Abortion Services and Providers' Perceptions: Gender Dimensions

This paper explores the gender dimensions of abortion-service providers' perceptions of women who access such care. A study in two districts of Maharashtra indicates that providers' responses to abortion situations are shaped largely by their attitude towards women, to women's health care and especially to abortion care. These attitudes in turn influence women's access to abortion and to the quality of service.

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I Introduction

Gender constitutes an important dimension of the socio-cultural and political context within which interactions between health service providers and users take place. Users as well as providers of health care services are part of a social system governed by patriarchal norms. By patriarchal norms we mean a worldview that considers males as inherently superior to females, and values and privileges men. Medical training institutions, medical curricula and the organisation and management of health services are not without the impact of patriarchal and gender biased value system. Thus, even though they may not be aware of it, service providers are more likely than not to reflect gender biases. In addition, their knowledge allows them to have an authority and upper hand while interacting with service users, which means that service users may find themselves at the receiving end of discriminatory attitudes and practices on the basis of gender.

This paper explores the gender dimensions of abortion-service providers' perceptions of users. Gender norms and values related to femininity and what is appropriate for women to do govern a whole range of issues related to women's abortion needs. Gender power relations between women and men place women in a situation where they are often without power and authority in negotiating sexual relations with men. They may also have limited access to contraceptives and power to use these even when available. Ironically, however, it is women who bear the brunt of non-use of contraception, while men seldom take responsibility for preventing pregnancies either through abstinence or through use of contraception themselves. When faced with an unplanned or unwanted pregnancy, women may once again find themselves facing barriers to termination of the pregnancy from their male partners and from others, including service providers.

Providers' responses to a particular abortion situation are shaped largely by their attitude towards women, to women's health care needs in general and to abortion care needs in particular. Their understanding of woman's status in the family and society; of the power dynamics between women and their partners and family members; all these have implications – desirable or undesirable – for women's access to abortion care and quality of care that she receives.

The significance of providers' perceptions and attitudes is evident when viewed against the fact that according to the Medical Termination of Pregnancy (MTP) Act, it is the medical doctor who decided whether or not an abortion seeker fulfils the criteria spelled out in the Act. It is for the medical professionals to decide as to how liberally or restrictively to interpret the Act in a given socio-political context. In addition to other factors, providers' attitude towards and understanding of women and their abortion needs influence the interpretations of the Act and is an important variable influencing women's access to abortion services.

In this paper, we examine providers' perceptions on women's abortion needs in terms of whether these perceptions reinforce the gender based value system victimising women or facilitates a gender sensitive (and not a gender neutral) value system empowering women. The information discussed in this paper was collected as part of a larger initiative entitled 'Research and advocacy programme for improving access to abortion' taken up by CEHAT, a non-governmental research and advocacy organisation. Research under this larger initiative was conducted primarily to assess the quality of institution based abortion care services. Providers' perception about women's abortion needs was studied because we believed that this will have an important influence on the quality of services provided.

II Study Area and Methodology

The study area consisted of seven sub-districts in two districts of Maharashtra, India. The study units were health care facilities. We undertook enumeration of health care service centres in the selected study area using the snow-balling technique to define the universe, viz, abortion care facilities, as there was no information available on this. One hundred and thirty (130) providers from 115 facilities participated in responding to questions regarding perceptions of providers about women's abortion needs. More than one third (36.2 per cent) of the respondents were women, and about half of the respondents were not qualified to perform abortions as per the MTP Act.

Providers were requested to express their views about: abortion as a spacing method, abortion in case of failure of contraception, abortion after sex determination, second trimester abortion

situations, and abortion as a woman's right. In addition, they were also asked to articulate as to who are responsible for women to face abortion situations in general.

Women researchers conducted interviews of head of the institutions and abortion service providers at health care facilities, which together lasted for about 90-120 minutes.

III
Providers' Perceptions

Providers held either individuals and/or individuals' circumstances responsible for women's abortion situations. Some providers articulated the dynamics among various factors and often shared information on specific situations.

The spectrum of individuals held responsible for abortion was wide and included those closest to the woman seeking abortion. Husbands alone were held responsible by about 35 per cent of the providers, the woman herself by 41 per cent and both the woman and her husband were held jointly responsible by 44 per cent of the providers. In addition, about 8 per cent of the providers held family members and relatives responsible and about the same number explained situations of abortions among single women specifically.

It is worth taking note of the fact that the woman seeking abortion was held responsible for being in that situation by more women providers than men (more than half as compared to only about one third), more urban than rural providers (45 per cent vs 32 per cent) and more private practitioners than public providers (44 per cent vs 20 per cent). One reason why public providers and rural providers tend not to blame the women may be that they interact with women from comparatively poorer communities and are better able to understand the situation of the abortion seeker. It is difficult to understand why women abortion providers are unable to empathise with women seeking abortions. Could it be that their privileged position alienates them from the experiences of average women?

Providers who held husbands responsible offered many different explanations. According to them, husbands did not accept available male contraceptives and forced their wives to undergo abortion in case of unplanned pregnancies. Husbands/men not having education was thought to be the reason why they did not understand the significance of planning pregnancies and using contraceptives to achieve the same. Providers felt that husbands dominated decision-making in this regard. Some providers talked about the power dynamics between married couples in terms of sexual negotiations. In case a woman did not fulfil her husband's sexual demands or meet the family's expectations regarding sex composition of their family, she was replaced by another wife. It was the fear that they were utterly dispensable which forced women into situations of unwanted pregnancies.

As mentioned earlier, a larger number of providers held women responsible for they facing the situations of abortion. Men were not to be expected to know about how women's bodies worked and what the risks of pregnancy in specific situations were:

> ...Wife must know about it (conception during post-delivery amenorrohea). Males do not know about such things. Women alone should know about that.

Others said that women needed to be more firm and decisive in implementing their decisions regarding the number and spacing of their children. It was women's responsibility to communicate with their husbands on matters related to regulating fertility, and make their husbands understand the difficulties involved in adding one more mouth to feed.

Many providers felt that women were not the helpless victims they were made out to be; and that they were perhaps not genuinely interested in planning and avoiding pregnancy. Contradictions, according to them, are too obvious to be ignored. For example, how was it possible that a woman be coerced and forced into unwanted or unprotected sex on the one hand, but be independent enough to terminate the resulting pregnancy? Why was it that educated women were not aware of reversible contraceptives when even uneducated women and women from the older generation knew about it? Why were women unwilling to use reversible methods of contraception even when these were available?

Providers often categorised the abortion needs of unmarried and other single women differently from those of married women. Opinions as to who was responsible for abortion situations of these women were divided. Widows, separated and even unmarried women facing situations of abortions were held responsible because they were the 'sexually indulging type'. In cases of abortion situations arising of rape, men were squarely held responsible.

There was a strong disapproval of pre-marital sex. Families were held responsible for not keeping watch on young unmarried girls who had a natural tendency to seek sexual pleasure and also denied that such a thing existed earlier in the past.

> Pregnancies among unmarried women (indicative of extra-marital sex) are on rise. People's attitudes are changing. One's character (moralities) is not valued now. People are after momentary pleasures in life. I think society is responsible as a whole.

Only a few providers felt that women's lack of decision-making power was responsible for their unwanted or unplanned pregnancies. Parents and parents-in-law played a decisive role in whether or not a woman could use contraceptives, on the number and sex composition of her children, among others. They said that women in joint families had no rights or autonomy to make reproductive decisions. While highlighting specific situations such as men migrating to cities for work, providers spoke of men's tendency to have complete control over women's sexuality by not allowing their wives to use reversible contraceptives. At the same time, neither did they use any contraceptive when they visited their families, and often caused unwanted pregnancies.

There were also a number of social factors mentioned by providers as responsible for women having to undergo abortions, including son preference, lack of sex education, ignorance about contraceptives and misconceptions about side-effects of available contraceptives.

Abortion as a Spacing Method

India's MTP Act allows abortions for the indication 'failure of contraceptive' and is silent about use of abortion as a spacing method. Of the total MTPs recorded in India in 1990-91, about 42.2 per cent were done for failure of contraception [Chhabra and Nuna 1994].

A community based study conducted in Maharashtra recorded a whooping 74.1 per cent of abortion either because desired family size was achieved or because pregnancy was mistimed [Ganatra et al 1997]. In another community based qualitative study, contraceptive failure did not get overwhelming support by women as a reason for abortion [Gupte et al 1997]. But the

same study indicated that women do resort to abortion as a spacing method and/or failure of contraceptives, reflecting its inevitability in absence of guaranteed access to safe and sure contraceptives. These data suggest that (a) there is an increase in resorting to abortion for the reasons of spacing and (b) abortions are not denied when sought for as a spacing method.

In the present study, opinions about use of abortion as a spacing method varied between two extremes – concern for women's health and using women's vulnerability to make business.

A large majority of the abortion providers (96/130) held the view that use of abortion as a spacing method was 'inappropriate', 'not good', 'not advisable' when there are a wide range of reversible contraceptives available. A substantial number of them explicitly articulated the consequences of abortion to women in terms of ill-health – bleeding, irregular menses, aches and pains, secondary infertility and life-threatening risks arising of anaesthesia. Many emphasised the risks involved in abortions, the procedure being invasive. According to some, use of abortion as spacing method also implied women's exposure to repeat abortions and thus, increased risks. A substantial number of providers (41/130) said that women should prevent unwanted pregnancies rather than going through the ordeal of an abortion.

Other providers said that they did not think it was their job to prevent unwanted pregnancies. They did not counsel for post-abortion contraception, because it was of no use. Women's repeat abortions because of non-use of contraception for spacing had earned abortion providers their business. They argued that by charging a higher fee from women of rural rich households who did not care for family planning, they would be able to provide abortions at subsidised costs to poorer women.

Forty three providers (43/130) were of the opinion that use of abortion as a spacing method cannot be completely eliminated. It was thought that accidental conceptions despite contraceptive use or intention to do so, and change in reproductive intentions after conceiving will make abortions necessary in any society.

From a medical point of view, second trimester abortions involve more risks of complications because of physiological reasons compared to the first trimester abortion.

However, India ranks among countries with the largest number of second trimester abortions. Of the total MTPs recorded in 1990-91 for India, the share of the second trimester MTPs was 15.69 per cent [cf Chhabra and Nuna 1994, pp 42]. According to a community based study conducted in Maharashtra, about 29.1 per cent of the abortions were second trimester [Ganatra et al 1997:8]. Community based qualitative research studies have shown that women are faced with second trimester abortions owing to the complex decision-making processes related to abortion seeking [CEHAT unpublished data, ICMR 1989].

Providers interviewed by us stated multiple reasons for women facing second trimester abortion situations. 'Abortions followed by sex detection' was the single most important reason mentioned by the majority of abortion providers. Some went as far as saying that sex selection was the only reason for second trimester abortion. Ignorance about indications of a pregnancy, negligence during lactational amenorrohea, missed periods mistaken as amenorrohea were the reasons mentioned by a significant proportion of providers. Some providers attributed ignorance to women being 'illiterate'.

The stigma attached to an act of abortion, the societal pressures that women have to face and their efforts to maintain confidentiality were some of the other frequently stated reasons for second trimester situations. According to some, the social stigma attached to an act of abortion also caused time lapse because women tried to terminate pregnancies using various other methods, and also because of delays in decision-making about terminating pregnancies.

It was said that in the case of unmarried women, delays in disclosing 'illegitimate' conceptions led to second trimester abortions. They added that in such situations, disclosure was feared because of its devastating social consequences given the severe social sanctions against such sexual 'indulgence'. Further, according to them, many unmarried women were denied abortion by providers because of social sanctions, which caused delays in getting an abortion done.

The above mentioned reasons stated by a large number of providers did not find significant variation across various analytical categories.

> ...Unmarried women can't approach. If they do, it may create problems. Doctors refuse to provide services. As a result they face second trimester abortion situation.
>
> ...in case of unmarried – (they tell) us that they had not come in contact with anyone. (Women) refuse to accept (sexual interaction with anyone). Those asleep could be awakened but not the ones who pretend to be asleep!

A few (14/130) also stated that women's domestic constraints such as work load, financial inability, lack of time which obstruct them to approach service providers in time. Most of the providers who said so (12/14) were males.

A few providers acknowledged malpractices that their fellow practitioners were engaged in, which caused women to face second trimester abortion. This included their lack of expertise and use of irrational drugs such as EP Forte, and involvement in providing abortion services by unqualified health personnel and general practitioners without a license to provide medical termination of pregnancy.

Thus, according to the providers, sex selection, social sanctions against seeking abortions by certain groups of women, women's own gender-related constraints and lack of access to safe abortion services contribute to second trimester abortion situations. In addition, malpractices by the medical community also contributed to second trimester abortions.

Sex Selective Abortion

A community based study documented 16.8 per cent of the abortions were after detection that the foetus was female [Ganatra et al 1997]. It is difficult to come across any community based study which would tell us sex selective abortion rates. A woman underwent nine sex selective abortions consecutively after having three daughters [CEHAT unpublished data]. The decreasing sex ratio has also been considered as one of the indicators suggesting increased sex selective abortions. For India, the sex ratio exhibits a downward trend over the decades. Providers' perceptions on the issue needs to be viewed against this backdrop.

There were three major trends reflected in providers' position on the issue at hand. The majority (64 per cent) said that they are against sex selective abortions; another 10 per cent said that they too were against it but they had to do it; and the rest about 24 per cent approved the practice of sex selective abortions. Most of the providers tended to explain their position on the issue of sex selective abortion.

There was not much variation across providers working in public/private health care facilities or rural/urban location of their practice. However, the pattern was different across men and women providers. Of the total men providers, about 28 per cent approved of sex selective abortion practice whereas it was much less in case of women providers (17 per cent). Correspondingly, higher percentage of women providers (68 per cent) compared to men (61 per cent) were against such a practice; and this trend continued in case of the position taken 'disapprove but have to do it'.

Of those – the majority – who opposed the practice, some said that they would not ever compromise on ethical principle and therefore had never indulged into abortion service provision at the cost of negative implications for their medical practice. Some of them expressed their opposition sharply by saying, 'it should be banned', 'it is criminal', 'it is inhumane', 'it is matter of principles (ethics and human rights)', 'discrimination based on sex is objectionable', 'I feel agitated to realise such practices prevail'. However, the majority who clearly stood against the practice did not always speak in terms of 'opposition to discriminatory practices'. The various other explanations offered included, 'it causes ill-health to women', 'balance between men and women will be disturbed', 'tests are not reliable and thus it is futile', 'for women to become mother is important and adequate'.

Those who disapproved of the practice of sex selective abortions but engaged in it against their principles expressed their helplessness. On the other hand some spoke of compulsions at their ends for two reasons. One, pressures arising out of unhealthy competition in the health care service sector. It was said that if they had not provided abortion care services, some others in anyway would have provided them. Two, the pressures those arise out of implications that women may have to face back home in case they did not get abortion done. Many talked of compulsions that women have at their ends to go for sex selective abortions arising either out of social norms fostering son preference or because their lives are put at stake in case they do not produce son. Some also said that unwanted girls run the risk of severe ill-treatment at their natal homes causing them emotional and mental trauma. In anyway, providers' empathy for women's social needs for sex selective abortions seem to have been a major factor.

Among those who responded in favour of sex selective abortion, there prevailed convictions about the legitimacy of sex selective abortion practice in the "interest of society" and "nation's larger objectives for everybody's good" without any regrets about violation of medical ethics or human rights issues involved in discriminatory practices. The explanations offered were 'people should be allowed to choose sex composition of their families', 'it contributes to population control goals of the nation', 'ill-treatment that the unwanted girls would receive'. A large majority of them appeared to be concerned about the number of girls (unwanted) born while waiting for an arrival of a son which adds to the burden on the family and/or to the state by increasing the population.

Some responses by one or two providers are quite revealing. The technique of ultra-sonography was perceived by one as having the sole utility of sex identification. And should be made use of to control population and adviced that government should allow use of such techniques for the purpose of sex detection.

> When there are techniques available for sex determination, why one should not do it? Otherwise what is the use of these (sonography) machines? ...The government should open (allow) up sex determination.

Thus, the views oscillated between 'opposition to' and 'in support of' sex selective abortions; between those who were willing to forgo their practice by not engaging themselves in unethical medical care and those who were capitalising on demand for sex selective abortions by indulging in themselves in unethical practices. Once again social compulsions and population control concerns featured prominently

As discussed earlier, the MTP Act is restrictive in nature as it allows abortion only for certain reasons. Though it has decriminalised abortion, it does not recognise abortion as woman's right despite its revolutionary characteristics, such as, allowing abortion for failure of contraception and not requiring husband's consent for undergoing abortion. Women perceived abortion rights more as an answer to their pragmatic needs without really been able to find answers to moral dilemma they face in various abortion situations [Gupte et al 1997]. They tended to be conditional while recognising abortion as woman's right. However, they have been able to overcome the various obstacles while striving to access abortion care facility when required. In that sense, women have been able to exercise their right to abortion and had their own ways to translate the abstract concepts in to reality. Their articulation was different than the feminists' understanding of abortion as woman's right. The latter looked at abortion as one of the important means to have control over the matters related to one's own body and articulate this in the context of women's human and political rights.

The majority of providers interviewed (70 per cent) said that women should have right to abortion, 17 per cent qualified their approval by specifying situations in which women should have right to abortion and mentioned that women should exercise this right responsibly. Ten (8 per cent) providers felt that it should be couple's right. Five (4 per cent) of the providers (Male-4, female-1) were against women having right to abortion. The variation across public/private and rural/urban was not noticeable. However, it does show a different pattern across male and females. In that about 76 per cent of males supported the idea of women's right to abortion unconditionally and about 10 per cent qualified their support, about 10 per cent said it should be couple's right and about 5 per cent were against it. The same percentages in case of female were 60 per cent; 30 per cent, 4 per cent and 2 per cent, respectively.

Those who approved of abortion as woman's right explained their position further. In that, women who shoulder the responsibility of child bearing and rearing should have right to decide about number of children was the major trend. Besides, new trends as regards woman's career aspirations, their entry in the workforce and the responsibilities arising of that were also seen as a reason for women having right to abortion. Some articulated factors relating to her secondary status in family, which has implications for her reproductive life. Coercive sex within marriage, lack of decision-making power in most of the family matters including child bearing, poor economic status and the trouble mothers face bringing up children without adequate support from the family members, husband's irresponsibility vis-a-vis contraception, poor health status of women, negative health consequences of frequent deliveries, ill-effects on the foetus in case it is not wanted, were the various explanations offered in support of their approval for women's right to abortion. Some other reasons less frequently mentioned were that it would help unmarried

women and rape victims, women engaged in farm labour during peak seasons, women when carrying have lost their husbands. In couple of instances, it was said that it is not women's duty to beget children and they should have scope and space to develop themselves. A few felt that such a right would contribute to population control.

Those who qualified their approval – conditional support to women's right to abortion – explained the situation specificity. They specified that a woman should have right to abortion in case of woman's ill-health, contraceptive failures and foetus anomaly and probable teratogenic effects. Some very explicitly mentioned that it should not be abused, for example, for sex selective abortions. Some others stated that in situations of primies, failure of contraception should have such right. Commercial sex workers were squarely denied right to abortion by some. Similarly, some also said that unmarried and singles should not have such right to abortion. Women should not use such a right to damage Indian culture, women should not set trends of not giving birth to children using this right, she should not evade her responsibility as wife were some of the critical concerns expressed by providers while specifying what responsibility it implies that women have to bear in mind. Providers often emphasised that women should use their right to abortion responsibly.

Thus, single women's right to abortion was both approved and not. Approved because it was perceived that women get cheated and deceived. Those who opined against it feared that such a right to women would encourage promiscuity among women to a large extent.

> I do not think they should have! If it happens, life would be with no reins. The child is also of the husband. If all rights are entrusted to her, husband will have no value. Women may start telling lies. If it is for the reasons of one's career, then it is fine. But it may encourage illegitimate relationships and therefore women should not have such a right.
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> It should be a couple's right! Tommorrow if women get commercial (about sex), poor husband will have to suffer. (Women's) licentiousness will increase. ... It would not be too far that we have to open the (abortion) centres at colleges.
>
> Should be... But those engaged in sex business (commercial sex workers) should not have such a right...They may entrap a man. Unmarried (women) should not be given such a right! Our culture hasn't yet become that matured. They should have the maturity to use contraceptives. But married women should have right to abortion as otherwise they have to keep producing children. Sometimes pregnancies are forced on them because of a want of son.

IV
Providers' Perceptions: Gaps and Contradictions

Some common issues emerge from the data presented and summarised till now. For convenience the discussion that follows is organised around these emerging issues with the central focus on implications of providers' gender biased perspective for quality of abortion care services.

In general, how people's ignorance and apathy towards contraceptives contributes to women's abortion needs corroborates earlier research findings and also falls in line with the reality.

However, providers' perspective about reasons for non-utilisation of contraception is devoid of analysis of larger health care system and lacks understanding of gender biased policies/programmes. People's ignorance about and apathy towards contraception cannot be seen in isolation without looking at the way the 50 year old family welfare programme is being implemented; its underlying anti-people philosophy – population control obsessions, and gender biased approach – over emphasis on female contraceptives and sterilsation; commercialised and unregulated private sector; dynamics between public and private health care sector; and the larger development paradigm, which is not able to create equitable access to resources. Besides, providers seem to have side tracked the critical fact that in addition to having knowledge about contraceptives, they should be available and accessible for people to make use of them.

Providers have a significant role to play in this sphere. This is because they have the necessary knowledge and potential opportunities to interact with the people on this. Also, most importantly people's trust with the medical community could be utilised for the benefit of people. However, not much has been said by the providers about their role in addressing the issue of people's ignorance about and apathy towards contraceptives.

Women were blamed and held responsible for abortion situations in two diametrically opposite contexts – one, various situations within marriage, and two, various situations outside marriage, including single women's pregnancies.

Married women are held responsible for being ignorant about the basics of sexual life, for being illiterate, for not being able to negotiate with their husbands on the issue of sexual relationship, not being able to convince and make husbands understand about circumstantial constraints, for being dependent on husbands and families, all of which lead them to face abortion situations some time or the other. These situations do occur in women's lives, which providers have captured quite aptly. However, holding women alone responsible for this seems to be naive and fragmented analysis. Providers expected women to be firm and determined to exercise their rights in these matters.

Contradictions are more than obvious. Firstly, in the male dominated society where even men are not aware of these matters, expecting women to be knowledgeable is a misplaced expectation. Secondly, in situations where men know about these matters, their responsibility to educate their women has not been mentioned. Thirdly, assuming that women become aware of these matters, expecting them to be in a position to initiate dialogue or negotiate with their men is quite an utopian fantasy being imagined by the medical community.

Internal contradictions in positions of providers about women's responsibility for their abortion situations/needs are revealed by aggregate response. On the one hand, women's secondary status and they having no voice in any familial matter is said to be responsible for her to face an abortion situation. On the other hand, women are expected to convince their partners about significance of using contraceptives. These are the misplaced contemplation of providers about women's knowledge about contraceptive methods and her power to negotiate – be it sexual or otherwise – with their partners/husbands.

Contradictions also arise when providers hold women entirely responsible by saying that it depends upon women to avail of opportunities for education and to be able to have voice in family matters. It appears that somewhere providers have missed out on the fact that women are part of the larger social system, which is patriarchal and gender biased.

In case of unmarried women, responsibility of facing abortion situations and in fact of getting pregnant was seen by some as their indulgence in undesirable sexual relationships. While

women's sexuality was questioned all the time, men went scot-free. It reflects on prevailing tendencies among providers to think of women in isolation and not as an integral part of the social system.

Pre-marital or outside marriage sex has strong connotations of 'illegitimacy' in our culture. Consequently, such 'illegitimate' connotations also obstruct those involved from taking adequate measures to have safe sex. These (mis)conceptions and (biased) opinions of providers about singles' abortion needs would affect quality of abortion care she receives, if any.

These one-sided views, disjoined from social realities will have mostly negative implications for quality of care.

That patriarchal compulsions in the form of son preference, which translate in reality in sex selective abortions, are at work at both ends – women and providers, have also figured in the observations made by the providers. Providers articulated the fact that women are easily dispensable in their own homes in case they do not meet reproductive expectations of their in-laws. Either they are not able to give progeny or are not able to provide male heir to the family line.

One can easily understand and empathise with patriarchal compulsions at the women's end given her subordinate status in the family and within society. However, it is difficult to do so in case of the medical community, which justifies their indulgence in sex selective abortions. The medical community has mostly argued that it finds itself in a helpless situation. In this context, two points need to be taken note of. One, it was the medical community, which opened the door to abuse prenatal diagnostic for sex detection. Medical ethics were compromised then and it continues to be so. Two, the fees charged to the same technique of ultra-sonography are much higher when used for sex detection. Sex selective abortions are also costlier compared to non-sex selective second trimester abortions. The views about the compulsions emerging of patriarchal value system, which force providers to conduct sex selective abortions, therefore, seem to be out of place and naive.

It is baffling to see the contradictions in this context. On the one hand sex selective abortions were justified on grounds of socio-cultural and patriarchal compulsions at both ends – medical community and women. On the other hand, in the process of 'salvaging' women's married life, they justified the role the medical community is playing in eliminating female foetuses without realising the damage they are causing to the society, both in long- and short-term.

Participation of a powerful and respected community like medical professionals in such anti-women practices has potential to legitimise them. In fact over the last decade, it has been shown to be true. It contributes to the consolidation of unhealthy patriarchal norms. In fact, as reality indicates the impact on people's attitude of medical community's participation in these practices is massive. As of today people assume that they too are contributing to 'nation's good' by eliminating female foetuses.

Providers have justified their engagement in abortion service provision in different situations of women's abortion needs including sex selective abortion needs on the grounds that it helps contributing to population control. The contradictions in these arguments and justifications put forward by the medical community are too glaring to be ignored. On the one hand, people's capacity to make informed choices about contraceptives is underestimated attributing it to their ignorance and lack of education. On the other hand, they are engaged in providing abortions care services without complementing it by quality contraceptive counselling.

This not only leads women to face repeat abortion situations, but also contributes to promoting and legitimising abortion as a spacing method. Concerns expressed by some about ill-health that abortion causes to women does not seem to reflect in the abortion practice of medical community in general. Assuming that medical community is genuinely concerned about the 'population explosion' and posses the scientific knowledge of ill-consequences of abortion, it will not be erroneous to expect that they played a significant role – needless to mention, along with others – in averting unwanted pregnancies and in reducing women's abortion needs.

V
Providers' Perceptions on Quality of Care

Perceptions of providers about women' abortion needs are divided. Some providers although have been insightful and had a sensitive understanding of certain aspects of women's abortion needs, not all providers share this understanding about the full spectrum of women's abortion needs and their socio-cultural context. The gaps in their understanding are glaring. Contradictions in their views are also obvious as regards range of abortion care situations.

In the presentation below, we have tried to briefly articulate the possible implications of providers' perceptions for quality of abortion care.

Ignorance, Apathy and Negligence

Providers' concern for women's health and well-being has the potential to reflect in the abortion service provision by way of counselling on contraceptive methods and making them and other concerned persons understand the negative consequences of abortions and the need to avoid repeat abortions. Similarly, providers and/or others from health care facilities can also play the role of educators given the fact that women and men are ignorant about various physiological aspects.

Providers understanding the inevitability of women using abortion as spacing method is expected to bring empathetic texture to their communication with women during abortion care service provision.

However, provider's attitude that women and others concerned were not bothered about using contraceptives, may lead to victimising women seeking abortion care. Besides, their articulation that abortion care service provision fetches them business has a tremendous potential to exploit women's abortion needs. It may lead to pushing women to face repeat abortion by keeping them away from knowledge about contraceptives and also physiological aspects.

Those who believed that women's "illegitimate sexual indulgence" has been responsible for their abortion needs are likely to formulate their own punitive measures, for example, by charging them exorbitantly. It may also lead to ill-treatment to such women and exploiting their vulnerable situations. Women's desperation to get an abortion in such situations naturally tends to be high and thus leads to having a reduced bargaining power with the medical community. As a result it is more likely that the quality of abortion care services they receive will be much poorer.

One anticipates that pressure of compulsions on providers for being in favour of sex selective abortions, among others, would make providers more sensitive to women seeking abortions in these situations, and will not charge exorbitantly, and will also make efforts to dissuade women and others concerned from doing so.

Those who believe that the sex selective abortions contribute to the 'noble objective' of population control will engage themselves in providing contraceptive counselling services to women in other situations. However, one can anticipate that they themselves may be engaged in sex selective abortion care service provision, which in turn may help promote such sex discriminatory practices.

As the majority was in favour of women's right to abortion, one anticipates that women would have easy access to humane abortion care services.

Abortion Practices[1]

In the same study, we explored circumstances under which providers allow women to have access to abortion care at their health care facilities. Additionally, we also studied provider-women interactions for 40 women who sought abortion care services at 23 abortion care facilities to understand softer facets of quality of abortion care.

Of these 130 providers, 113 said they did not provide services of abortion care to women coming alone. 'Pregnancies outside marriage', 'lack of resources – human power, finances', 'need for confidentiality' were reasons mentioned by providers for women seeking abortion care on their own. This reflects on the gap between providers' empathy for women's abortion care needs at the level of perceptions and their abortion care service practices.

Of 130 providers, 51 (public – 4 of 20; private – 47 of 110) said that they insist on the husband's signature before they conduct abortion. Of 130 providers, 36 (public – 9 of 20; private – 27 of 110) said that it was mandatory for women to adopt some method of contraception post abortion at their health care facilities.

Of the 40 women who sought abortion care at the sub-sampled abortion care facilities, 30 (75 per cent) had sought it for the purpose of family planning. Providers did not seek any information from 27 of 40 women about their contraceptive history.

This pattern of practice once again indicates that perceptions and concerns for women's health in the context of their abortion needs do not go with their abortion care service pattern. This is because a large number of providers have mentioned that it was not advisable for women to use abortion as a spacing method. One expects that they would provide contraceptive counselling to women seeking abortion care to avoid repeat abortions. It needs to be noted that there was no contraceptive counselling offered to these women or their partners. Instead, contraceptives were forced without leaving much space for making informed choices and denying opportunities to educate themselves vis-a-vis contraceptives. Demanding husband's signature not only is a non-legal practice, but it also contradicts providers' favourable opinions about women's right to abortion care.

Sex selective abortions were generally charged more than other abortion. Similarly, abortions in case of unconventional or 'illegitimate' pregnancies were charged exorbitantly and women had to bear the humiliation and the ill-treatment by the medical providers and other paramedical staff. Once again the gendered understanding of women's abortion needs seem to be more a face to show and exhibit, as their abortion care practices often did not match their perceptions.

Against this pattern of abortion care service provision, the overwhelming response of the medical community in favour of 'abortion as women' right' would carry little meaning for women. In general, their commercial interest in abortion care service provision seems to overpower their understanding of women's abortion needs, which is swarmed with gaps and contradictions.

This anecdotal information is suggestive perhaps of medical community attempting to be 'politically correct' while articulating their perceptions of women's abortion needs. These gaps between perceptions and practices could be better explained with the help of forces at work which are pushing medical care service sector towards its commodification. Commercial interests of the medical community in abortion service provision in particular can further explain these gaps. Combating the irrational and unethical abortion care practices in isolation without understanding the dynamics of the larger health care system will be a difficult and perhaps even futile task. However, the gap between the perceptions and abortion care practices perhaps forms a solid case to look into the health care delivery system, which is paralysed with the obsession of commercial interests of the medical community. This is complemented by the convenient patriarchal attitudes towards women specific health care needs, such as, abortion care needs.

One concrete strategy to repair the damage and bring back the humanitarian and ethical spirit in health care service provision is to revamp the entire health/medical education system in which ethics and gender are integrated and an organic link is established between health care practices and users of health care services. Number of interim strategies – organising gender sensitisation workshops for members of the medical community, improving regulatory mechanisms, motivating bodies like IMA to play a proactive role – could be designed for actually making the services gender sensitive and ethically sound. EPW

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Note

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1 The research study has an elaborate component built in to delve into patterns of abortion care practices. Presentation of the data does not fall under the scope of the present paper. Only the anecdotal information to highlight the gaps between perceptions and practices is provided.

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