% said cost was not important ($N = 376$, $p<0.01$)).

Men in both states considered most of the options presented to be important. There were very few factors they considered not important. The only factors that at least 10% of the men thought not important were female provider (10%) and distance from home (14%).

Figure 3 shows the summary responses per states for both women and men combined.

Where opinions differed according to whether respondents had experienced abortion or not, we wished to know more. Because privacy was cited as unimportant by only four women in Jharkhand, the numbers are too small to investigate any further. In the case of the women in Gujarat, however, there were enough responses for further analysis. We wished to examine whether the difference in attitude to cost between women with and without abortion experience remained the same if we took into account their education level, age and religion, which we considered to be likely confounding factors. We found that even once these variables had been accounted for in a logistic regression analysis, women who had had an abortion were about half (0.53) as likely to report that the cost of an abortion is important compared with women who had not had an abortion.

3.1.3 Perception of dangers of abortion

Women were asked about their view of how dangerous abortion is. Women in Jharkhand were more likely to agree that abortion leads to major negative side effects if they had had an abortion themselves (42% strongly agreed, compared with 25% of women who had not had an abortion). By contrast, women in Gujarat were more likely to strongly disagree that abortions are dangerous if they had had an abortion (45% vs. 24% of women who had not had an abortion).

Men also responded differently according to state. Half of the men in Gujarat strongly disagreed that abortion leads to major negative side effects, while only 15% disagreed in Jharkhand. About half of the men in Jharkhand strongly agreed with the statement, while only nine percent strongly agreed in Gujarat. On the other hand, about half of all the men disagreed that abortions are dangerous, although more disagree in Gujarat. In Jharkhand, 24% of men strongly agreed abortions are dangerous, while in Gujarat only 13% strongly agreed with this. Men did not differ according to whether their wives had had an abortion or not.

Overall, then, the view of abortion among the men and women in Jharkhand was more negative than among the men and women in Gujarat.

Table 9 Views of women and men on side effects and dangers of abortion, by state, and by whether or not they themselves have had an abortion

	Women						Husbands		
	Gujarat			Jharkhand					
	No abortion attempt %	Had abortion %	Total %	No abortion attempt %	Had abortion %	Total %	Gujarat %	Jharkhand %	Total %
Undergoing abortion leads to major negative side effects									
Strongly disagree	28.2	32.9	29.3	16.1	5.5	14.5	49.5	14.9	32.3
Disagree somewhat	16.8	14.1	16.2	9.7	10.9	9.9	10.4	9.0	9.7
Neither agree nor disagree	14.4	21.2	16.0	30.3	16.4	28.3	5.4	16.4	10.9
Agree somewhat	17.5	11.8	16.2	19.1	25.5	20.0	25.2	15.4	20.3
Strongly agree	23.0	20.0	22.3	24.8	41.8	27.3	8.9	44.3	26.6
Total	100	100	100	100	100	100	100	100	100
Total (N)	291	85	376	330	55	385	202	201	403
Abortions are dangerous									
Strongly disagree	24.1	44.7	28.7	53.6	38.2	51.4	55.0	48.3	51.6
Disagree somewhat	6.5	8.2	6.9	5.2	9.1	5.7	7.9	5.0	6.5
Neither agree nor disagree	14.8	10.6	13.8	8.5	9.1	8.6	2.5	10.4	6.5
Agree somewhat	29.9	17.6	27.1	20.9	27.3	21.8	19.8	12.4	16.1
Strongly agree	24.4	18.8	23.1	11.8	16.4	12.5	13.4	23.9	18.6
Total	100	100	100	100	100	100	100	100	100
Total (N)	291	85	376	330	55	385	202	201	403

We examined further whether the differences in opinion about the danger of abortion varied according to whether women had had abortion experiences themselves by analysing whether the differences remained after controlling for age, religion and education level in a logistic regression analysis.

The association between attitudes and abortion experience remained significant. Women in Jharkhand who had had an abortion were nearly three (2.72) times as likely as other women to report they thought abortion had major negative side effects. Once the other variables were taken into account, women from Gujarat were about half (0.46) as likely to say that they thought abortion was dangerous if they had had an abortion themselves. In other words, women who had not had an abortion were more likely to think that abortions are dangerous.

It seems that experience of abortion may have had a negative impact on women from Jharkhand. It is possible that this is because services are poorer, or because abortion is generally seen more negatively in Jharkhand.

3.1.4 Perceived social support for abortion

Women and men were asked various questions to try to understand their perceptions of social support for abortion among their social networks. Women differed by state in their perceptions of social support around abortion. In Gujarat, 32% of women agreed that only the man can decide whether or not his wife should have an abortion, compared to 40% in Jharkhand; 61% of the husbands in Jharkhand also agreed with this. However, only 14% of men in Gujarat agreed and a large majority (78%) disagreed. Most women said that their spouse would support them if they used abortion pills (94% in Gujarat, and 70% in Jharkhand). However, the men did not agree: half the men in Gujarat and 26% of those in Jharkhand disagreed.

Because these results were for the all the women versus all the men, we examined their responses in husband-wife pairs to see whether there was also disagreement within couples about a wife's idea of her husband's support of her use of medical abortion. In 55% of cases, the responses of the husband and wife tallied - either they both thought the husband would not support use of abortion, or both agreed he would. However, in nearly half of cases in Gujarat, the wife said she agreed her husband would support her use of medical abortion when in fact her husband said he disagreed or was neutral about it. In Jharkhand the figure was lower, but still accounted for 20% of the women. In Jharkhand, some women took an over-negative view of their husband's attitude, thinking he would not support their use of medical abortion. In 18% of cases, the women said he would not when in fact he agreed that he would support it. The equivalent disparity in Gujarat was smaller - 2.5%.

Overall, women tended to have an over-positive view of their husband's support for their possible use of medical abortion, thinking he would support them when in fact he said that he would not. This was true in both states, but was particularly evident in Gujarat. In Jharkhand about the same proportion of women who had an over-positive view (22%) had an over-negative view of their husbands' likely reaction to their use of medical abortion (18%), i.e. assuming he would not support her when in fact he said he would.

Table 10 Women's and men's responses to whether or not the husband would support the wife if she decided to use medical abortion tablets

Spouse would support medical abortion use – husband and wife responses	Gujarat %	Jharkhand %	Total No.	Total %
Husband and wife agree in their responses	50.5	60.2	221	55.4
Wife agrees but husband disagrees/neutral	47.0	21.9	137	34.3
Husband agrees but wife disagrees/neutral	2.5	17.9	41	10.3
Total	100	100	399	100

While 69% of women in Gujarat and 50% in Jharkhand said they thought their friends and family would support them if they used abortion services, the equivalent figures were 38% and 44% among men. There appears to be a bigger disparity in perceptions between women and men in Gujarat compared with Jharkhand, with the women in Gujarat appearing to perceive a social environment broadly supportive to abortion, and men perceiving the opposite. In Jharkhand, men's and women's views were more similar to one another.

Table 11 Perceptions of the social support around abortion, women and husbands, by state

	Gujarat %	Jharkhand %	Women total %	Gujarat %	Jharkhand %	Men total %
In my community, only the man can decide whether or not his wife should undergo abortion						
Strongly disagree	25.8	37.4	31.6	77.7	22.4	50.1
Disagree somewhat	15.0	12.5	13.7	4.5	12.4	8.4
Neither agree nor disagree	27.5	9.7	18.7	4.0	4.5	4.2
Agree somewhat	15.7	24.2	19.9	6.4	17.4	11.9
Strongly agree	16.0	16.2	16.1	7.4	43.3	25.3
Total	100	100	100	100	100	100
Total (N)	407	401	808	202	201	403
If I/my wife decide to use abortion tablets my spouse would support me/I would support her						
Strongly disagree	2.0	7.5	4.7	50.5	26.4	38.5
Disagree somewhat	2.5	11.2	6.8	1.0	5.0	3.0
Neither agree nor disagree	2.2	11.2	6.7	0.5	7.0	3.7
Agree somewhat	33.4	42.1	37.7	12.9	23.4	18.1
Strongly agree	60.0	27.9	44.1	34.7	38.3	36.5
Total	100	100	100	100	100	100
Total (N)	407	401	808	202	201	403
I think my friends and family will support my/my wife's using abortion services						
Strongly disagree	9.8	25.7	17.7	47.0	32.8	40.0
Disagree somewhat	9.8	10.5	10.1	3.5	8.0	5.7
Neither agree nor disagree	11.1	13.7	12.4	11.4	14.9	13.2
Agree somewhat	32.7	30.9	31.8	13.4	22.4	17.9
Strongly agree	36.6	19.2	28.0	24.8	21.9	23.3
Total	100	100	100	100	100	100
Total (N)	407	401	808	202	201	403

3.1.5 Perceptions of service availability

Women and men all report that abortion services are generally available nearby. There were differences by state, but within states, the women who had had abortions did not differ from those who had not, and men whose wives had abortions did not differ from those whose wives had not. Around 85% or more women and men said that abortion services were available nearby. However, more women in Gujarat (71% vs. 48% in Jharkhand) strongly agree that they could talk confidentially to their doctor about terminating an unwanted pregnancy. More of the men in Gujarat also strongly agree that they could talk to their doctor confidentially about this (86% vs. 54% in Jharkhand) and 22% of the men and 16% of the women in Jharkhand say they either disagree or strongly disagree with this.

Table 12 Perceived availability of abortion services by women and husbands

	Women			Husbands		
	Gujarat %	Jharkhand %	Total %	Gujarat %	Jharkhand %	Total %
There is a healthcare provider with information on abortion tablets less than a 30 minute walk from my house						
Strongly disagree	3.4	6	4.7	0.5	3	1.7
Disagree somewhat	6.4	14.5	10.4	2.5	6	4.2
Neither agree nor disagree	4.9	2.2	3.6	4.5	5.5	5
Agree somewhat	31.4	19.2	25.4	29.2	15.9	22.6
Strongly agree	53.8	58.1	55.9	63.4	69.7	66.5
Total	100	100	100	100	100	100
Total (N)	407	401	808	202	201	403
I can confidentially talk to my doctor about terminating unwanted pregnancy						
Strongly disagree	0.7	6.2	3.5	0.5	17.4	8.9
Disagree somewhat	0.7	9.7	5.2	0	4.5	2.2
Neither agree nor disagree	0.7	6.7	3.7	0	5.5	2.7
Agree somewhat	26.3	29.4	27.8	13.4	18.9	16.1
Strongly agree	71.5	47.9	59.8	86.1	53.7	70
Total	100	100	100	100	100	100
Total (N)	407	401	808	202	201	403

3.2 Medical abortion: knowledge and attitudes

Women and men were asked specifically about medical abortion. Most women had not heard of medical abortion, although it is possible that they might have known it by a different name, as three of the women who later reported having medical abortion also said they had not heard of it. Women who had not had abortion had heard of it via the media, whereas women who had had an abortion found out through healthcare providers or personal contacts. Most women thought it was effective and over half knew it could be obtained from pharmacists.

Nearly half of the men (42%) had heard of medical abortion. Three-quarters of those men knew that medical abortion tablets are available from pharmacists.

Women and men were asked whether medical abortion should be promoted as a method. More said that medical abortion should be promoted than said it should not. Around two-thirds of all respondents were in favour of promotion of medical abortion, but even more women were in favour than men (65% vs. 57% of men in favour of promotion of medical abortion).

Men whose wives had had an abortion (57%) were different to the men who reported no abortion. More of them said they had heard of medical abortion (vs. 40% of men whose wives had not had an abortion), and a much higher proportion of the men whose wives had

experienced abortion (81%) said that medical abortion should be promoted compared with a lower proportion (53%) of the other men.

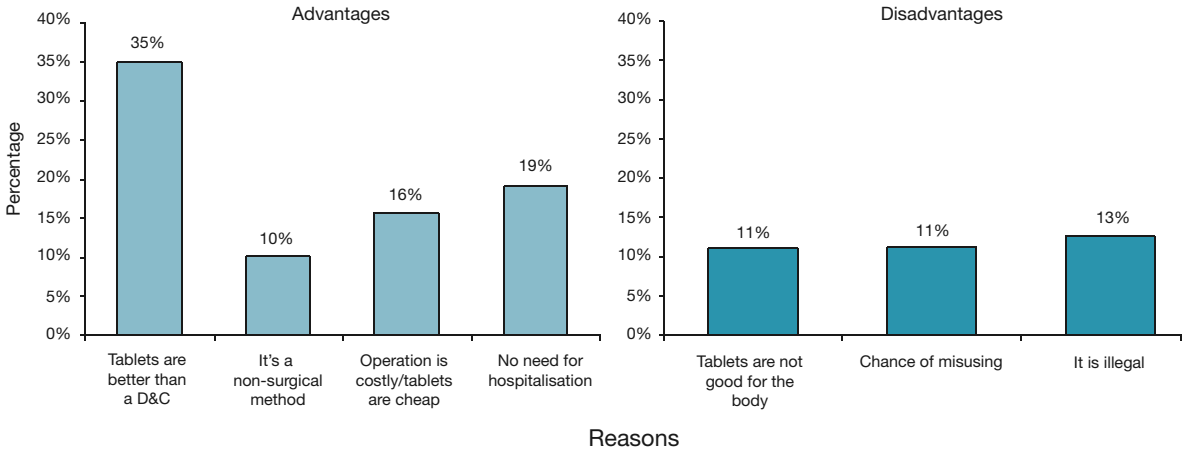
Women were asked in the survey to come up with reasons for their view that medical abortion should or should not be promoted. The most popular reasons women gave for saying that medical abortion should be promoted were that pills are better than surgical abortion (half of respondents in favour of promotion of medical abortion - a total of 35% of all the women) ,there is no need for hospitalisation and that pills are cheap.

The most popular reasons for saying that medical abortion should not be promoted were that "it is illegal", belief that the tablets are harmful, and there is a chance of misusing the tablets. Given that the major reason cited against the promotion of medical abortion is the incorrect belief that it is illegal, the number of people in favour of its promotion might rise if they were better informed about its legal status.

Table 13 Attitudes to medical abortion, women and husbands, by whether or not they or their wives have previously had an abortion

	Women			Husbands		
	No abortion attempt %	Had abortion %	Total %	Abortion %	No abortion %	Total %
Heard of medical abortion						
Yes	27.3	34.3	28.5	56.6	40.2	42.4
No	72.7	65.7	71.5	43.4	59.8	57.6
Total	100	100	100	100	100	100
Total (N)	627	134	761	53	343	396
How effective is medical abortion?						
Very effective	52.6	52.2	52.5	56.7	44.9	47
Somewhat effective	18.7	17.4	18.4	23.3	27.5	26.8
Not effective	4.1	10.9	5.5	0	10.1	8.3
Can't say	24.6	19.6	23.5	20	17.4	17.9
Total	100	100	100	100	100	100
Total (N)	171	46	217	30	138	168

Figure 4 Pros and cons of promoting medical abortion: women's spontaneous reasons for saying the method should or should not be promoted*



*footnote as per other figures about women able to give multiple responses and we only present those given by at least 10% of them

Chapter Four: Abortion service provision: practitioners and pharmacists

As well as asking women and their husbands about their views and experiences of abortion, MSI also wanted to find out about service provision from the point of view of practitioners and pharmacists.

In order to assess the types of services available from pharmacists and medical practitioners in the areas where the women and husband interviewees lived, 88 pharmacists and 87 practitioners were interviewed, approximately half coming from each state.

4.1 Healthcare providers' knowledge and opinions about medical abortion

Pharmacists and practitioners were asked what they knew about medical abortion and what their opinions were on the method (see Figure 5 over the page). Seventy-eight percent of pharmacists and 85% of practitioners considered the method to be somewhat or very effective. However, -10% said it was not effective, with the proportion rising to 16% among practitioners in Gujarat.

Pharmacists had very different views on the length of gestation for which medical abortion could be used, ranging from 10 days to 90 days. It seems likely that they were also passing these varying estimates on to their clients. Practitioners more consistently stated that the method can be used up to between 30 and 59 days of gestation (69%), but the remaining 31% either quoted shorter or longer periods, or said they did not know.

Over half of the pharmacists (57%) said they would like to know more about medical abortion. Among the practitioners interviewed, 83% said they would like to know more in Jharkhand, compared with 38% in Gujarat.

Two-thirds and three-quarters of pharmacists in Gujarat and Jharkhand respectively said they stocked medical abortion tablets. Approximately 10% in both states said they did not stock them, but would be willing to do so. The remaining 22% in Gujarat and 14% in Jharkhand said they would not be willing to stock medical abortion tablets.

For the practitioners, 44% and 19% in Gujarat and Jharkhand respectively reported providing medical abortion services. Around 20% in both states said they were not currently providing medical abortion, but would be willing to do so. However, a relatively large proportion of practitioners interviewed - 33% in Gujarat and 60% in Jharkhand - said they would not be willing to provide such services.

Those who were not opposed to providing medical abortion were asked how much they would charge for the method. Pharmacists all quoted amounts under 600 rupees (US$12). Practitioners quoted a large range of prices, from 200 to 3000 rupees. They estimated clients would pay a maximum of approximately the same amount.

Very few practitioners or pharmacists gave a reason for saying why they would not provide medical abortion, although three practitioners and four pharmacists incorrectly said that it was because the method was illegal.

Most providers thought it would be useful to make medical abortion available in the community (see Table 14 over the page). Only 21% of pharmacists and 10% of practitioners said they thought it would not be useful. Pharmacists and practitioners perceived various advantages and disadvantages to making medical abortion available. The most popular reasons for believing it would be useful were connected with the idea that medical abortion is better than other methods and does not require surgery. Side effects were the most common concern of those who felt it would not be useful.

Figure 5 Pharmacist and practitioner knowledge and opinion about medical abortion

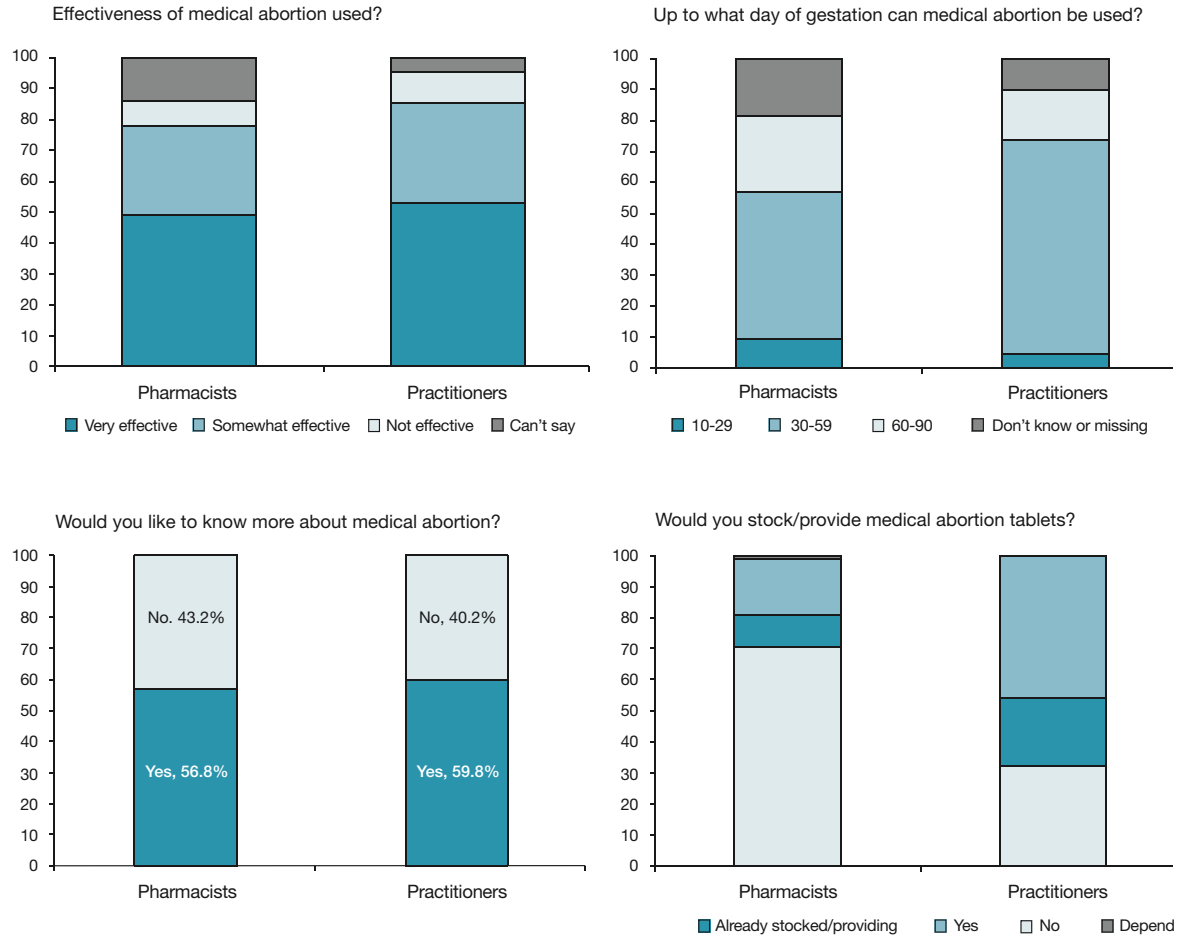


Table 14 Would it be beneficial to make medical abortion available to the community? Pharmacists' and practitioners' responses and reasons, by state

	Pharmacists			Practitioners		
	Gujarat %	Jharkhand %	Total %	Gujarat %	Jharkhand %	Total %
How beneficial would it be to make medical abortion available to the community?						
Very useful	42.2	37.2	39.8	46.7	45.2	46.0
Somewhat useful	35.6	44.2	39.8	33.3	54.8	43.7
Not at all useful	22.2	18.6	20.5	20.0	0.0	10.3
Total	100	100	100	100	100	100
Total (N)	45	43	88	45	42	87

4.2 Service provision practices reported by healthcare providers

The number of medical abortion clients ranged from one every couple of months to around 50 per month for pharmacists, and up to 20 per month for practitioners. Pharmacists report that more men than women request the method, and that men and women sometimes come for the services together.

Only 34 practitioners reported providing abortion tablets, but even among this small group the quantities they reported that the clients should take varied. Most practitioners (88%) who offered medical abortion services said clients took 200mg of mifepristone but the amount of misoprostol in most cases ranged from 200-800 µg.

When asked why they chose medical abortion tablets over other methods of abortion, practitioners said the method was easier (18%), there were fewer side effects (20%), and that they would use it if the pregnancy was less than seven weeks (18%).

Table 15 Summary of medical abortion service provision by pharmacists and practitioners, by state

Pharmacists				Practitioners			
	Gujarat %	Jharkhand %	Total %		Gujarat %	Jharkhand %	Total %
Medical abortion customers per month				Medical abortion customers per month			
<3 per month	37.8	17.6	28.2	<3 per month	13.0	0.0	9.1
3-9	32.4	26.5	29.6	3-9	60.9	20.0	48.5
10-20	24.3	35.3	29.6	10-20	26.1	50.0	33.3
21-50	5.4	20.6	12.7	21-50	0.0	30.0	9.1
Total	100	100	100	Total	100	100	100
Total (N)	37	34	71	Total (N)	23	10	33
Who usually comes for medical abortion tablets?				Do you normally stock or prescribe the tablets?			
Husband	83.3	90.6	87.1	Stock	78.3	60.0	72.7
Wife	76.7	59.4	67.7	Prescribe	21.7	40.0	27.3
Both	23.3	3.1	12.9	Total	100	100	100
Total (N)	30	32	62	Total (N)	23	10	33

4.2.1 Assessing suitability for medical abortion and providing information to clients

The providers were asked what questions they used to assess clients for suitability before providing medical abortion and what information they gave clients about the method.

Few of the pharmacists interviewed reported asking questions before dispensing the method, although most said they provided the method according to a doctor's prescription. Less than half of those interviewed said they provided information on dosage, and only 16% said they gave information on advantages and side effects. Twenty-three percent of pharmacists said that they gave no information when selling medical abortion pills.

Practitioners reported asking questions to assess eligibility for medical abortion. About three-quarters said they asked about obstetric history. Over 90% of them said they gave information about how to take the tablets.

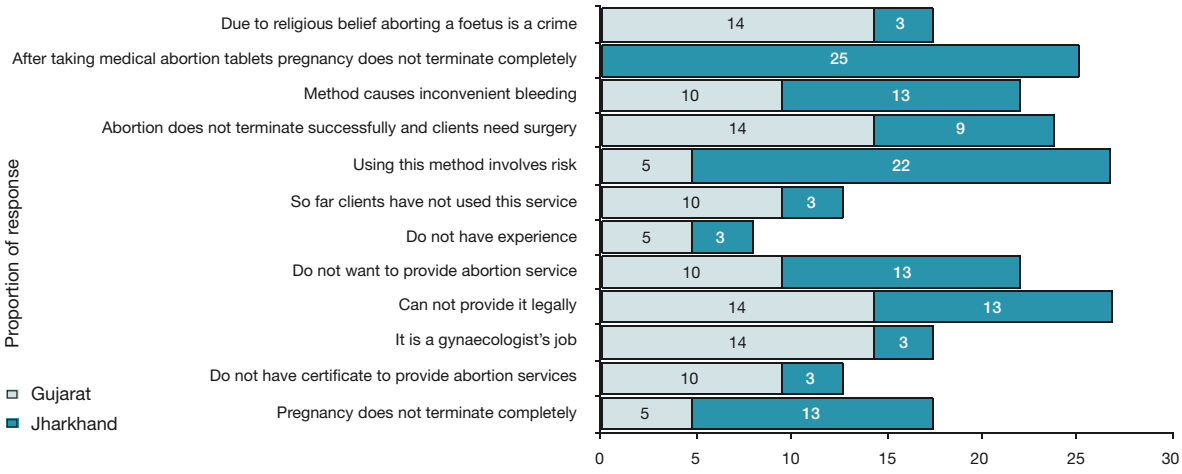
However, despite the well-known side effects of the method, such as prolonged bleeding and abdominal pain, only five (15%) said that they discussed side effects and their management. It seems possible that medical abortion clients would not know that many perceived side effects are a normal consequence of this method because so few of the practitioners and pharmacists reported discussing what would happen after taking this medication.

Table 16 Questions asked and information given before providing medical abortion: pharmacists and practitioners, by state

Pharmacists				Practitioners			
	Gujarat %	Jharkhand %	Total %		Gujarat %	Jharkhand %	Total %
Questions before providing medical abortion							
Asks if client has a doctor's prescription.	83.3	62.5	72.6	Previous obstetric history	66.7	100	76.5
Asks about date of last menstrual period.	10	12.5	11.3	Timing of last menstrual cycle	20.8	10	17.6
Nature of client request and body language.	3.3	9.4	6.5	Only after seeing sonography report	25	0	17.6
				Asks about last menstrual period	16.7	40	23.5
				Confirmation of pregnancy	12.5	20	14.7
				Any illness	12.5	0	8.8
				Health of client	4.2	0	2.9
Information provided							
None	30	15.6	22.6	Regimen of the tablet	83.3	100	88.2
Consume as per doctor's advice	30	31.3	30.6	How to take it	87.5	100	91.2
Dosage	53.3	40.6	46.8	Advantages of the method	91.7	100	94.1
Advantages and side effects	0	31.3	16.1	Side effects and their management	20.8	0	14.7
Timings	13.3	15.6	14.5				
Total (N)	30	32	62	Total (N)	24	10	34

Practitioners who did not offer medical abortion were asked why not. The reasons are summarised below. Side effects and risk of method failure were the most common reasons given.

Figure 6 Reasons practitioners gave for not providing medical abortion, by state



Chapter Five: Experiences of abortion

This chapter focuses on the experiences of women who reported that they had had an abortion.

In total the sample included 118 women who had had a surgical abortion and 45 women who had had at least one medical abortion. As mentioned in Chapter Three, this sample of women includes those identified through the household survey as well as those identified through purposive sampling so the figures for experiences of medical abortion are not generalisable.

Women were asked to describe the provider they had gone to, what type of abortion they had had and other details such as cost. These are described below. The women who had had a medical abortion were asked additional questions about that method in particular. Their answers are described in the final section of this chapter. In many of the tables in this section, we divide the women according to the type of abortion they have had.

Most women report having their most recent termination in the first trimester of pregnancy and the most popular reason given for termination was birth spacing (35% and 44% of women in Gujarat and Jharkhand respectively). Limiting the number of children they had was the reason given by 30% of women in Gujarat and only 14% in Jharkhand. The husband not wanting the child was given as a reason by 24% of women in Jharkhand and seven percent in Gujarat.

In Gujarat, four percent of women who had had a non-medical abortion and 12% who had had a medical abortion at least once said they had hidden their abortion from someone. The figures for Jharkhand were approximately double: eight percent and 21% respectively. It is notable that the women who have had a medical abortion report hiding their abortion in higher proportions than the other

Table 17 Details of most recent abortion, by state and by type of abortion

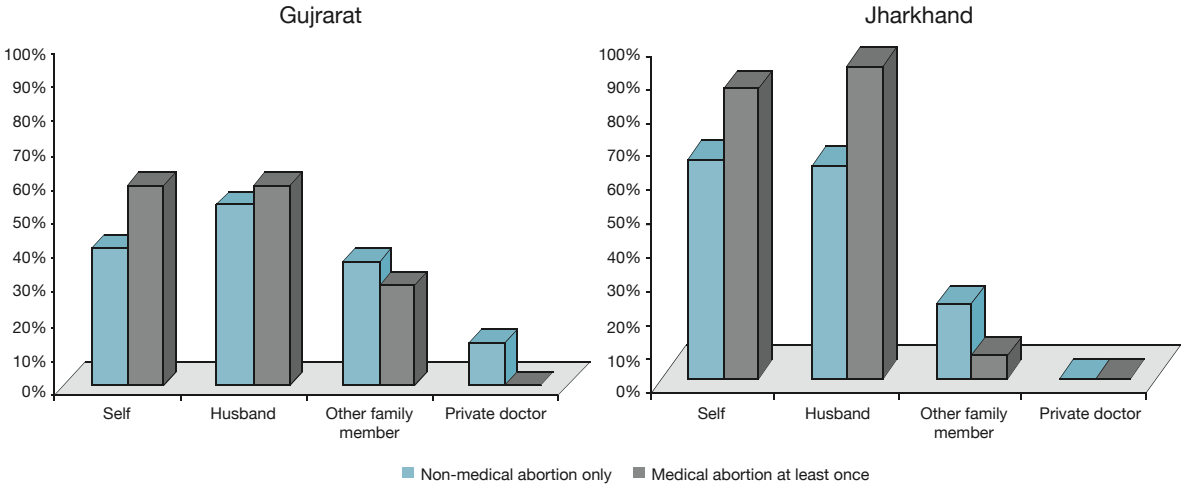
	Gujarat			Jharkhand		
	Non-medical abortion only %	Medical abortion at least once %	Total %	Non-medical abortion only %	Medical abortion at least once %	Total %
In which month of your pregnancy did you undergo your last abortion?						
First trimester	86.1	100	88.8	84.8	84.6	84.7
Second trimester	12.5	0	10.1	13.0	15.4	13.9
Third trimester	1.4	0	1.1	2.2	0	1.4
Total	100	100	100	100	100	100
Total (N)	72	17	89	46	26	72
Why did you have this abortion?*						
Spacing	34.7	35.3	34.8	46.9	37.9	43.6
Limiting	29.2	35.3	30.3	0	37.9	14.1
Husband did not want the child	4.2	17.6	6.7	26.5	20.7	24.4
Health problems	2.8	11.8	4.5	16.3	0	10.3
Foetus had congenital defects	8.3	0	6.7	4.1	0	2.6
Bleeding started so opted for abortion	8.3	0	6.7	2.0	0	1.3
Total (N)	72	17	89	49	29	78
Did you hide your abortion from anyone?						
Yes	4.2	11.8	5.6	8.2	20.7	12.8
No	95.8	88.2	94.4	91.8	79.3	87.2
Total	100	100	100	100	100	100
Total (N)	72	17	89	49	29	78

*Women were asked to come up with reasons. Only those given by at least five percent of each subgroup are presented here. Multiple responses were allowed.

women. However, because the medical abortion figures are not representative of the general population, further study would be needed to ascertain whether this is generally the case or not. It seems plausible that women who have medical abortions would be more able to hide them than women who have surgical abortions; largely because medical abortion is cheaper and does not usually require hospitalisation.

Of the 89 women in Gujarat and the 78 women in Jharkhand who had had an abortion, 44% of the women in Gujarat and 73% in Jharkhand said that they themselves had decided to terminate their pregnancy. In Gujarat and Jharkhand, 54% and 74% respectively said their husband decided, and 35% and 17% that another family member decided. Note that women could give more than one response, so these options are not mutually exclusive.

Figure 7 Who decided the pregnancy should be terminated, by abortion type and state*

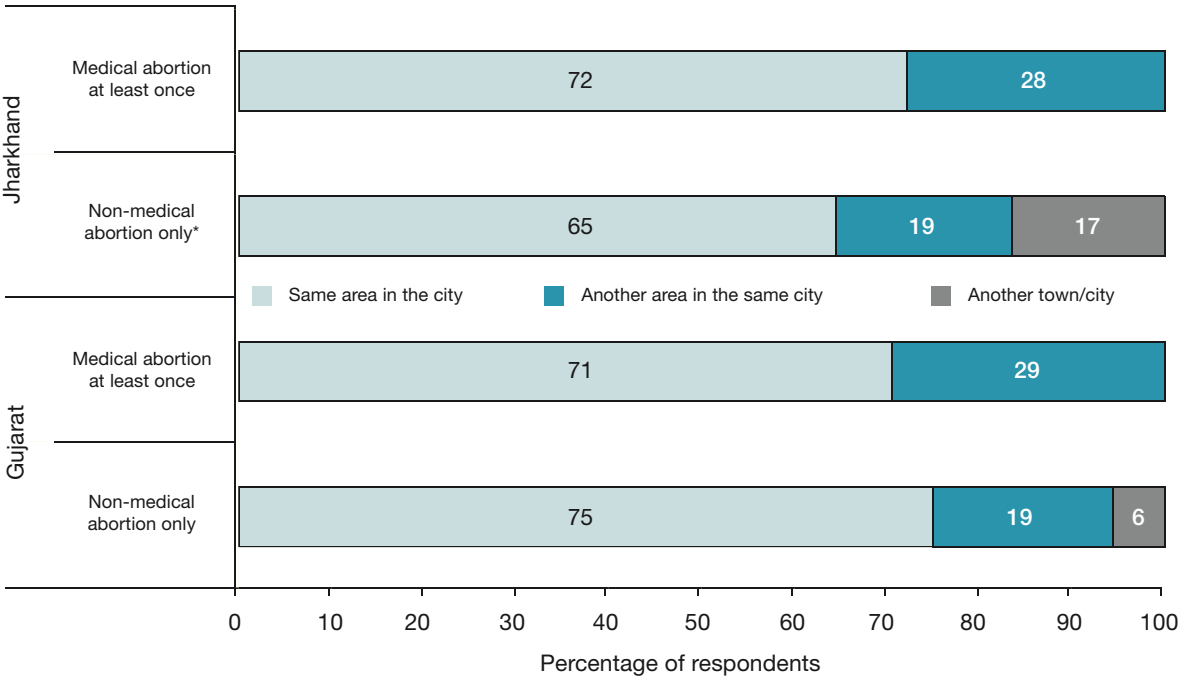


*Women could give multiple answers and were not restricted in what they could answer. Only those responses applying to at least 10% of any one subgroup are shown here.

5.1 Provider characteristics

Women were asked to describe the provider for their most recent abortion. Most women (75% in Gujarat and 65% in Jharkhand) who had had a surgical abortion used providers from their area, although six percent and 17% in Gujarat and Jharkhand respectively reported that their most recent provider was in another town or city. None of the women who had had a medical abortion reported the provider being located in another town or city. We do not know whether the women who reported having their abortions out of town left town on purpose to terminate their pregnancies. It is possible, however, that some travelled in order to conceal their terminations. If this is true, however, such women are in the minority.

Figure 8 Women's reports of location of most recent and second most recent abortion provider, by state, and by whether or not they report ever having medical abortion



* figures add up to more than 100 as rounded up

Women were asked who the provider was, and what type of abortion they had had. Most women went to a private doctor for their most recent abortion, although the proportion was larger in Gujarat (83% of women vs. 63% in Jharkhand). The next most commonly-used provider was a government doctor (15% in Gujarat, 12% in Jharkhand). In Jharkhand, 11% went to a Population Health Services (PHS) clinic. In Gujarat and Jharkhand, 13% and 30% respectively of the women who had had a medical abortion had gone to the pharmacist to obtain the method.

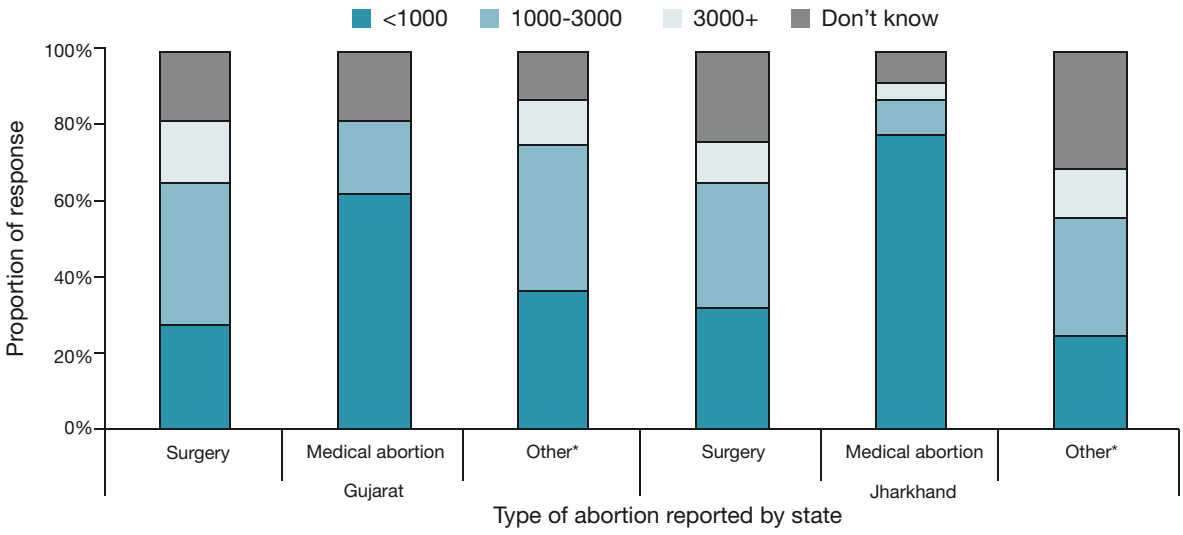
Table 18 Type of abortion women report having with most recent provider

	Gujarat				Jharkhand			
Most recent pregnancy: what type of provider did you go to?	Surgery %	Medical abortion %	Other* %	Total %	Surgery %	Medical abortion %	Other* %	Total %
Government doctor	18.8	6.3	0.0	14.8	16.2	0.0	18.8	11.8
Private doctor	81.3	81.3	100.0	83.0	70.3	47.8	68.8	63.2
Chemist	0.0	12.5	0.0	2.3	2.7	30.4	0.0	10.5
Herbalist/traditional birth attendant/other traditional practitioner	0.0	0.0	0.0	0.0	2.7	0.0	0.0	1.3
PHS clinic	0.0	0.0	0.0	0.0	5.4	21.7	6.3	10.5
Other (central government)	0.0	0.0	0.0	0.0	2.7	0.0	0.0	1.3
Total	100	100	100	100	100	100	100	100
Total (N)	64	16	8	88	37	23	16	76

*Illegal, injections, indigenous, roots, herbs, foreign bodies, massage.

One of the advantages of medical abortion is its low cost. Women were asked about the cost charged by the most recent abortion provider they had used. As would be expected, the women who had had a medical abortion reported paying less for their treatment than those who had had surgery. The majority (63% in Gujarat and 78% in Jharkhand) reported a cost of under 1000 rupees (US$20) for medical abortion. In some cases, women did not know the cost charged by the provider because their husband had paid.

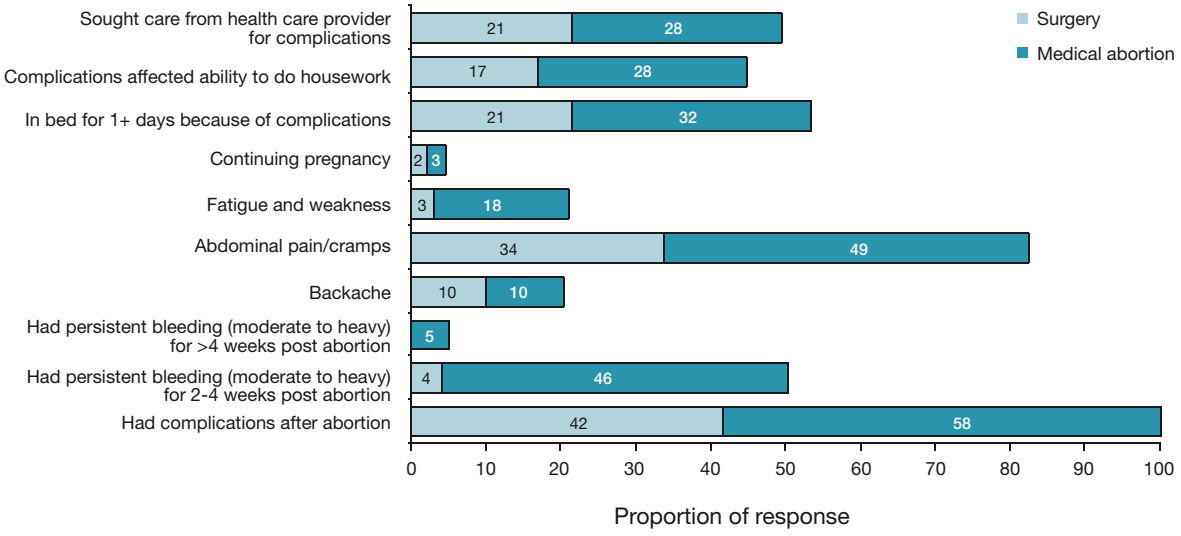
Figure 9 How much women report paying for their most recent abortions, by state and by type of abortion



5.2 Complications

All women were asked whether they had had any health problems after their most recent abortion. Overall, nearly half of the women reported some complications after having an abortion. For those who had had surgery, 42% reported complications. Among those who had had medical abortion, nearly two-thirds reported complications (64%). For the medical abortion users, however, the most common complications were moderate to heavy bleeding for 2-4 weeks (46% of women who had a medical abortion) and abdominal pains or cramps (49% of women who had a medical abortion). These are known side effects of the method and are therefore not considered complications, although women's perceptions of them are important. Approximately the same proportions of women who had surgical and medical abortions went to a healthcare provider for help with the complications, and double the proportion of women with complications after surgery were hospitalised as the result of them (10% vs. four percent of the medical abortion cases).

Figure 10 Complications reported by women after their most recent abortion, by type of abortion



5.3 Post-abortion family planning

Women were asked whether or not they had started using any form of contraception after their abortion. Half of the respondents (51%) said they did start using contraception after their most recent abortion. Of the half who did not, most said they or their husband did not want to use a method. Women who had had a medical abortion rather than a surgical abortion were less likely to take up contraception following their abortion and were more likely to cite lack of information as the reason why.

Table 19 Whether or not women used contraception after their abortion, and if not, why not, by abortion type

	Surgical abortion %	Medical abortion %	Other* %	Total %
Did you start using contraception after abortion?				
Yes	56.4	41	45.5	51.0
No	43.6	59	54.5	49.0
Total	100	100	100	100
Total (N)	94	39	22	155
Reasons for not adopting post-abortion contraception				
Didn't want to use	88.0	57.1	70.0	73.2
Both didn't want to use and didn't have info	4.0	23.8	0.0	10.7
Didn't have info	8.0	19.0	30.0	16.1
Total	100	100	100	100
Total (N)	25	21	10	56

* Illegal, injections, indigenous, roots, herbs, foreign bodies, massage.

For the women who did adopt some form of post-abortion contraception, most adopted a modern method. Among those who had had surgery, 53% adopted long-acting or permanent methods and 19% used oral contraceptive pills or injectables. Condoms were used by 28%. Among the women who had had a medical abortion, 25% adopted long-acting or permanent methods, 38% used pills or injectables, and 38% used condoms.

Table 20 Post-abortion contraception adopted, by type of abortion

Post-abortion contraception	Surgery %	Medical abortion %	Other* %	Total %
Sterilisation/intrauterine device (IUD)	52.8	25.0	30.0	44.3
Oral contraceptive pill (OCP)/injectables	18.9	37.5	30.0	24.1
Condom	28.3	37.5	30.0	30.4
Traditional method	0.0	0.0	10.0	1.3
Total	100	100	100	100
Total (N)	53	16	10	79

*Illegal, injections, indigenous, roots, herbs, foreign bodies, massage.

Approximately two-thirds of women who took up long-acting methods said they were still using them over 12 months after the abortion. Only one-third who used pills and injectables said they used them for this long, although 46% of those who used condoms said they were still using them 12 months after the abortion. The numbers are very small, so it is difficult to draw any firm conclusions.

Alarmingly, eight women report having been obliged to take up methods as a precondition of their abortion. Of these, two say they used pills and two intrauterine devices (IUD), and even more seriously, four say that they sterilised.

Table 21 Details of post-abortion contraception

	Sterilisation/ IUD %	OCP/ injectables %	Condom %	Traditional method %	Total %
For how long did you use those methods after abortion?					
<1 month	8.6	21.1	16.7	0.0	13.9
2-6 months	11.4	21.1	25.0	0.0	17.7
7-12 months	14.3	21.1	12.5	0.0	15.2
>12 months	65.7	36.8	45.8	100.0	53.2
Total	100	100	100	100	100
Total (N)	35	19	24	1	79
Did you want to accept method or was it precondition for abortion?					
Willing	77.8	75	94.1	100	82
Precondition for abortion services	22.2	12.5	0.0	0.0	13.1
Don't know/missing	0.0	12.5	5.9	0.0	4.9
Total	100	100	100	100	100
Total (N)	27	16	17	1	61

*Illegal, injections, indigenous, roots, herbs, foreign bodies, massage

5.4 Medical abortion: specific details

The women who had had a medical abortion were asked to give details about their experiences. Most of these women were specifically sampled for interview because they had had a medical abortion and so these findings are not generalisable to the wider population of women having medical abortions. However, they provide an indication of some features of how the method is used.

A majority of the women (78%) reported deciding to terminate their pregnancy in the first six weeks. Eighty-three per cent reported their spouse was supportive and only one woman reported that her spouse was unhappy about her use of the method.

Figure 11 Week of pregnancy and spouse support for termination using medical abortion

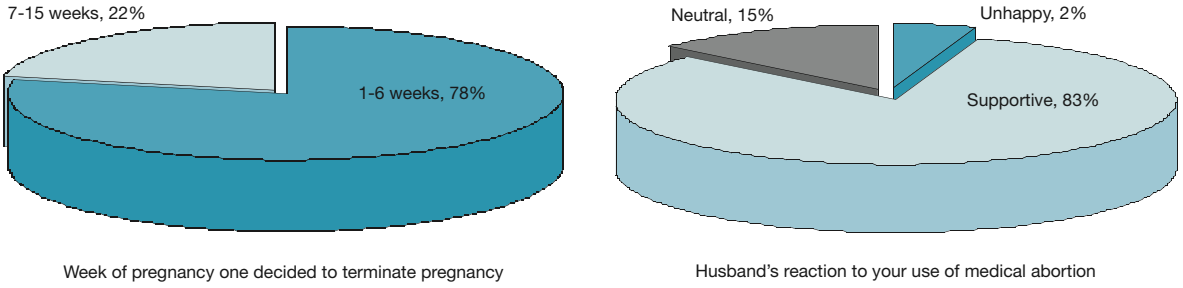


Figure 12 Women's spontaneously stated reasons for choosing medical abortion* [*disclaimer as per other figures]

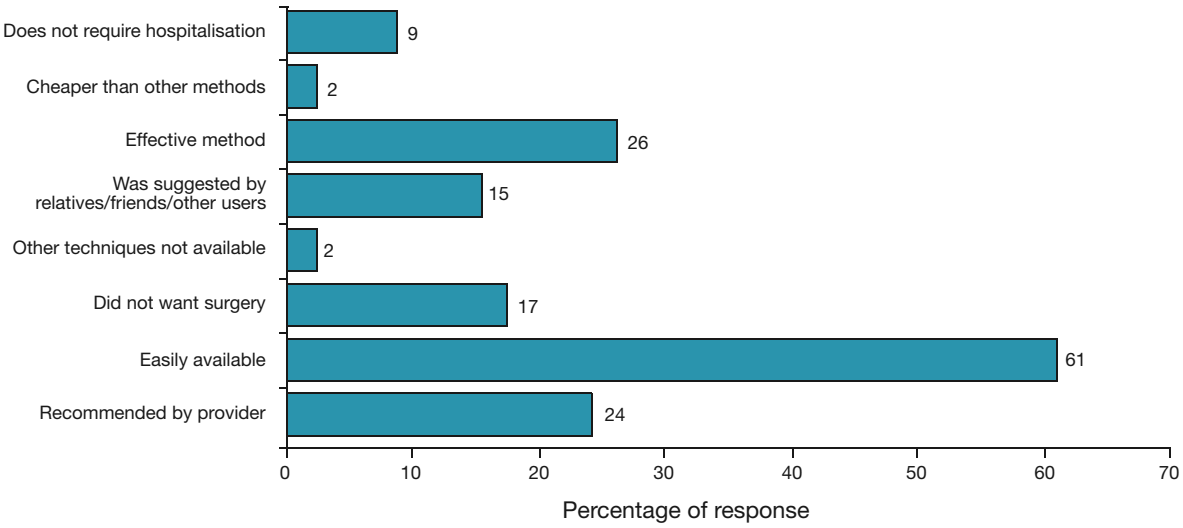


Table 22 Women's reports of the questions they were asked before they were given medical abortion

	No.	%
How many months of pregnancy?	19	41.3
Why do you not want child?	21	45.7
Any intake of pills or not	4	8.7
Total	46	

Over half the women said they chose medical abortion because it was easily available.

Women were asked what questions had been posed by the provider before they were given medical abortion. Under half (41%) said they had been asked how many months pregnant they were.[iv]

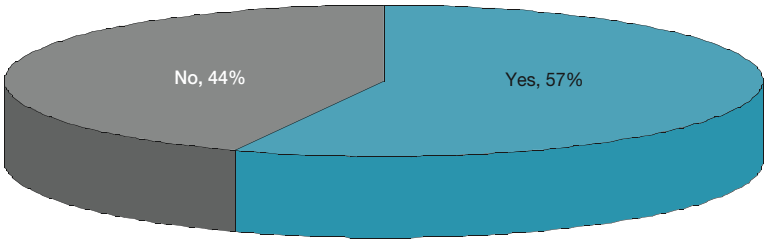
About two-thirds (67%) of women obtained the method from doctors, and one-third (32%) from pharmacists. Just under half of the women interviewed could remember the name of the tablets. Where they could remember the name, it was either medical termination of pregnancy (MTP) pills or mifepristone. Most were given instructions on use by the provider and 61% reported also having read the instructions given with the tablets. Less than half of the women went for follow up after taking the tablets. Of those women who did go, about half went in the first week.

In 65% of cases, women said they were very satisfied with the method and 56% would recommend it to others. In four cases, women said they had to take more tablets before the pregnancy was terminated. It is not clear, however, that they had taken the correct tablets or dosage in the first place as we do not have details of this. Two of these women report they were very satisfied and would recommend the method to others, suggesting that this was not a major problem. The most unsatisfied women were those where the pregnancy did not terminate with medical abortion and surgery was required. This happened in 10 cases. Just under half of women interviewed said they would not recommend the method to others. The main reason for this, which 28% of women cited, was the risk of incomplete abortion. Despite this, among the whole sample of women who had had a medical abortion, 80% said they were satisfied or very satisfied with the method.

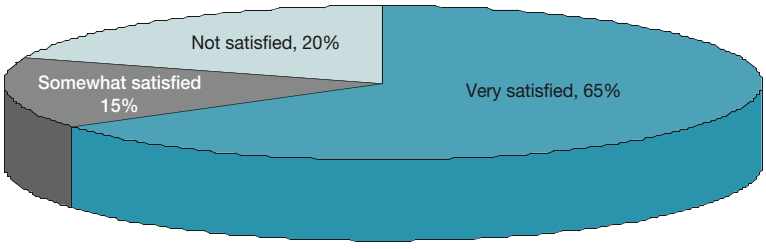
Table 23 Process of taking the medical abortion tablets

	No.	%
Source of medicine		
Doctor	31	67.4
Pharmacist	15	32.6
Total	46	100
Name of tablets		
MTP pills	8	17.4
Mifepristone	10	21.7
Kushi-Misho	1	2.2
Unknown	27	58.7
Total	46	100
Did you receive instructions from provider about how to take tablets?		
Yes	44	95.7
No	2	4.3
Total	46	100
Did you read instructions given with tablet?		
Yes, read instruction	28	60.9
Saw instruction, did not read	4	8.7
Did not read instruction	14	30.4
Total	46	100
How many days after last tablet did you go for follow up?		
Within first week	16	34.8
Between one week and one month	5	10.9
Did not go for follow up	25	54.3
Total	46	100

Figure 13 Results of medical abortion use and reported satisfaction with the method: women who had had medical abortion



Would you recomend medical abortion to others?



How satisfied are you with your experience of medical abortion?

[iv] Note: women were not restricted in how many questions they could cite. Only those cited by at least 5% of women per subgroup are included here.

Chapter Six: Conclusions and recommendations

Medical abortion distributed through low-level providers (such as pharmacists) has gained acceptability and uptake among providers and consumers alike with no major causes for concern. Medical abortion in the two states of Gujarat and Jharkhand is easily accessible, popular and associated with fewer serious complications than surgical abortion – even in the context of low levels of knowledge and training.

In conclusion, India's model of liberalised access to medical abortion has, on the whole, gained high levels of acceptability from both women and men (demand side) and healthcare providers (supply side). Although the law does not allow for pharmacists to provide the drugs without prescription, it is clear that over-the-counter sales are fairly widespread.

The study has implications beyond India as well. While India is perhaps unique in its extensive network of literate pharmacists who often self-educate by reading package inserts and drug reference manuals, other countries should also consider the possibility of extending access to medical abortion via low-level providers. The findings suggest that lower level healthcare providers such as pharmacists and informal doctors ("quacks") can provide medical abortion safely and effectively. Ideally, they would be trained to ensure correct regimen administration, quality counselling on complications and effects, and effective post-abortion contraception counselling.

Attitudes toward abortion

Overall, both women and men in the two states are generally accepting of abortion under a wide range of conditions. What is somewhat worrying is that knowledge about the legal status of abortion is low with a majority of women and men thinking that abortion is illegal. This lack of knowledge demonstrates possible taboos around open and accurate discussion on issues related to abortion as well as a failure of government to educate communities about the MTP Act.

In terms of what women and men view as important in an abortion provider, women and men in both states view a range of quality indicators as important. Interestingly, women who have had an abortion are less likely to see cost as an important issue, regardless of their socio-economic characteristics.

About two-thirds of all respondents thought medical abortion should be more widely promoted to communities, with support being even higher amongst women, especially those who had had an abortion.

There was a fairly widespread view that women could get medical abortion pills from a pharmacy and few stated that they would go to a doctor to obtain the pills. This suggests that these pills are generally seen as being available over the counter and without a prescription despite the law stating otherwise.

Perceived side effects

Interestingly, women from Jharkhand who had had an abortion were 2.72 times more likely to report that abortions had major negative side effects than women who had not had an abortion. In Gujarat, the inverse relationship was found, whereby women who had had an abortion were 0.46 times less likely to say that there were major side effects.

It is difficult to interpret this finding but it does suggest that abortion services in Jharkhand might be of a lower quality and that women who have abortions in that state may be more likely to have major side effects. This possible difference in service quality between the two states is also supported by the finding that far fewer men and women in Jharkhand compared with Gujarat reported that they could talk confidentially to their doctor about abortion. An alternative hypothesis is that there is less abortion counselling in Jharkhand and therefore women are misunderstanding minor and expected side effects and are perceiving them as major side effects. This possibility is supported by the findings in Chapter Five, which suggest that many women who undergo a medical abortion interpret the expected side effects as complications. Whatever the reason, there are generally more negative attitudes to abortion

in Jharkhand than Gujarat, with husbands from Jharkhand more likely to think there are negative side effects of abortion (regardless of whether or not their wife had had an abortion).

Support from husband

In terms of decision-making, women and their husbands from Jharkhand were much more likely to say that it was up to the husband to decide if the wife should have an abortion compared with couples from Gujarat. There were striking differences between men's attitudes towards this between the states, with 61% of men in Jharkhand saying that the decision was up to the man only compared with only 14% in Gujarat. Again, this exemplifies the more conservative and negative attitudes towards abortion in Jharkhand. The power of the man in making the decision was not just confined to perceptions of decision-making but was also evident in the analysis in Chapter Five on experiences of women who had had an abortion: 74% of women who had had an abortion in Jharkhand said that it was their husband's decision and more than half agreed in Gujarat.

It is worrying that more than one-third of women believed that choosing to have an abortion or not was up to the husband. This suggests an imbalance of power when it comes to making decisions that directly affect a woman's physical and mental well-being. Education, campaigns and counselling can help to improve understanding of women's rights as well as their sexual and reproductive health rights as laid out in the MTP Act and the 1994 International Conference on Population and Development (ICPD).

Given that data were collected on couples within households, it was possible to compare the views within a wife and husband pair. Overall, 55% of wives and their husbands agreed with each other on whether or not the husband would support the woman if she wanted an abortion. However, in Gujarat, the remaining women were overly positive that their husband would support them when in fact the husband reported that he was not supportive. In Jharkhand, where there was disagreement it was either because the wife thought her husband was less or more supportive than he actually was or more supportive than he really was. Twinned with the finding that women in Gujarat appear to perceive a social environment broadly supportive of abortion while men perceive the opposite, it seems that there are genuine differences within couples about perceived support for abortion. Given the taboo surrounding sex and abortion in India, more efforts need to be made to encourage open communication around these issues that have an impact on both women and their husbands.

Healthcare provider perspectives

The study included the views of 87 pharmacists and 88 healthcare practitioners to assess their levels of knowledge with regard to medical abortion as well as how they provide medical abortion services.

The vast majority of both pharmacists and practitioners viewed medical abortion as effective and thought that it should be promoted to communities. Despite this high level of support for the procedure, levels of knowledge and skills appear to differ somewhat between pharmacists and practitioners, with the latter group less homogenous in the advice given regarding days of gestation and regimen as well as the amount of information that they provide to clients. This suggests a possible knowledge and skills gap amongst pharmacists that should be addressed through increased training about regimens and side effects. The responses from the pharmacists correspond with the responses from women themselves, who were quite often unclear about side effects or about post-abortion contraception.

Although practitioners seemed to have higher levels of knowledge, many still wanted to learn more with especially in Jharkhand. Overall, procuring medical abortion pills from pharmacies is cheaper than going through practitioners, with pharmacists estimating costs below 600 rupees (US$12) in comparison with up to 3000 ($60) rupees amongst the practitioners.

Interestingly, the majority of healthcare providers report that it is men who buy the medical abortion pills – yet again emphasising the important role that men play in both states in deciding about abortion and procuring the drugs.

Experiences of abortion

Examining the experiences of women who had had an abortion was revealing. Compared with women who had had a surgical abortion, women who had had a medical abortion were:

- more likely to have hidden their abortion from someone
- more likely to have had their abortion locally.

Although there are various possible explanations for these differences between the behaviours of medical and surgical abortion users, it does seem that, overall, having a medical abortion might be easier to hide. This increases the possibility for women to keep the matter private, as well as to undergo the abortion closer to home.

In terms of experiences with providers, the vast majority of women went to a private provider with very few going to a government clinic (this is especially the case for medical abortion users). The cost of medical abortion is clearly much less than a surgical abortion: 78% of women paid less than 1000 rupees (US$20) for a medical abortion whereas the median amount paid for a surgical abortion was between 1000 and 3000 rupees (US$20 and US$60).

Specific medical abortion experiences

More in-depth questions were asked of the 45 women who had had a medical abortion. Most women chose to have a medical abortion because it was seen as easily available. Most women got the pills from a doctor although one-third said they obtained their pills from a pharmacy. It is not clear whether or not these pills had been prescribed earlier by a doctor. The vast majority of women were given instructions on how to take the pills, which is a positive sign. However, it seems that, in many cases, only superficial information was given (as evidenced by confusion over effects and lack of information about the family planning options available following the abortion).

About 54% of women did not return for a follow up. It is not clear, however, whether or not they had been asked to go back and so these findings are difficult to interpret. On the one hand, women are probably less likely to return if the termination of a pregnancy is successful and there are no complications. However, on the other hand, without follow up it is impossible to know to what degree the method was successful, or led to complications.

Questions were included about what drug regimen each woman followed. However, less than half of the women could remember the names of the drugs so it was difficult to untangle what drugs had been taken, in what quantities and with what intervals. The findings and analysis of this issue were therefore removed from the study.

Overall, 80% of women were satisfied with their medical abortions and 56% would recommend the procedure to others. Of those who were not satisfied, most were women for whom the medical abortion did not work and they had to have a surgical abortion (ten women). We cannot calculate a success rate for the method from these data for three main reasons: the women were purposively recruited from clinics where they may have gone because they had complications (so one would expect a higher rate of complications here than in the general population); the sample size in any case is too small to find a generalisable rate; and finally, we do not know exactly what regimen of drugs the women followed. Overall though, satisfaction with medical abortion was high, with even half of the women for whom the medical abortion did not work still saying they would recommend the procedure.

Complications

A large proportion of women reported complications following their abortion: 40% of surgical abortion users and nearly two-thirds of the medical abortion users. If these figures were to be interpreted as the real complication rates then these results would be alarming to say the least. However, on closer inspection it appears that the women were not actually suffering from complications but rather from some of the known and expected physical symptoms following an abortion. For example, the most commonly cited complications for medical abortion users were abdominal cramps and heavy bleeding – evidence that the process of medical abortion is working rather than necessarily being evidence of complications. Instead, these findings point to a lack of awareness on the part of women about what to expect when they undergo an abortion, which in turn suggests a lack of adequate counselling from the abortion provider.

Women who had had a surgical abortion were more than twice as likely as those who had had a medical abortion to

have been hospitalised as a result, suggesting that major complications associated with medical abortion were comparatively uncommon.

Post-abortion family planning

Women who had had an abortion were asked about what contraception they used following the termination of their pregnancy. The findings point to several worrying trends: first, medical abortion users are less likely than surgical abortion users to report using any contraception following their abortion and more likely to cite a lack of information as the reason why. Second, medical abortion users were less likely to report taking up long-acting or permanent methods of contraception compared with surgical abortion users (25% vs. 53% of surgical abortion users). Given the findings above regarding complication rates, it seems that medical abortion users are not receiving adequate information or counselling from their abortion providers. Again, however, it is important to remember that the medical abortion users are not necessarily representative of all medical abortion users.

Of extreme concern is that four women claimed that they were sterilised as a pre-condition for having their abortion. It is difficult to know exactly what happened in these individual cases but clearly if any healthcare provider is forcing women to be sterilised (or indeed forcing women to use any form of contraception) then that is a serious infringement of the law and should be punished accordingly.

Recommendations

Ideally, pharmacists who provide medical abortion pills should be able to assess the woman's suitability, prescribe the pills, explain the side effects, give counselling about abortion and post-abortion care and suggest follow up and referral mechanisms. In addition:

- more training on counselling is needed for providers to ensure that women are given information about any expected side effects in advance. This is particularly important in the case of medical abortion, where some of the side effects may be misinterpreted as life threatening and as a result cause unnecessary distress
- medical abortion providers should have a referral system in place in case of incomplete abortion. In these cases, women need to be referred to a safe and high quality surgical abortion provider
- education programmes should focus on improving communication within couples on reproductive health issues and should target men as well as women
- power imbalances between men and women within couples need to be addressed, especially when the result is that women are not in control of making decisions that affect their own physical or mental well-being
- quality standards need to be in place to ensure that women are adequately counselled about their options. At a minimum, women need to be given information about what side effects to expect with a surgical or a medical abortion, how to identify a complication, and what to do in the case of a complication, or in the case of failure of the method to terminate the pregnancy
- regulators need to ensure that medical abortion products meet the highest standards of quality and efficacy
- more efforts are needed to support the uptake of contraception following medical abortion and to ensure that providers are trained on how to counsel women about family planning
- women who wish to space or limit their pregnancies following an abortion should be encouraged to consider long-acting, or permanent methods of contraception as these are more reliable in the long term
- law enforcement needs to be strengthened to ensure that nobody is forced to undergo sterilisation against their will, or in return for other services
- more research is needed to determine the success and complication rates associated with over-the-counter prescriptions of medical abortion drugs
- lessons from India (and Gujarat in particular) should be applied to other countries that wish to scale up access to medical abortion services.

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