

Induced Abortion: The Current Scenario in India⁺

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Abstract

Although abortion services in India were liberalized more than three decades ago, access to safe services remains limited for the vast majority of women. This paper synthesises recent evidence on the induced abortion scenario in India, and explores some of the factors why women continue to seek and receive abortion services from unqualified providers. The review highlights that a host of factors, notably lack of awareness of the legality of abortion services; limited access to safe services; poor quality of services; and gender roles and norms, lead women to seek services from untrained providers. In the Indian context, where the preference for sons is particularly strong, the practice of second-trimester sex-selective abortions is becoming widespread, and thereby also placing women at risk of undergoing unsafe abortion. The introduction of new technologies and legislation is expected to make safe abortion services more accessible. However, the challenge remains in effectively implementing these measures. The paper concludes with suggestions for areas that need further programme and research attention.

Introduction

Despite the liberalization of abortion services since the early 1970s, access to safe abortion services remains limited for the vast majority of Indian women, particularly in rural areas. An overwhelming proportion of induced abortions (6.7 million annually as per indirect estimate¹) take place in unauthorized centres, which provide abortion

services of varying degrees of safety. At the same time, in recent years significant changes in the abortion scenario have been taking place in the country, which have had wide ramifications.

The Changing Face of Abortion

The period since the 1990s has witnessed major changes in the field of abortion

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including the adoption of new legislative measures, the introduction of new technologies and the growing demand for sex-selective abortion. Some of these developments, such as the recent amendments to the Medical Termination of Pregnancy (MTP) Act and the introduction of innovative abortion technologies, such as the improved manual vacuum aspiration technique and medical abortion, are expected to increase the availability of safe abortion services. However, other trends, such as the growing demand for sex-selective abortion, are likely to increase the incidence of unsafe abortion and adversely change the gender dynamics even further.

Legislative measures

Recognizing the failure of the MTP Act of 1972 to make legal abortions widely available, the government amended the Act in 2002. With the amendment, the authority for approval of registration of MTP centres has been decentralized from the state to the district level.²⁻³ In the year 2003, the government introduced a further amendment to MTP Rules which has rationalized the criteria for physical standards of abortion facilities -- fixing different criteria as appropriate for conducting first-trimester and second-trimester abortions. While facilities such as an operation table and instruments for performing abdominal or gynaecological surgery, and equipments for anaesthesia, resuscitation and sterilization continue to be the minimum requirements for centres offering second-trimester abortion, the MTP Rules 2003 require a gynaecological or labour table rather than an operation table and resuscitation and sterilization equipment but not anaesthetic equipments for centres

offering first-trimester abortion.⁴ These rules also permit a registered medical practitioner to provide medical abortion services in the case of termination of pregnancy up to seven weeks, provided the practitioner has access to a facility for offering surgical abortion in the event of a failed or incomplete medical abortion. The Reproductive and Child Health Programme launched in 1997 and the National Population Policy, 2000 have also delineated a number of strategies to increase the access to safe abortion at the primary health care level.⁵

Amendments have also been introduced in the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act of 1994. This was necessitated as the PNDT Act had failed to curb the practice of testing for sex determination and consequent sex-selective abortion in the country.⁶ With the recent amendment to the PNDT Act, preconception and pre-implantation procedures for sex selection are banned in the country. The Amendment stipulates compulsory maintenance of written records by diagnostic centres/ doctors offering sonography service. Local authorities have also been given powers to ensure the enforcement of the Act.^{3, 7} With these measures, the government expects to prevent women from resorting to sex-selective abortions, which are conducted during the second-trimester and carry a high risk of complications for women.

Medical abortion

Medical abortion or abortion by orally administered regimens of mifepristone and misoprostol has recently been accepted worldwide as an effective and safe option for

early abortion. Clinical trials in a number of countries, including India, have shown that the use of the standard French regimen, which includes administering 600 mg of mifepristone during the first visit and 400 µg of misoprostol during a follow-up visit after two days, combined with a follow-up visit after two weeks, is effective in 95% of cases of early abortion (i.e. up to 49 days from the last menstrual period) and safe (major complications were reported in only 0.5% of cases).⁸

The Drug Controller of India approved the use of medical abortion in April 2002.⁸ Given the current situation in India, where abortion-related mortality and morbidity are high, medical abortion offers great potential for improving the access to abortion and safety, as it does not require extensive infrastructure and is non-invasive. Further, as the patient does not need to be hospitalized, medical abortion offers women greater independence, control and privacy. However, the potential for misuse is a matter of concern. In fact, although abortion tablets are required to be sold by medical prescription and consumed under medical supervision, these pills are reportedly widely available over-the-counter and unsupervised consumption is rising.⁹⁻¹¹ Plans to develop national guidelines to introduce abortion pills in family welfare programme are currently under discussion.

Apart from initial clinical research to explore the effectiveness, safety and acceptability of medical abortion,¹²⁻¹⁵ limited research has been carried out on issues such as women's experiences of this new method, availability, affordability and providers' perspectives, although some studies are currently under way.

Sex-selective abortion

With the introduction of amniocentesis to detect abnormalities of the foetus, sex determination techniques have been available in India since 1975. The expansion of facilities offering sonography in the mid-1980s made testing for sex determination widely and easily available. Although the government tried to curb the increase in sex-selective abortions by introducing the PNDA Act in 1994, the Act proved to be ineffective in preventing such abortions.⁶ This is not surprising given the strong "son" preference prevailing in most parts of the country, and the loopholes in the Act *per se* and in its enforcement.

Recent evidence, both direct and indirect, highlights that the number of sex-selective abortions has increased vastly.⁶ This is indirectly reflected in the latest Census figures that indicate that the child (0-6 years) sex ratio declined from 945 females per 1 000 males in 1991 to 927 females per 1 000 males in 2001.¹⁶ Although it is difficult to quantify precisely the prevalence/incidence of sex-selective abortion, a growing number of community- and facility-based studies provide direct and indirect estimates. A number of community-based studies in different parts of the country report a prevalence of sex-selective abortion ranging from 3-17% over different reference periods, i.e. two years preceding the survey to lifetime.¹⁷⁻²⁰

Facility-based studies report a much higher prevalence, for example, two in five women with one or more daughters, but no living sons had had an abortion in a Patiala (Punjab, India) hospital.²¹ Indirect estimates derived from NFHS-2 data indicate that among women who received ultrasound or

amniocentesis during antenatal check-ups, 6.4% of female foetuses can be assumed to have been aborted.²²

Available evidence shows that the practice of sex-selective abortion cuts across all socio-economic groups.^{19, 23-24} In several studies, sex-selective abortion is reported to be a family building strategy to achieve the conflicting goals of limiting family size and achieving the desired sex composition.²⁵ For example, the prevalence of sex-selective abortion is found to be higher among women with one or more living daughters but no living sons.²³ However, some studies report that sex-selective abortion is practised by couples who already have a living son or no children.^{19, 24} Further, evidence from qualitative studies indicates that sex-selective abortion is perceived and projected as an easy alternative to female infanticide, a way to save girl children from an unhappy life and a means to prevent dowry payment in future.^{20, 26} *To give birth to a female child would mean spoiling her life as well as her parent's life. So, we felt it was right to abort the female foetus [27-year-old woman with a son and a daughter].*²⁶

While sex-selective abortion per se is little researched, decision-making related to sex-selective abortion is even less explored. Limited evidence available from a small-scale qualitative study, though not amenable to generalization, reports that the decision to pursue a sex-selective abortion is taken primarily by the couple; at the same time, providers appear to play a key role in providing information on sex-determination services: *"Either you get your abortion before sonography or after, I will charge you the same money but if God hears your wish and the foetus is found to be male, then you can escape from abortion. [41-year-old woman*

with four daughters narrating her experiences with a provider]".²⁶

Magnitude and context

Official figures report that about 0.6 million induced abortions take place annually in India.²⁷ Given that only approximately 10% of abortions are conducted by qualified providers in approved institutions,²⁸ and that abortions taking place at registered facilities are grossly under-reported,^{1, 25, 27} this represents only a fraction of the total number of induced abortions taking place in the country. Indirect estimates for the year 1991, using parameters arrived at on the basis of a small-scale study conducted in 1966, project the number of induced abortions annually at 6.7 million.¹

Estimates of the ratio of induced abortion derived from community-based surveys, again likely to be grossly underestimated as women tend to under-report the incidence of induced abortions in survey settings, show wide variations. For example, NFHS-2 data reveal that 1.7% of all pregnancies over a lifetime ended in induced abortions.²⁹ In comparison, small-scale studies report 3.4–14.0 induced abortions per 100 live births.^{18, 25}

Profile of abortion-seekers

While women of all age groups seek abortion in India, a recent review suggests that the majority of those seeking abortion are in the age group: 20-29 years.²⁵ A substantial number of adolescents, both married and unmarried, also seek abortion services. Between 1-10% of abortion-seekers are adolescents,²⁵ though a few facility-based studies report that the proportion of

adolescent abortion-seekers is as high as one in three.^{30, 31} Nationally, data from NFHS-2 show a lifetime induced abortion ratio of 1.1 among married adolescents.³²

The vast majority of women seeking abortion in India are married.²⁵ Among the unmarried, adolescents constitute a disproportionately large percentage of those who seek abortion. At least one half of unmarried women seeking abortions are adolescents, many of whom are below 15 years.³³

Reasons for seeking abortion

Although official records show that contraceptive failure and risk to mother's health are the leading reasons for women seeking abortion,^{1, 34} studies suggest a different picture. Several studies indicate that most abortions are sought to limit family size or space the next pregnancy.^{17,18,25} For example, in a study in Madhya Pradesh, women reported the achievement of desired family size as the reason in 41% of attempted abortions, and the need for spacing in 30% of abortion attempts.¹⁸ A few recent studies indicate that risk to women's health is also a relatively common reason for seeking abortion.^{17, 18} For example, a study in Madhya Pradesh found that women reported health reasons in 22% of attempted abortions.¹⁸

The not-so-commonly-reported reasons for seeking abortion include contraceptive failure, pregnancies occurring soon after marriage or occurring outside of marriage or problems with the foetus.^{18, 25} For example, a review shows that only a small proportion of women seeking abortion (less than 5%) reported contraceptive failure as the reason for an abortion²⁵. Even though the first pregnancy is highly valued and hence

women generally do not opt for induced abortion, a study in Madhya Pradesh shows that women mentioned a pregnancy that happened too soon after marriage in 6% of abortion attempts.¹⁸

Type of provider

Available evidence, though limited, indicates that the majority of abortions take place in private facilities.^{18, 19, 35, 36} For example, in a community-based study in Madhya Pradesh, more than one half of abortions among urban women took place in a private facility compared to one fourth of abortions in a public sector facility and the remaining resorting to folk methods or self-induction.¹⁸ However, a study in Rajasthan indicates that 50% of women sought abortion from a public sector provider,¹⁷ though it is not clear whether the service was dispensed in a public or a private sector facility.

The practice of self-induction or using lay practitioners is declining among abortion-seekers in general, though adolescents, unmarried women, rural and economically disadvantaged women still rely on these methods.^{18, 25, 37} For example, in a study in Madhya Pradesh, 56% of rural women relied on folk methods or self-induction.¹⁸

Mortality and morbidity

There is limited information on abortion-related maternal deaths in India.³⁸ A conservative estimate places the number of abortion-related deaths in a year in India at 15 000-20 000.¹ The official figures indicate that unsafe abortion accounted for 9% of maternal deaths in the year 1998.³⁹ However, evidence from facility-based

studies suggests that abortion-related complications account for 25-30% of maternal deaths taking place in hospitals.²⁵

Abortion-related mortality represents only a fraction of abortion-related complications, and many more women experience life-threatening and other morbidities. For example, in a community-based study in Madhya Pradesh, India, more than one in two abortion attempts among rural women (57%) and more than two in five abortion attempts among urban women (46%) resulted in at least one complication. The complications were severe in one third of abortion attempts among rural women and one sixth of attempts among urban women.¹⁸ The most frequently reported abortion-related morbidities are menstrual irregularities, backache, and excessive bleeding.^{17, 25} Little data exist on chronic abortion-related morbidities, including pelvic inflammatory disease, secondary infertility and the risk of future ectopic pregnancy.²⁵

As is widely recognized, abortion-related complications are higher when performed either by inadequately trained providers, or in unhygienic conditions. For example, a study in West Bengal, India reports a complication rate of 12.2% for abortions conducted by a specialist, 45.8% by a private general practitioner, and 100% by unqualified providers or paramedics.⁴⁰ Similarly, second-trimester abortions carry a higher risk of complications.^{25, 38, 41} A hospital-based study reveals that the risk of abortion complications is 12 times higher for second-trimester abortions than the first-trimester ones.³⁵ Unmarried adolescents, women who are illiterate and those living in rural areas are perhaps more prone to major abortion complications because they seek

late abortions or use the services of unqualified abortion providers.^{18, 25, 33, 38}

Factors Underlying Persistence of Unsafe Abortions

Despite the liberalization of abortion services and the introduction of safer abortion techniques, abortion continues to be unsafe for the vast majority of women seeking such services. Several factors operating at the individual, family, and community level contribute to this situation, some of which are discussed below.

Lack of awareness

Lack of awareness of the legal status of abortion and the facilities where abortion services are legally provided may lead many women to seek abortion from untrained and unqualified providers. Studies in different parts of the country show that even though abortion has been legalised in India for more than three decades, only a small minority of men and women know that abortion is legal.^{17, 18, 28, 35} For example, in a community-based study in Rajasthan, only one in six men and women were aware that abortion was legal. Even more alarming was that nearly four in five men and more than one in two women believed it was illegal,¹⁷ and formal services are less likely to be sought when women perceive abortion to be illegal.²⁵ Even when women are aware of the legal status of abortion, they may not be fully aware of the conditions under which abortion is allowed. For example, in a study in Madhya Pradesh, India while 15% of women knew that abortion was legal, only 9% knew the correct timing under which abortion was legally permitted.¹⁸

Misconceptions about the conditions under which abortion services are provided are common; for example, husband's consent is needed for seeking abortion.^{18, 42} Moreover, often women may not be aware of the existence of registered facilities where these services can be accessed.^{35, 43}

Apart from lack of awareness of the legal status of abortion and registered facilities, lack of awareness about pregnancy may contribute to many women, especially adolescent girls, delaying seeking abortion services and obtaining care from unqualified providers.⁴⁴

Limited access to services

Although the number of approved abortion facilities in India has increased significantly from 1 877 in 1972-1976 to 9 806 in 2001,⁴⁵ access to safe abortion services continues to be limited for the vast majority of women in the country. In fact, some of the clauses in the MTP Act, 1972 have in effect contributed to restricting the availability and access to abortion services.²⁷ For example, only gynaecologists or physicians who have received training in MTP are allowed to perform an abortion, and only in government clinics or hospitals, or institutions approved by the government for this purpose. Moreover, the approval of two doctors is required to abort pregnancies between 12 and 20 weeks' gestation. Stringent criteria for the approval of centres, although well intentioned, have in effect restricted the expansion of registered facilities in the private and non-governmental sectors.^{46, 47, 48} The decentralization of authority for the approval of MTP centres and the government's commitment to increase the access to abortion services at

the primary health care level may improve the availability of abortion facilities in the near future.^{2, 3}

Not only are approved facilities inadequate in number, but they are also distributed unevenly between and within states. For example, Maharashtra with 10% of India's population has more than one fifth of the total number of facilities in the country. In contrast, Bihar, also with about 10% of the total population, has only 1% of the facilities.²⁷ Within each state, the approved facilities are concentrated in urban areas, resulting in limited access for a vast majority of women in rural areas.^{1, 28}

Even where approved facilities exist, services in the public sector are rarely or erratically provided due to the lack of trained manpower or equipment or both.^{27, 49} For example, district-level teaching institutions, sub-district hospitals, community health centres, postpartum centres and primary health centres are required to provide abortion services. However, a situation analysis of abortion facilities in Gujarat, Maharashtra, Uttar Pradesh and Tamil Nadu shows that only about one fourth to nearly three fifths of primary health centres offered abortion services.²⁷ The most recently conducted national-level facility survey reports that only 3% of primary health centres provide MTP services. The survey also reports that most primary health centres lack essential equipment. Only one in six primary health centres, for example, have MTP suction aspirators.⁵⁰

Poor quality of services

Few studies have explored the quality of abortion services in the public and private sectors, particularly in the private sector.

Available evidence highlights the poor quality of abortion services. Often providers in the public and private sectors are not trained or are inadequately trained.^{27, 45, 51} The most recently conducted national-level facility survey reports that only 13% of primary health centres in the country have at least one medical officer trained in MTP. The situation is worse in several states including Bihar, Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh and West Bengal where only 2-6% of primary health centres have a medical officer trained in providing MTP services.⁵⁰ In a facility study in Haryana, nearly one third of the 52 private providers had not received any training on conducting an abortion. Similarly, in Maharashtra, more than one third of public sector providers and more than two fifths of private sector providers were reported to be untrained.⁵¹ Moreover, as there are few MTP cases in the training centres, trainee doctors do not receive sufficient practical experience in conducting MTPs. Therefore, even after training many providers do not feel competent to provide services.²⁷ Further, it is reported that most teaching hospitals prefer to offer training on electric vacuum aspiration, dilation and curettage and induction methods, rather than on manual vacuum aspiration, a relatively simple method of abortion.^{27, 49, 52}

The judgemental attitude of providers in public and private sector facilities, particularly in the public sector, is likely to force many women to seek informal sector providers who are unlikely to provide safe services: *"in the government hospital the nurses demand money and also use abusive language. In X's nursing home, the doctor does not use bad language. We can get an abortion and sterilization done on the same*

*day and return to our house. Hospitalization is just for one day. The waiting time is only one hour. Things are fast and if we have any problems we can go back to him".*³⁶ Studies show that providers often disregard the need to respect the privacy and confidentiality of women seeking abortion: *"privacy and confidentiality is not an issue with women. After all where can you get more anonymity than at a public hospital where thousands are milling around in the out-patient department?"*⁴⁶ Coercive contraception following an MTP is not uncommon, and many women reportedly refuse to go to a primary health care centre for an MTP because they do not want to get sterilized.^{36, 37, 53, 54} Further, several studies highlight that providers often insist on husband's consent, though the law does not mandate it nor is it preferred by women.^{17, 25, 37} In a study in Rajasthan, four in five women reported that the provider took their husband's consent.¹⁷ Moreover, even when services exist, providers may selectively refuse services to some women. For example, a study in Maharashtra reports that 40% of providers (of whom 24% were in legally recognized MTP centres) selectively refused services to unmarried and separated young women.⁵⁵

Studies show that pre- and post-abortion services have often been given a low priority. For example, a study among abortion service providers in slums in Gujarat reports that no physical or internal check-ups were carried out, and only cursory enquiries about medical and obstetric history were taken.⁴⁶ Moreover, women were not often informed of the possible risks of the procedure, potential complications and their treatment, need for a follow-up visit, and post-abortion contraception, especially the range of contraceptive choices available to prevent repeat abortions.^{27, 46, 56} A multi-state

study reports that less than one half of women were informed about the possibility of infection.²⁷ A study in Andhra Pradesh indicates that follow-up care was provided only in selected cases by auxiliary nurse midwives.⁵⁶ Moreover, emergency services to deal with incomplete abortion and life-threatening post-abortion complications are totally lacking in the current service delivery system.³⁸

Cost of services

Even though there is evidence that women are willing to pay for services that meet their needs and perceptions of quality,¹⁹ the financial burden of abortion services is substantial.^{42, 57} Economic constraints may compel many women, particularly those who are poor and dependent on others, to seek services from unqualified providers.^{17, 18, 58, 59} Unfortunately, in public sector facilities that are expected to provide services free of cost, it is reported that women incur hidden costs in the form of cost of medicine and illegal fees for staff.^{1, 27, 35, 52, 53, 58, 60} A study in Madhya Pradesh reports that only one in ten abortions in public sector MTP centres were provided free of cost.¹⁸

Gender roles and norms

Available evidence, though limited, reveals that gender roles and norms operate in many ways to limit women's access to safe services. Even though a number of studies report that the decision to undergo an abortion among married women is taken jointly by the woman and her husband,^{17, 18, 19, 61} a not-so insignificant proportion of women, especially unmarried and married young women, may find it difficult to take decisions on their own regarding abortion or

to communicate about abortion-related needs to those who wield power in the household,^{18, 62} leading to delays in seeking abortion and thereby jeopardising safety. For example, in a community-based study in Madhya Pradesh, husbands, unilaterally or jointly, played the major decision-making role in 20% of abortion attempts.¹⁸ Moreover, studies show that some women who wish to terminate a pregnancy may face opposition from the family.²⁵

Stigma attached to abortion, particularly when sought by women who are not currently married, may also compel women to delay seeking services or to seek services from confidential but unsafe providers.⁶³ For example, in a study in Pune, women seeking an abortion outside of marriage ranked confidentiality, discreetness and distant location of abortion services as the most important indicators of quality of services.³⁷ Yet another study in Pune reports that nearly one-fourth of unmarried women sought abortion services from traditional providers compared to 2% of married women.¹⁹

Finally, the increasing practice of sex-selective abortion also tends to place women at risk of undergoing unsafe abortion. Women attempting sex-selective abortions may not opt for legal abortion services. Sonography can detect foetal sex only at the beginning of the second trimester when the risk of abortion complications is much higher,^{19, 35, 38, 41} therefore sex-selective abortion-seekers are vulnerable to unsafe abortions.

The Way Forward

Although abortion services in India were liberalized more than three decades ago, the

vast majority of women continue to seek and receive abortion services from unqualified providers. As a result, many women die or suffer serious life-threatening complications. A host of factors notably lack of awareness of the legality of abortion services, limited access to safe services, poor quality of services and gender roles and norms lead women to seek services from untrained providers. In the Indian context, where the preference for sons is particularly strong, the practice of second-trimester sex-selective abortions is becoming widespread.

The introduction of new technologies and legislation is expected to make safe abortion services more accessible. However, the challenge remains in effectively implementing these measures.

Programme recommendations

- The widespread lack of awareness of the legal status of abortion services and women's rights under the existing law as well as of the facilities that offer abortion services call for socially and culturally appropriate information, education and communication (IEC) campaigns. There is also a strong need for efforts to promote awareness of the dangers of unsafe abortion practices and the gestational age at which safe abortion can be obtained. Equally important are communication efforts to remove the stigma associated with induced abortion.
- Given the uneven distribution of existing facilities, efforts to increase the accessibility of safe abortion services to hitherto unserved or under-served areas and population groups, including married and unmarried adolescents, need to be vigorously pursued. The lack of trained manpower needs to be addressed by improving training facilities and facilitating the training of private practitioners. The training curriculum should include new and safer methods of abortion, including manual vacuum aspiration techniques and medical abortion, as well as emphasise the quality of care elements.
- Given the poor quality of existing abortion services in the country, establishing service delivery guidelines regarding technical standards of service, patient-provider interaction, confidentiality, pre- and post-abortion counselling and care is critically needed. All existing MTP facilities should be regularly monitored and evaluated.
- The fact that many women seek abortion services to limit family size or space the next pregnancy highlight the importance of improving the access to quality family planning services.
- Finally, given that women, especially young women, have very little say in reproductive and sexual health decisions, including abortion-related decisions, the need for multi-sectoral activities to raise the women's status cannot be overemphasized.

Research recommendations

- Research on abortion has increased in recent years, but significant gaps in our understanding of the multiple dimensions of abortion-seeking behaviour prevail. The evidence on the prevalence and patterns of abortion is limited, and even the latest available estimates of induced abortion are more than a decade old. The need for assessing the incidence of induced abortion, using multiple and innovative methods of data collection cannot be overemphasised.
- Abortion-related needs and service-seeking patterns of many vulnerable groups including adolescents, and unmarried, divorced or separated women remain less studied and hence there is need for future studies to focus on these sub-population groups.
- The review highlights that the practice of sex-selective abortion is increasingly becoming common in many parts of the country. An in-depth understanding of the prevalence/incidence and perspectives of those involved in decisions on sex-selective abortion, clients' profile and experiences, is needed to formulate effective policies and programmes to prevent this practice.
- Very little information exists on abortion-related complications, especially chronic complications. Follow-up studies are needed to estimate the extent of these complications and their implications for women's health and well-being.
- There is a need to explore the potential of paramedics to conduct early abortion and provide abortion-related care through well-designed studies.
- Studies show that the quality of abortion services in the country is generally poor. The constraints that providers face in providing quality service need to be explored to design more appropriate interventions.
- While abortion *per se* is less studied, the pathways between pregnancy and abortion are even less explored in India. An in-depth understanding of the complex nature of abortion-related decision-making, provider choice and the actual utilization of abortion services would help in designing effective interventions to improve the access to services.

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