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Women's Role in Decision Making in Abortion: Profiles from Rural Maharashtra

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Abstract

This paper presents a part of the qualitative exploratory study conducted in rural Maharashtra from April 1994 to April 1996 to understand the issue of abortion from women's perspective. The paper explores the decision making process in abortion and the factors that affect this process in the overall context of women's lives. Four important landmarks in a woman's life have been used as indicators to assess women's role in decision making. Profiles of women and men, collected through case studies, interviews and observation have been presented here to represent the various situations in which abortion was conducted, namely as a method of family planning, following foetal sex determination or when there was a risk to the woman's life. Some women who have undergone natural abortions have also been included to give an understanding of the family's attitude towards the woman during an abortion. The paper highlights the fact the process of decision making involves not only the couple in question, but the larger family, also. Multiple factors intervene during the decision making phase, making the process dynamic and situation-specific. The ethical and practical dilemmas that men and women go through during the process are also ignored. The findings make out a strong case for encouraging a dialogue between the couple through counselling services before and after the abortion, providing health education related to safe, effective, reversible and user-controlled contraceptives, reaching safe abortion services to women as closed to the village as possible and increasing women's decision-making capacity in all areas of life, including those related to reproduction and sexuality.

Introduction

Women's invisibility within and outside the home is reinforced through the drudgery and the low-paid labour that she has to undertake (Shramshakti, 1988). This invisibility and silence leads a woman to accept her secondary status, even in relation to her own health and well being. Lack of access to health care, poor dialogue with her spouse and the family's utilitarian attitude towards it's women members make it difficult for a woman to discuss issues of contraception, childbirth or white discharge. Lack of the responsibility on the man's part renders the woman the victim of repeated and unnecessary abortions. This silence assumes dangerous proportions when single women in an attempt to get

rid of socially unacceptable pregnancies risk their lives in unsafe abortions or when married women conform to social norm by aborting female foetuses in an attempt to give the husband a male heir and thereby consolidate their own position in his household.

Son preference is known to affect the use of contraceptives, especially the terminal methods, in India (Rajan et al, 1996). The 'regulation' of women's fertility through foetal sex-determination in a bid to achieve the desired number of sons in also widely prevalent in the country (Ravindra, 1992 and Kanojia, et al., 1996). Abortion when used for getting rid of unwanted daughters raises dilemmas not only for the women's movement (Menon, 1995), but also for the individual woman inside her home (Gupte, et al, unpublished paper by CEHAT). The fact that medical termination of pregnancies (MTPS) are sometimes perceived as a method to reduce population growth in India has been regarded with alarm on the grounds that women's access to safe abortions is reduced when contraceptives are pushed at women after the abortion Chhachhi and Sathyamala, 1983).

Alterative approaches to women and health reiterate the fact that a lot more happens behind the scene than just choosing a particular contraceptive (Saheli, 1994). Most research studies are centred around family planning, treating decision making, autonomy and gender inequalities as determinants of fertility (Morgan et al, 1993) and linking these to unmet needs of contraception. Gender bias in contraceptive acceptance has also been documented as a hurdle within this context (Raju and Bhat, 1996). The poor social content of contraceptive programmes has been deplored with the recommendation to incorporate the related health and social needs of the prospective clients', with a view to make the high-investment projects more successful (Bongaarts and Bruce, 1995).

Oil the other hand, male dominance in sexual relationships and the indifference of the State in addressing women's health issues has been identified as a major problem by women's health activists in India, noting that it is because of these reasons that women have no control over their fertility and ill-health (Karkal, 1995). The question is thus as follows: is the central issue the availability of information and provision of user-friendly service related to contraception or abortion, or does one also have to address issues of sexual politics and critique the State's undue emphasis on family planning and its neglect of most other health needs of women. The women's movement has 'now begun to question the simple connection between women's inability to plan their pregnancies and the concept of 'unmet needs' of contraception. The same truism holds for making a choice related to abortion. A multitude of factors affect the reason why women seek abortions in India, ranging from financial constraints and spacing to son preference and stigma (Chhabra and Nuna, 1995).

The link between a woman's parity and the family's decision to abort her pregnancy has been established in a retrospective study in China. No induced abortions in the first pregnancy, and the almost universal termination of the second pregnancy were determined by cultural norms and the State's policy regarding family planning (Pitig and Smith, 1995). Cost, distance, as well as quality of care affect women's decisions to seek health care, as also do the interactions between the various actors involved in decision making, namely the family, status of women, opportunity cost and financial cost, previous experience with the service and so on (Thaddeus and Maine, 1994).

The present paper is based on one aspect of a qualitative study conducted in six villages of the drought prone part of rural Maharashtra. A note on the methodology and background of the entire study has been appended herewith. The data was collected through in-depth interviews with the women, meeting each one of them between eight and thirteen times. In this paper, we have presented parts of these interviews, as profiles of twelve women from different caste, class and age groups. We have attempted to document the different course a decision making process takes in different abortion situations and the impact that these decisions cave on a woman's body and mind. Since abortion cannot be fully understood in isolation, we have explored the decision making process in four other important aspects of a woman's conjugal life as well, in an attempt to contextualize her role in decision making in abortion.

1. Decision Making in Context:

As mentioned above, the woman's role, if any, in choosing her spouse, contraception and the first pregnancy, place of delivery and children's education. This paradigm, we feel, can throw light upon whether it really is possible for a woman to decide whether to have an abortion in the reality of her existence as a daughter-in-law in a rural area.

a. Fixing up of the Marriage.

In most of the instances, our respondents had seen their spouse before being married to him. Most of our couples reported that their consent had been asked for before the family finalised the proposal. In their narration's, however, we found that in most situations, women agreed to the match for reasons other than genuine desire to be married to the prospective groom. One's parent's inability to pay large sums of dowry; the number of younger sisters to be married in the future, parents fear that their daughters were growing and so on were major reasons why they agreed to be married. Even when the woman didn't actually like a prospective groom, compromises were made in the wider interests of the natal family.

Some narration's quoted below would give a glimpse of what actually happened in the lives of our respondents: Before my husband came to see me, there was an executive engineer's proposal for me. He was smart, I too had liked him. But he demanded Rs.25,000 in dowry. I rejected that proposal because I had two younger sisters. It would have been a had precedent. My husband did not ask for dowry. Since I was working, I had decided not to agree to any dowry.

My parents fixed up my marriage. I don't feel strongly about it now. Well, even if they had asked me What would I have known? Once, after the wedding I had a fight with my mother about this match. because everybody used to say that my parents hadn't selected the right groom for me. I was married here because my uncle wanted his daughter and myself to be married in the same, house. Both of us were married at the same time, to reduce expenses. My father repaid the money to my uncle after his retirement.

I wasn't pleased with my present husband when I saw him. There had been another proposal for me at the same time; that one was very smart looking. My father didn't want to wait too long, whereas those people were not ready for an early wedding. So the engagement broke up and this one was fixed.

My consent was asked for I didn't have much education. My husband has passed his tenth standard examination. Where would 1 get a more educated husband? My in-laws also did not want an educated girl. We were not in position to give any dowry and they did not ask for any.

b. Planning for the First child and the use of Contraceptives.

None of our women or men actively thought about or decided when to have their first child. The first pregnancy 'just happened'. In fact it was expected to happen once the couple were married. Dialogue between the spouses immediately after marriage, even about routine matters is often lacking and therefore is not very practical to expect that some conversation regarding sexual relations and about when to have the first child would actually take place is not very practical.

"Nothing was ever decided. I conceived one year after marriage. What and how could anything be decided anyway? We did not have the freedom even to speak to each other as long as we stayed with my in-laws".

"I got pregnant a year and a half after marriage. We did not decide anything. We had not even spoken on this topic."

Women as well as men said that the idea of planning for (in terms of delaying) the first child is not an accepted norm in the rural context. The family as well as the woman herself starts worrying if she does not conceive within a year or two and it is generally agreed that sooner the bride proves her fertility, the better it is not only for the woman concerned but for the whole family. Delayed conceptions are frowned upon. In the majority of the cases even the second issues were not planned.

A few of the couples have used contraceptives at some point of time, though the others did not use them at all. The deterrent against using contraception were voiced by a few.

We never used a contraceptive. When to speak and when to use? So many of us were staying at home. I used to feel so shy. Others come to know about everything that went on between husband and wife. What can one do when there is no space ? We never did it (had sex) in that crowd. 1 just couldn't do it that way".

c. The Fast Delivery

Except one, for all our women respondents, the first delivery took place in their natal villages. In most cases this decision, which is in accordance with local custom, was taken by the couple, sometimes along with the in-laws. Even then, this apparently simple decision was taken for many complex reasons. When a woman felt that her in-laws were reluctant to look after her during and after child-birth, she spoke with some amount of bitterness.

I decided to go to my mother's place. Since my mother-in-law gets possessed, childbirth is taboo in this house. She told me to go to my mother.

My husband is a suspicious man. He wouldn't trust me to go alone, even for a delivery. He sent his aunt to escort me. The second time I went to my mother on my own, once the labour pains started.

By custom the first delivery takes place at the mother's place. Besides, there wasn't any one here to care for me. My father came and took me.

My in-laws had spent so much money on my pregnancy that they didn't want to give my mother the credit of having looked after me. My mother was quite poor, so 1 stayed back in my in-laws household.

I went to my mother because my mother-in-law said that she couldn't give a bath to a small baby. God knows who brought up her own children. Anyway, my mother had already started preparing for me as any mother would naturally do.

Though women prefer to be with their mothers and natal family during the first pregnancy, they feel let down when the in-laws refuse to take care of them, in spite of the problems at their mother's place. Women's power to negotiate is quite low in the decision regarding the first delivery and more often than not, the convenience of the family is considered to be more important than the woman's needs or desires.

d. Decision about Children's Education.

Women responded very emphatically that they would educate their children irrespective of whether it was a boy or a girl further saying that their husbands too felt similarly. While trying to fulfill their own aspirations through their children, women felt that external factors, such as the economic condition of the family and the mandate of the head of the household ultimately decide how much education their children would receive. As farming was becoming more and more unproductive the family members were forced to educate their children, even at the cost of seeking loans.

"They will be educated to the extent that they can stand on their own feet. What happened to us should not he repeated with them."

"I will not give my daughter to a farmer. I am going to educate her a lot. My son does not have such a sharp brain, though".

"My, husband wants to educate the children and see that the daughters get jobs. Boys prefer educated brides to pretty or hard-working ones these days".

1. Decision Making in Abortion

A. Natural abortions: Profiles:

1. Diksha. (Age: 21 yrs; age at marriage (aam): 13 yrs; education(ed): 6th standard occupation(occ): works in family farm in addition to household duties)

Diksha had a son through her first pregnancy. When the son fell ill the local doctor diagnosed it and gave Diksha a medicine with the intention of curing her son through the breast milk. At that time she had been two months pregnant, but

the doctor had been unaware of this fact. When she started getting abdominal cramps.

She went back to him. He gave her an injection this time. That night, the pains increased and Diksha aborted', with acute pain and heavy bleeding of clots. She was unconscious by the time her husband reached her to a city hospital. She had to undergo a curetting there. Diksha is unaware as to who took the decision of the curetting. She thinks that the doctor may have decided on his own, after seeing her condition. All the relatives who lived close by, were by her side, when she underwent this traumatic experience. Another son was born to her, later on.

2. **Leela (Age: 32 yrs; aam : 17 yrs; ed: 7th standard; occ: teacher in Nursery in addition to household duties)**

Leela gave birth to a still-born child in her first pregnancy, whereas the second pregnancy resulted in a miscarriage. When, during the third pregnancy she started to bleed, she was taken to a private hospital. For two days she received treatment, after which the doctor advised a curetting. Since she could not afford the doctor's charges, he suggested that she be taken to the civil hospital. That night, at home, Leela spontaneously aborted and had to undergo a D and C at the civil hospital on the next day. Leela's fourth pregnancy resulted in a seventh month premature delivery at home. The child died immediately after birth. At this stage, Leela started to have dreams of local spirits (water nymphs) called the Mavlayas, who according to local belief control women's fertility. She made offerings to them, begging for her fertility, after which, Leela got pregnant once again. The fifth pregnancy, which according to Leeta was a blessing from the Mavlayas, resulted in a full-term normal delivery of a daughter, though there had been some bleeding during the third month. The private doctor on hearing her problematic obstetric history, consulted a specialist and Leela's cervix was stitched up to prevent another premature delivery, this time. After the birth of this daughter, Leela had an infertile period for seven years, during, which no treatment for, infertility was given to her by the family. However, Leela strongly maintains that her husband is a caring man and he always said that he didn't care even if they never had a single child throughout their lives.

When Leela got pregnant after this long wait, she went with her husband for a sex-determination. The couple had planned to abort the foetus if it had been female even before returning to the village. She says that even though the husband had always been supportive, she didn't want to take any risks and jeopardise her marriage by not giving a son to his family line. Since the foetus was male, the pregnancy was continued after stitching up the cervix once more. The much awaited son was born. Leela's seventh pregnancy resulted in a natural abortion. After this, the next (eighth) pregnancy was terminated for FP reasons.

The MTP was conducted in a private hospital in strict confidentiality. Only the husband accompanied her. She was scared of getting the abortion done, but she feels that she will not be scared any more because she now has experience. Her tensions, and emotional turmoil were because of the natural abortions she underwent and not because of the MTP. Because the son is only two years old, Leela is waiting for a few years before getting sterilised. In the meanwhile, she doesn't want any more children.

3. Anandi (Age: 31 Yrs; aam : 14 yrs; ed: 8th standard; occ: housemfe)

After seven Years of infertilitv Anandi's husband's family had begun to mention remarriage for the husband. At this point the mother-in-law did not allow the re-marriage to take place, as Anandi was her brother's daughter and because they had got her as their daughter-in-law after great persuasion. Otherwise, Anandi's mother-in-law did not get along with Anandi at all, and the older woman did not approve of medical intervention either. Anandi's father-in-law took her for treatment on the motivation of a nurse in the neighbourhood. Anandi conceived, but no one believed her and thus she was not taken for a check-up to the doctor as promised. Anandi had a natural abortion after doing some heavy, washing. She fainted and then was given an intravenous drip at home. She, was then taken to the earlier specialist for treatment and eventually gave birth to two daughters and a soil. Anandi's husband who was violent to her before her first conception, mellowed down after the first daughter was born. Anandi was very upset at the birth of the second daughter, but once again, the father-in-law gave her emotional support. All the initiative to give Anandi some medical attention also came from the father-in-law. The husband was not concerned in the earlier phase. Only during the later conceptions he accompanied Anandi to the doctor largely at his father's behest and with the old man paying for all the bills. Anandi's mother-in-law still feels that too much of the family's hard-earned money was wasted on Anandi's treatment. Anandi had a tubectomy three years after the son was born, the reason being that this son was rather weak, was overmedicated and had required constant invocations to the local village deity.

4. jyoti. (Age: 20 years; aam: 17 yrs; ed.. Sth standard; occ: daily wage labourer)

Jyoti had to undergo an abortion during her first pregnancy because there was a risk to her life. Having not had any ante-natal care during pregnancy, in the seventh month of pregnancy she, accompanied by her sister, went to enroll herself in a private hospital. The doctor saw that her blood pressure was extremely high and when the family said that they could not afford her fees, she directed Jyoti to be taken to the civil hospital, without giving any medical treatment. Jyoti wanted to go back home and wait, since she was unable to take any financial decision on her own, in the absence of any member of the in-laws'

family. The doctor then called for an ambulance to take Jyoti to the city civil hospital where a sonography report confirmed the fact that the foetus was already dead. The doctor in the civil hospital asked for the husband to warn him that he may have to conduct a Caesarean section. To this, the sister replied that there was no husband around to decide or to give his written consent and she requested the doctor not to conduct any surgical procedure. At this point the doctor got angry saying that he lied to save Jyoti's life at any cost. The next morning the husband came and signed the consent form. The decision to abort was thus taken by the doctors in question. No confidentiality regarding the abortion was maintained and her mother as well as her brother & sister-in-law visited her when she was in hospital. A fortnight later, after the BP was under control, Jyoti returned home. The in-laws were upset that the investment they had made during Jyoti's pregnancy, in terms of nutrition and money had all gone waste. She has never received any medical attention thereafter in spite of the fact that she has not conceived during the past two years. She spends most of her time in her mother's village.

Discussion

In Diksha's life, the fact that she aborted was not conceived by the family as 'her fault'. In fact, she was a victim of an iatrogenic abortion. Since she already had a son, Diksha's status in the household was relatively high and so found that the husband's family stood by her through the curetting. Another son down the line consolidated Diksha's position in the family, again.

Leela's obstetric history was so hopeless that the family almost gave up on her. Through eight difficult pregnancies, Leela had to muster inward strength and also use her body and mind as a coping mechanism, through her mystical dreams. Leela's infertility was never treated by the family. Leela feels that she is lucky that the husband did not re-marry at all. In spite of being aware of this benevolence she underwent the sex-determination test so as not to try his 'goodness' too far. Also induced abortion in Leela's life was also as stigmatised as her earlier inability to produce a child, with confidentiality being maintained about this act. The fear that the family may pressurise her to produce more children was at the root of this secretive behaviour. The insecurity in the earlier phase does not allow Leela to get sterilised immediately, for if the son were to die, and she were sterilised by then, the husband would still be encouraged to remarry.

Anandi gets some support from her mother-in-law, because the latter wants to save her own face with the brother with whom she pleaded for his daughter's hand. The brother had obliged in spite of the fact that the son-in-law was dark-skinned because the dowry demanded was very paltry. Having a first cousin for

a husband however did not save Anandi from his beatings in her infertile phase, nor was she taken for any treatment, until a health worker motivated the father-in-law. Throughout, the husband did not wish to incur any expense on her medical care and the mother-in-law was resentful.

While Jyoti did not get any ante-natal care during pregnancy, her sister took her to the doctor for a check-up and a serious health problem was detected. The sister, being from the natal family cannot take financial decisions nor can she decide whether Jyoti can go through a Caesarean section. These important decisions, can only be made by the husband and his family. Since the pregnancy resulted in a dead foetus, the-in-laws feel that all their investment into Jyoti's pregnancy was a waste. Because she had no child before this abortive pregnancy and because the family somehow believe that having gone through a Caesarean the first time has resulted in her inability to get pregnant again, Jyoti ends up spending more time in her mother's village more or less deserted by the in-laws.
In the above four profiles, we find that something as innocuous as natural abortions are not as value-free as one would imagine.

Rarely was the woman in question considered the central figure around whom the decision's took place in the family. A single mis-carriage may be seen by the family as a unfortunate accident, but repeated abortions are frowned upon, almost as though they were the woman's own fault and worthy of stigma. Whether the women has borne a child, especially a son before the miscarriage also makes a difference to the manner in which, she will be treated or cared for.

It is in this context that one has to scrutinize the choice or decision making powers that a woman would exercise the process of undergoing an induced abortion.

B. Abortion for Family Planning: Profiles:

1 - Shweta. (Age: 42 yrs; aam: 16 yrs, ed: illiterate; occ: runs a grocery shop)

Shweta's first two pregnancies resulted in natural abortions. Since her periods, her husband had been taking her to a see private hospital (where he had insurance coverage) for treatment. There, the doctor, had said that it was, impossible for her to conceive because her uterus was too small. Nonetheless, she had two sons, both with normal deliveries. After her two sons were born, twenty years ago, she had an MTP because they couldn't afford another child. She decided about the, abortion along with her husband, and it was conducted in the same semi private hospital because of earlier positive experience with that place. Her husband and her sister came with her. Since she wasn't on good terms with her in-laws, she did not tell them about the abortion. Her own parents could not

visit her in the hospital, being illiterate and too old to travel to the city on their own. She was not scared during the procedure and was even sterilised at, the time of the MTP. She did not suffer very much emotionally due to the abortion. she had some other tensions of her own at that time, she said. She would talk to other women in favour of abortion and says that had she got pregnant once again. she would have gone through an abortion again.

2. Radba. (Age: 25 ym aam: 17 yrs;. ed: 4th standard; occ: daily wage labourer)

Radha underwent an MTP for family planning reasons. The couple has never practised any form of contraception as Radha had a 'natural' spacing of four years after her first pregnancy. She has two sons and this time the conception occurred almost immediately after the last delivery. She said that the decision to abort this pregnancy was taken by her husband and herself. All the other family members, including her natal family, were strongly against the decision, but they finally gave in. Her husband's sister took her to a private doctor with whom she had a positive experience herself. Radha's husband, mother-in-law and the sister-in-law accompanied her. She was also sterilised at the same time. Her mother and brother visited her in the hospital. The family were emotionally upset because not only did they see the aborted foetus, they were also asked by the doctor to dispose it off. During the procedure, Radha was scared that she would die. She says that she would have undergone another abortion too, if needed because they just could not afford another child. If consulted, she would counsel other women in favour of abortion, though she feels a little disturbed about dropping a foetus.

3. Surekha. (Age: 24 years; aam: 18 yrs; ed: 7th standard; oce: works in family farm)

Surekha, who also underwent an abortion for FP reasons, is not sterilised as yet. She has two sons. When she didn't want another child, she decided to abort her pregnancy. She went to a local abortionist in the second month, thinking that she would be given an oral abortifacient. The local healer told her that she would have to insert some stems into the uterus to pierce the foetus and to bring it out after eight to twelve hours. She also told Surekha that fever with chills or severe pain were to be expected after the abortion. Besides, the charges may run up to Rs. 200, at the rate of Rs. 100 per month of pregnancy. This frightened Surekha and she decided against an abortion. The decision to undergo an MTP was taken by the couple together.

After this, Surekha went to the rural hospital to get a flee MTP. There she was told that abortion services were not available at the moment, but that she could undergo a sterilisation on the day of a camp, later on Surekha returned, without

the MTP. At this point, a distant relative suggested a private doctor and so Surekha went to her. The doctor gave her some tablets and told her to return after a week if her menstrual periods did not resume. Accordingly, Surekha returned, accompanied by her husband because his signature was asked for at the time of abortion. The husband told the doctor to perform a sterilisation on Surekha, but the doctor did not have laparoscopy facilities. Surekha could rightly stay for a week to undergo a tubectomy, and so she returned without a sterilisation. Surekha was afraid that she would die during the procedure. No one visited her and confidentiality was maintained about the MTP, especially from the in-laws. Though she would prefer to avoid an abortion in future, she would be ready to go through it again if necessary and would advise other women in favour of abortion too. She has no negative feelings about having undergone an MTP.

4. Sanivani. (Age: 30 yrs; aam: 18 yrs; ed- 4th standard; occ: Nursery teacher)

Sanjivani underwent an abortion for FP reasons after having given birth to one son and a daughter. Sanjivani's experiences with pregnancy have been negative, especially since there she received no support from her in-laws. The deliveries had also been very painful and so she was totally against going through one more childbirth. She underwent the MTP and sterilization at the same time. The couple took the decision together and Sanjivani first 4 went to a private doctor to confirm her pregnancy. She could not afford the doctors charges and so she went to a public hospital after being advised by women neighbours. Her husband and sister-in-law accompanied her. None of the in-laws visited her; to date her mother-in-law does not know that Sanjivani is sterilised. She was so scared because, the procedure that she wanted to run away from the hospital. Sanjivani also feels that while she would prefer it avoid an unwanted pregnancy she would also be ready to go through an abortion again if needed and will go through an MTP, if circumstances demand such a thing.

5._Vimal (Age: 35 yrs; aam: 17 yrs; ed: 10th standard; oce: Nursery teacher)

Vimal has undergone an abortion for FP reasons, as well. She has three daughters and one son. The eldest daughter was eighteen, and the youngest son was ten years old, when suddenly, Vimal became pregnant. Both she and her husband were embarrassed by this late pregnancy and so they made the decision to abort. When she went to the health centre of the local women's group, she was found to be over three months pregnant. She was advised to wait for another month and then to undergo induced labour. However, Vimal was impatient to end the pregnancy and she went to a private doctor because the doctor had a good reputation. Her husband accompanied her because the doctor said that in an emergency it might become necessary to shift her to the city. She had no

visitors and her in-laws were kept in the dark about the abortion. She was afraid of the abortion, not having gone through anything like that before. She too would try to avoid an abortion, but she was prepared to undergo one herself, if needed. She feels that an abortion is much less trouble than a delivery and she would tell other women the same thing. Neither she nor her husband are sterilised as yet, because she doesn't want a laparoscopy and neither can she stay away from home for a week as she is a balwadi teacher. A vasectomy was never considered.

Discussion

All the five women who used abortion as a method of family planning had children before they underwent the MTP. Whereas two of the women had one son, the other three had two sons each before they decided upon an MTP, mostly in lieu of a sterilization. In spite of the specific situations that each woman was in, there are a number of similarities in the stories of all these five women. The husband's family was not a confidante with any of the women; in fact, fearing their negative interference, the abortions were kept a secret from the in-laws. Four of the women had been scared during the procedure; yet all of them would be ready to go through an abortion again, if needed, rather than have an unwanted child. They would also advise other women to use abortion services, if and when required.

We must note that when the women say that they were scared during the abortion, they were not so much concerned about the fate of the foetus, or the ethical and moral dilemmas at this point, as they were for their own safety, fearing harm and death. The only woman who said that she felt disturbed about killing a foetus was the one whose in-laws were given the aborted foetus for disposal by the doctor. The family, who had anyway been against the abortion from the start, were visibly upset at having to go through this ordeal. Counselling services, which explain the procedure to women before the abortion would do much good to the woman undergoing this invasive medical intervention.

Three of the women also underwent sterilisation at the time of the abortion. Radha, who underwent a sterilisation in spite of the fact that her younger son was an infant, already had another older son. None of them had wanted any more children; the pregnancy had surprised them and had been unwanted right from the start. Yet, none of the couples had practised any method of contraception, either at this point in time or throughout their entire married lives. The two women who did not undergo a sterilisation during the abortion, did so because they did not approve of the method of sterilisation available with the doctor. Surekha had wanted a laparoscopy because she wanted to go home

immediately. The unavailability of this technique has left Surekha without a sterilisation, to date. On the other hand, Vimal did not trust a laparoscopy and neither could she stay away from home for a week to undergo a tubectomy. As a result, she has not been able to have a sterilisation as yet. The family, while reluctant to provide physical support to a woman does not even consider vasectomy of the husband as an option.

Choice of provider depended on earlier experiences and recommendations from relatives and neighbours. When women fail to get decent services in the public sector, they turn to the private doctor. On the other hand, when they cannot pay the fees of the private doctor, they go to the civil hospital. Quite often, women do not receive medical care in the sector they prefer. Saving money is a major concern for women. When women cannot work, as in Vimals case, they are forced to seek the closest and quickest service available, even if large expenses are involved.

C. Abortions following foetal sex-determination: Profiles

1. Sakhu (Age: 27 yrs; aam: 21 yrs; ed: commerce graduate; occ: works in family farm)

Sakhu underwent an abortion following a pre-natal sex-determination test. The female foetus was aborted in spite of the fact that Sakhu already had one son, born after the elder daughter. The family urged her to go through an SDT because they were convinced that two sons are necessary in a family. The father-in-law had suffered many hardships and he felt that had there been another brothers his life, his problems with the extended family would have been shared. Sakhu had seen that her daughter was discriminated against at home and she felt upset at the differential treatment meted out to the son and daughter. She was not ready to give birth to another daughter in this environment.

While the test was performed in the fourth month of pregnancy through sonography in a private hospital in Kolhapur the abortion was carried out in a private hospital near Pure because of a previous positive experience she had had there. She went to stay with her mother following the SDT because her husband went out of station for some work. She went through the MTP in her husband's absence as the pregnancy was fast advancing. Her sister accompanied her to the hospital. She had no visitors in hospital and even though the family convinced Sakhu to go through the SDT, the abortion following the test was kept confidential from the in-laws. Her sister had experienced trouble during an abortion and so Sakhu was quite scared during the procedure. The procedure was conducted by inducing labour and she suffered a lot of pain and discomfort. When her husband returned, he was very upset to see his wife in such a bad

physical state and remarked that he was unaware that women have to undergo so much trouble after an abortion. She says that she will never go through an abortion again and will also never advise another woman to do so. She feels mentally disturbed that one should kill one's own child with such careful planning. She also feels that it is unfair that a woman has to go through so much trouble and pain during an abortion.

2. Suvarna. (Age: 27 yrs; aam: 22 yrs; ed: Arts graduate and holder of a Diploma in education; occ: Primary School teacher)

Suvarna underwent an abortion following a sex-determination test through sonography in a private hospital during the fourth month of pregnancy. She had one daughter at that time. Her maternal relatives and friends convinced her to undergo the test; she herself also had badly wanted a son. She and her husband agreed to the test because Suvama is a working woman and they could not afford to have too many children. Her relatives experience with a private hospital had been favourable and so she went there for the abortion. Her husband accompanied her. The abortion, conducted by inducing labour, was kept a secret from the in-laws, especially from her husband's brother, because the two families do not get along. Suvarna's husband is emotionally closer to her parents than to his own family.

Suvarna did not feel emotionally upset after the MTP because the whole thing had been firmly decided upon by her and her husband. Though Suvarna was not scared when she underwent the MTP, she will never want to go through an abortion again and will tell women not to undergo a SDT or an abortion, ever. Because the doctor gave the foetus to the family for disposal, she is, haunted by the feeling that she has done something wrong. She is pregnant at this point in time, but she will not go through a SDT again, in spite of the fact that she still wants a son.

Discussion

Sakhu already had a son when she underwent the SDT. Because of family pressures and due to discriminatory behaviour at home, she did not want a daughter. On the other hand Suvarna did not have a daughter and actively wanted a son. Both of them got put off after the abortion to the extent that Suvarna gave up her desire of acquiring a son through selective abortions.

What makes these two profiles startlingly different from the earlier ones is their aversion to abortion once they have gone through it themselves. On closer consideration, one can see three reasons. Firstly, it is not the pregnancy that is unwanted, the daughter is. Therefore, women are not mentally prepared for an

abortion until the moment when the pre-natal test detects a female foetus. The decision to abort has to be made within a short time span. Since the test is performed in the fourth month an immediate abortion is imminent. Such an abrupt and unplanned abortion must surely cause a lot of trauma to a woman. Secondly, when one selectively decides to do away with a female foetus, it must be precipitating guilt feelings as well. Further, the fact that one has now to go through one or more pregnancies to give birth to a male child must also create emotional pressure on the woman in question.

Thirdly the fact that abortions following sex-determination occur in the second trimester, the emphasis of having gone through unnecessary labour as well as the fact that the foetus is quite developed must also create a sensation of having committed infanticide.

The aversion of these two women to abortion has to be seen in the combined context of the SDT, followed by a selective and late abortion of a pregnancy that would have been continued if the foetus had been a male.

D. Secretive abortions: Profiles:

1. Dina. (Age: 41 yrs; aam: 16 yrs; ed: 7th standard; occ: daily wage labourer)

Dina had a number of abortions. The first pregnancy resulted in a miscarriage. A son and daughter were born to her ,after that Dina had to take care of her husband's younger brothers and sisters as well and in this situation she could not take care of one more child therefore the decision to abort the third pregnancy was entirely decided upon by her husband and herself. This MTP was conducted by a local abortionist, due to financial pressures and because Dina could not leave her husband's younger siblings at home alone. Soon after, her husband became very suspicious of her fidelity to him and oven now, he often denies paternity of both his children as well as of the foetus that had been aborted.

Thereafter, Dina never told him of all the abortions she underwent. On one occasion, she took a loroquine tablets from the local health worker hoping that she would abort, but it didn't work. She went through one more abortion, again at the local abortionist, since she was convinced of the good skills of the old woman. The third abortion was conducted in a public hospital. Dina also underwent two more abortions in private hospitals, without any one accompanying her. She had no visitors during any of these occasions; in fact the abortions were kept a secret from all, including the husband. She experienced a lot of pain during the local abortions and that scared her about abortions in general.

Dina was ready to go through any number of abortions, because she didn't want any more children. Her husband refused to let her use any form of contraception because he feared that she would become promiscuous. Dina has attempted to use pills as well as a Cu-T without the husband's knowledge, but somehow, these attempts have not been long-lasting. She cannot undergo a sterilisation because her husband will see the scars and he may not abstain from sex for the prescribed period after the operation. She is unhappy about destroying a foetus; even then she will tell other women to undergo an abortion if needed. She feels safe now, because she reached menopause at a rather early age, eight years ago.

2. Uma. (Age: 20 years; aam: 15 yrs; occ: labourer

Uma was married five years ago at the age of fifteen. Her husband was a physically violent man and in spite of many negotiations on the part of relatives, he would continue to beat her. For the past two years, Uma has been living with her mother. Uma's mother was convinced that her son-in-law was having a sexual relationship with his own sister and so she had filed a legal suit for separation on behalf of her daughter. In the meanwhile, Uma got pregnant. When questioned, she said that her husband had visited her once in her mother's absence, two months ago. However, the pregnancy however was nearly three months old and the neighbouring women whispered that Uma was having a relation with another man and was now trying to pass off his child as that of the husband.

Uma's mother contacted the health centre of the local women's group for advice and counsel. The gynaecologist there told her that if she went to the government hospital, they would insist on the husband's signature besides which they would insist on her using some contraceptive after the abortion. On the other hand, if she said that the husband was not the father, she could get a legal abortion only if she said that it was a conception through force and rape. If she didn't feel like facing up to these 'options', then she would have to go to a private clinic. Naturally, Uma and her mother went back depressed.

A week later, Uma's mother came to tell us that Uma had suddenly menstruated and that in fact, she had never been pregnant at all. Almost everyone knew that Uma had been taken to the local abortionist in a neighbouring village for a clandestine abortion.

Discussion

Dina and Uma have had to go through secretive abortions because of 'problematic' sexuality, within and outside marriage. In both cases, the paternity of the foetus was in doubt. Not only was an abortion absolutely necessary in

these cases to maintain the status quo, the abortions, also had to be conducted in secrecy. Dina's suspicious husband does not trust his wife even to use a contraceptive and Uma's violent husband has deserted her (and perhaps even visits her secretly). These women cannot take their husbands into confidence. Dina's sexuality within marriage is regarded with suspicion by her own husband, whereas Uma's sexuality is altogether denied, because she is deserted. Whereas Dina's abortions received some public sympathy, Uma's abortion became an outright scandal.

The fact that Dina and Uma made their decisions without consulting their husbands can create a false illusion of autonomy. As in the earlier profiles where the in-laws are kept in the dark. these two women hide the abortions from the husbands because they are worried about the husbands' negative reactions to their pregnancy and the decision to abort. The space of decision making in this context, may actually be considered to be diminished, rather than liberated. When one's sexuality or sexual loyalty is under question, deciding alone may actually be a reflection of being lonely and abandoned, besides being refrained from acknowledging one's feelings, sexuality and motherhood. Having said this, the two women who go ahead and get an abortion for themselves are brave in their refusal to remain passive victims of the force of circumstance, even at the cost of hurting their bodies and minds.

The fact that both these women went to local abortionists in a clandestine manner shows their reduced bargaining power in negotiating sexuality. Putting themselves at physical and emotional risk, and at the risk of punishmnent if caught in the act, these women try to navigate their way out of the quicks and of sexual politics.

Conclusions

In the above profiles we find that women are unable to make decisions regarding most major events in their own lives, ranging from marriage to the education of their children. Family members decide the fate of women depending on the needs of the household, which in turn are governed by social norms and traditions. As the years go by, women seem to gain more space if they have produced children, especially sons. Women spoke with some vehemence only when speaking about the children's education. Here again, social norms dictate that as a mother one should make-proper decisions on behalf of one's children. Just as one's mother decided for oneself, so the woman replays the role of caretaker of her children. Whereas a woman is not permitted to make important decisions regarding her own life, she is expected to participate in making decisions regarding her children later on. Some, space is thus accorded to her even by the traditional family at this point in time. This observation would lead

one to, believe that a women's participation in decisions that get taken in the first few years of marriage would be low, whereas her negotiating space would gradually and relatively increase as the, years go by provided that she has conformed to social norms and expectations.

The fact that a woman has a bad obstetric history does not necessarily mean that the family will take extra care during her succeeding pregnancies. Remarriage is considered an easier and cheaper (in fact lucrative, because the second bride also bring's in a little dowry option to deal with infertility or troublesome obstetrics. Bigamy is rampant in our region, with instances where the husband has deserted an earlier wife for 'her' infertility, in the absence of any diagnostic tests or has sent a wife home because she has no sons. In our focus-group meetings, women's remarriage and bigamy for the husband, saying at the same lime that remarriage for any woman was unthinkable in whichever situation. To save themselves from desertion, women have no option but to allow their reproductive and sexual rights to be trampled upon by the family. Their silence in decision-making become their survival strategy in a household that may otherwise turn hostile.

On the other hand, in spite of going through troublesome pregnancies, women desperately want to have a son. The obsessive desire to continue the male family line is a factor, which determines the nature of the treatment meted out to women. The family that grudges spending on a woman s health does not worry much about money when a sex-determination test has to be performed, or when an abortion is performed in a private hospital to ensure confidentiality. 'Important decisions like expenditure and invasive medical intervention are also considered the prerogative of the husband and his family. Furthermore, a woman may actually suffer because she went through such an intervention. No wonder then that women hesitate to take these decisions on their own, leaving the responsibility of the act upon the in-laws.

However when women have some amount of dialogue with their husbands, they hide their abortions from the joint family, perhaps because they resent the in-law's interference in their private lives or because they are afraid that the family may create hurdles for them. While this partial confidentiality may actually be an indicator of good relations between husband and wife. Women who undergo abortions in absolute secrecy have to trade minimum standards of quality of care in order to maintain the dark secrets of socially unacceptable pregnancies (Gupte et al., 1995).

Contraception for a man is hardly ever considered. A husband will not normally use a contraceptive, whether it is a condom or a terminal method like vasectomy. Perhaps the husband wants to keep his reproductive choices open even after the wife has been sterilised, either for bigamy or for re-marriage. In this light, we can

understand the refusal of the wife to undergo tubectomy if she does not have a son, and also her fear that her husband will re-marry thereafter on the pretext that he does want a son after all. In some cases, we find that husbands refuse to let their wives use any method of contraception, out of the fear that she will then become promiscuous.

The same family is willing to let a woman go through repeated abortions throughout her fertile phase even after she has had the number of children the husband wants. The woman complies, because even she is worried that if her youngest son does not survive (the chances of this are high if the son is very young, she might need to bring forth, another son. To make matters worse, the State pushes sterilisation or provides controlled contraceptives at women when the latter come for abortions, further reducing the, space that women have in accessing abortion. Health education and counselling before and after the MTP are better option for increasing the dialogue between couples so, that women are not forced to go through reated abortions.

It is interesting to note that though most of our couples stated 'failure of contraception' as the official reason for demanding an MTP, none of them were actually using a contraceptive prior to the conception. Since MTP is available to Indian women only under certain situations, women sometimes have to, bend the truth a little in order to get a safe abortion. If married and cohabiting women also face a problem in accessing a, legal treatment it is no wonder that women whose sexuality is 'suspect' go to a local abortionist. The gap between women's real needs of abortion and the limitations of the MTP Act have been explored by the authors (Gupte et al ibid). When we found that the present Act is inadequate in its scope implementation and in providing, access to women who bleed safe abortions the most.

When some of the women said that they were scared during the abortion procedure, it is interesting to note that they were, more concerned about, their own well-being, then about the foetus. If women do feel a little, guilty about the 'foeticide' act, it is either before or after the abortions especially if they saw the globe head, foetus this and from going through the procedure. In after the procedure. In no instance did guilt actually prevent a woman most of the stories, women said that they would undergo another abortion if necessary and, would give similar counsel to other women. At the same time, they were not happy about women being made to go through repeated abortions. When women know for a fact that husbands will in no way accept the responsibility of contraception, they see abortion as their last and much needed defence when an unwanted pregnancy occurs.

The only two cases where women said that they would never go through an abortion, again were those where a sex-determination test was involved. The decision to abort a pregnancy is accompanied by disappointment for the couple who wanted a son. Seeking an answer to a traditional value like son preference from reproductive technology can create confusion and uncertainty. Suppose the foetus is actually male?

The fertility of the whole exercise as well as the knowledge that one will have to go through a similar process nice again can also create a feeling of being trapped. After procedures such as; amniocentesis came into ill-repute, currently the most prevalent method of SDT is through sonography (which is reliable for sex-determination only after the fourth month of pregnancy) and therefore these women have had to undergo induced labour as a method of abortion. Being subjected to the sight of a semi-developed foetus after the abortion can trigger tremendous guilt, as well.

Similarly, safe abortion services must be available and accessible to all women at an early stage in their pregnancy to alleviate the physical and emotional trauma as far as possible. Cost, distance, quality of care, safety and confidentiality are important determinants for women's access to these services. A non-threatening, woman friendly environment would go a long way in making women feel, safe and cared for. A holistic approach to reproductive health within a comprehensive public health programme that is available to all people irrespective of their capacity to pay, would be the key to increased choice or women in the Indian context.

Increasing space for women to negotiate their sexual and reproductive rights within and outside the family is extremely important, in the absence of which it would be difficult to expect her to make active decisions regarding abortions in specific. While a woman's rebellious act may temporarily increase space for herself, the same act may boomerang unless there is an active back-up support through legislation and social activism. Furthermore, one should not expect women to merely 'negotiate' all the time. Enhancing women's role in decision making in other aspects of their lives, including marriage is an important prerequisite to making women more assertive in reproductive rights. While reproductive and sexual health could become good anchors for a woman to understand and reclaim her body, a fragmented focus on reproductive health can be inadequate to create real freedom for women to take charge of their own lives. Policies and legislations that are pro-woman and pro-poor in character would also be needed as a backup for marginalized sections, to voice their needs and to demand services. Empowering women in all aspects of life, within or without marriage is essential if we wish to increase women's role in decision making in the area of reproduction and sexuality.

Note

The intention was not to perform a comparative analysis, but to record the qualitative nuances in the narrative of the %men in differing situations. An established rapport with the people of the region since the past eight years and the fact that women with whom we had a long retationship of work were identified as contact-persons to authenticate the collected data and also served as the voice of conscience to us. Informed consent was taken from all respondents before collecting all data and the data were constantly reviewed throughout the one year of data collection. The methodology was participatory and woman-oriented. A three-woman ethics committee, which included local rural woman, was involved in the on-going social audit (in the research project)
During monthly meetings of the focus groups (through eight months), we documented women's reproductive health problems, abortion needs, their perceptions and little experiences with abortion services quality of care, choice of provider, decision making processes, sexuality and so on. Simulated role-plays, semi-structured questionnaires and in-depth interviews of men and women, provided the techniques through which data were gathered. Twelve women who had a abortion were identified as case studies for more detailed interaction. The data pertaining to this paper are based on some of these life stories.

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