Internship Training

at

International Planned Parenthood Federation
New Delhi

# A SECONDARY EVIDENCE SYNTHESIS ON ABORTION SCENARIO IN SOUTH ASIAN COUNTRIES: EXPLORING THE CURRENT SITUATION AND WAY FORWARD

By

**DR NIDA SHAIKH**

**PG/21/064**

Under the guidance of

Dr Vinay Tripathi

PGDM (Hospital & Health Management)

2021-23


**International Institute of Health Management Research New Delhi**

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**International Institute of Health Management Research New Delhi**

(Completion of Dissertation from respective organization)

The certificate is awarded to

**Dr Nida Shaikh**

in recognition of having successfully completed her Internship

in the department of '**Sexual and Reproductive Health'**

and has successfully completed her Project on

**'A secondary evidence synthesis on abortion scenario in South Asian countries: Exploring the current situation and way forward'**

**Date- 27th February to 26th May**

**International Planned Parenthood Federation**

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning. We wish her all the best for future endeavours.

**Training & Development**

**Officer-Human Resources**
**IPPF South Asia Region**

**TO WHOMSOEVER IT MAY CONCERN**

This is to certify that **Dr Nida Shaikh**, student of PGDM (Hospital & Health Management) from International Institute of Health Management Research, New Delhi has undergone internship training at International Planned Parenthood Federation from 27th February 2023 to 26th May 2023.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical. The Internship is in fulfilment of the course requirements. I wish her all success in all her future endeavours.

| | |
|---|---|
| Dr. Sumesh Kumar | Dr Vinay Tripathi |
| Associate Dean, Academic and Student Affairs | Associate Professor |
| IIHMR, New Delhi | IIHMR, New Delhi |

# Certificate of Approval

The following dissertation titled **"A SECONDARY EVIDENCE SYNTHESIS ON ABORTION SCENARIO IN SOUTH ASIAN COUNTRIES: EXPLORING THE CURRENT SITUATION AND WAY FORWARD"** at **"INTERNATIONAL PLANNED PARENTHOOD FEDERATION"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **PGDM (Hospital & Health Management)** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

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| --- | --- |
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| Rupsa Banerjee | |
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# (Certificate from Dissertation Advisory Committee)

This is to certify that **Dr. Nida Shaikh,** a graduate student of the **PGDM (Hospital & Health Management)** has worked under our guidance and supervision. She is submitting this dissertation titled "**A SECONDARY EVIDENCE SYNTHESIS ON ABORTION SCENARIO IN SOUTH ASIAN COUNTRIES: EXPLORING THE CURRENT SITUATION AND WAY FORWARD"** at **"INTERNATIONAL PLANNED PARENTHOOD FEDERATION**" in partial fulfilment of the requirements for the award of the **PGDM (Hospital & Health Management).**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr Vinay Tripathi,
Associate Professor
IIHMR, New Delhi

Dr Arpita Das
Senior Technical Advisor,
IPPF, New Delhi

**INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI**

## CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "A secondary evidence synthesis on abortion scenario in South Asian countries: Exploring the current situation and way forward" and submitted by Dr Nida Shaikh, Enrollment No. PG/21/064 under the supervision of Dr Vinay Tripathi, Associate Professor, IIHMR Delhi for award of PGDM (Hospital & Health Management) of the Institute carried out during the period from 27th February 2023 to 26th May 2023 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

## FEEDBACK FORM

**Name of the Student:** Dr Nida Shaikh

**Name of the Organisation in Which Dissertation Has Been Completed:**

International Planned Parenthood Federation, New Delhi

**Area of Dissertation:** A secondary evidence synthesis on abortion scenario in South Asian countries: Exploring the current situation and way forward

**Attendance:** She sincerely attended the whole internship tenure.

**Objectives achieved:** She successfully completed her work and the objectives that set on the first day of internship, fulfilled those objectives.

**Deliverables:** Completed her internship report

**Strengths:** Very sincere and dedicated for her work

**Suggestions for Improvement:** More reading of literatures for accruing the in-depth knowledge in SRH field and continue using the large-scale data.

**Suggestions for Institute (course curriculum, industry interaction, placement, alumni):**

Nothing as such.

**Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)**

**Date:** 21.06.2023

**Place:** New Delhi

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| | |
|---|---|
| AHW | Assistant Health Worker |
| ANM | Auxiliary Nurse Midwife |
| AYUSH | Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy |
| CPR | Contraceptive Prevalence Rate |
| DHS | Demographic and Health Survey |
| FHB | Family Health Bureau |
| LHV | Lady Health Assistant |
| MMR | Maternal Mortality Rate |
| MR | Menstrual Regulation |
| MVA | Manual Vaccum Aspiration |
| MTP | Medical Termination of Pregnancy |
| NFHS | National Family Health Survey |
| NGO | Non Government Organisation |
| SEA | South East Asia |
| SRH | Sexual and Reproductive Health |
| TFR | Total Fertility Rate |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organisation |

# ABSTRACT

**Introduction:**

An abortion is defined as the loss of pregnancy before foetal viability. Induced abortions are those in which a deliberate action is undertaken with the intent to end a pregnancy. In an unsafe abortion, the unintended pregnancy is terminated with no medical skill, in an environment that fails to meet the bare minimum of medical requirements, or both. Unsafe abortion is the leading cause of maternal morbidity and mortality, accounting for 8–11% of all maternal deaths worldwide. The complications of pregnancy and childbirth kill 30.3 thousand women every year across the globe. Among the 227 million pregnancies held annually worldwide, 44% (99 million) are considered unwanted or untimely, leading to 56% abortions, 32% unplanned births, and 12% miscarriages. High rates of unsafe abortions are seen, primarily in developing regions, in nations with violent laws. South Asia (Bangladesh, India, Nepal, Pakistan, and Sri Lanka) is home to 28% of the world's people, accounting for 30% of the world's maternal deaths. Lack of access to safe, legal abortions and contraceptives is one of the key reasons for the high maternal mortality rate. According to the UNFPA, unsafe abortions are the third leading cause of maternal mortality in India despite the MTP Act of 1971 legalising abortion; 10 women still perish every day from unsafe abortions. The aim of the present study is the secondary evidence synthesis on the abortion scenario and legal framework of abortion situation in South Asian countries.

**Methods:**

**Study Data:** A number of search engines will be used for the literature search. Access to technical references will be made through specialised websites run by organisations including the WHO, UNFPA, UNDP, and Guttmacher Institute. Peer reviewed articles and reports will be accessed by typing keywords in the search engine.

**Study population:** Pregnant women of reproductive age (married or unmarried).

**Study tool:** NFHS 5 and DHS factsheet & secondary data on abortion scenario and legal framework in South Asian countries.

**Data Analysis:** SPSS will be used to analyse the data.

**Result and Discussion:**

Afghanistan, Sri Lanka, Pakistan and Maldives are restricted settings. Although abortion is legally restricted in Bangladesh, early menstrual regulation (MR) is permitted. According to the Bangladesh Demographic and Health Survey 2017-18, 71.3% of ever-married women in Bangladesh have heard of menstrual regulation, but only 7.4% have used it. Working women (27%) accessed public health facilities more frequently than non-working women (25.6%). Interestingly, more than a fifth of women in the younger age group (29.9%) and (24.9%) of women in the middle age group in contrast to 17.1% of women in the older age group report having self-abortions. Surprisingly, 1.9% of young women chose a Vaidya, hakim, or homoeopath and 3.9% preferred a family member, relative, or acquaintance. Younger women (70.8%) utilised medications over other means of abortion, more frequently than older women (53.7%).

**Ethical consideration:**

As we are using the secondary evidences and data which is available in public domain therefore no direct ethical approval is required for this assignment.

**KEY WORDS:** Abortion, South Asian countries, pregnancy, family planning, maternal mortality, DHS& NFHS 5, abortion laws, pregnancy consequences.

# A SECONDARY EVIDENCE SYNTHESIS ON ABORTION SCENARIO IN SOUTH ASIAN COUNTRIES: EXPLORING THE CURRENT SITUATION AND WAY FORWARD

## Background:

An abortion is defined as the loss of pregnancy before foetal viability i.e. before a foetus becomes capable of independent extra-uterine life. An induced abortion, also known as a termination of pregnancy, is an abortion initiated by deliberate action undertaken with the intent of terminating pregnancy. The World Health Organisation (WHO) defines an unsafe abortion as the termination of an unplanned pregnancy carried out by a person who lacks the necessary skills, in a location that does not comply with the very minimal medical standards, or both. Abortion is a frequent medical intervention. It is risk-free when performed by a qualified professional using a technique advised by the WHO and suitable for the stage of pregnancy. Around 73 million induced abortions are carried out year all throughout the world. Six out of ten (61%) of all unexpected pregnancies and three out of ten pregnancies (29% of all pregnancies) end in an induced abortion. Approximately 45% of all interventions are performed in underdeveloped countries. Globally, maternal mortality is an alarming problem as a matter of public health. 3,03,000 women are estimated to die annually due to complications during pregnancy and childbirth worldwide. The leading cause of maternal morbidities and mortality, accounting for 8–11% of all maternal deaths worldwide, is unsafe abortion, which is preventable. (1) This is a grave concern for both public health and human rights as unsafe abortions are so prevalent, and are more common in vulnerable and marginalised populations. In addition to putting social and financial strain on communities and

healthcare systems, it may have negative effects on women's physical and mental health. (2)

The annual rate of unintended pregnancies declined significantly from 74 per 1000 women between the ages of 15 and 44 in 1990-1994 to 62 between 2010 and 2014. Unwanted pregnancies can be a consequence of an array of factors, including the improper or non-use of contraception. Risk to a woman's wellbeing, including her physical and mental health, as well as pregnancy brought on by rape or incest, are additional factors to take into account. Among the 227 million pregnancies that take place annually around the world, 44% (99 million) are believed to be undesired or untimely, of which 56% result in abortions, 32% in unplanned births, and 12% in miscarriages. A total of 55.9 million abortions are thought to have occurred between 2010 and 2014, with around 49.3 million of those occurring in underdeveloped countries and 6.6 million in developed ones. When industrialised and developing countries are compared, developing countries have a higher rate of abortions among women between the ages of 15 and 44 (36 per 1000). (27 per 1000). In other words, if there were 35 abortions per 1000 women annually, a woman would have one abortion in her lifetime. In countries with strict laws and a predominance of low- and middle-income nations, mainly in developing areas, high rates of unsafe abortions are observed. (3)

South Asia (Bangladesh, India, Nepal, Pakistan, and Sri Lanka) is home to 28% of the world's people and accounts for about a third (30%) of the world's maternal deaths. Complications from unsafe abortions are responsible for 13% of all maternal fatalities in South Asia, and they are nearly always preventable. In Asia, there were reportedly 35.5 million induced abortions per year between 2010 and 2014. Abortion rates in the area are expected to be 36 per 1,000 women (15–44) who are of reproductive age annually, which is a minor decrease from the rate of 41 per 1,000 between 1990 and

1994. Three Asian countries—Iraq, Laos, and the Philippines—do not legalise abortions under any circumstances. (4,5)

South Asia is responsible for one in every four maternal deaths globally. The absence of safe, legal contraceptives and abortion services is one of the key factors contributing to the high maternal mortality rate in the region. Less than half of abortions in South and Central Asia, according to the World Health Organization (WHO), were safe. In India, Nepal, and Bangladesh, the prevalence of illegal abortions ranges from 58 percent to 90 percent, according to a recent study by the Guttmacher Institute. The same poll found that medical facilities in these countries turned away between 22% and over 50% of women who would have otherwise qualified for an abortion or menstrual regulation procedures. 10 women still die from unsafe abortions every day in India, even though the Medical Termination of Pregnancy (MTP) Act, 1971 made abortion legal. Every year, about two out of every five abortions carried out in India are regarded as safe. A recent survey found that less than 40% of public institutions in India and Nepal that are legally permitted to provide abortion services actually do. In Bangladesh, the figure is 53 percent. (6)

Abortion regulations in Asia range from being extremely restrictive to being quite liberal. While Sri Lanka continues to allow easy access to and availability of illegal abortions, Afghanistan has arguably of the region's strictest and most draconian abortion laws. According to a UNFPA report from 1998, there were 45 abortions for every 1,000 women of reproductive age in Sri Lanka, which is the most recent data available. The Sri Lankan government attempted to modify the abortion law in 1995, 2011, and 2013, but failed due to anti-abortion sentiment. In Pakistan, where abortion is only permitted when necessary to save a woman's life or maintain her physical health, only 68% of women who have illegal abortions receive their procedure from physicians, nurses, or midwives, according to a poll of medical experts. Due to their use of traditional medicine, their reliance on pharmacies or other for-profit enterprises, or their self-induction, the remaining women

are more likely to encounter problems. According to 2012 research by the Population Council, one of the highest abortion rates in the world is reportedly found in Pakistan. 50 abortions per 1,000 women aged 15 to 44 were predicted to occur annually. Afghanistan, the nation with the highest natality rate in Asia, continues to forbid both abortion and birth control. Abortion is only permitted in Afghanistan, when a woman's life is at risk or there is a likelihood that the baby will be born with severe birth problems. In Afghanistan, a woman passes away from pregnancy-related issues approximately every two hours. Safe abortion is difficult to obtain in many areas of the region due to stringent restrictions, but even in those areas where the law is more liberal, access to abortion remains problematic due to ignorance of the law. Health system limitations include a shortage of qualified physicians, an uneven distribution of treatments, and excessive costs have been linked to deaths from unsafe abortions. Sociocultural attitudes that put women in danger includes the emphasis on male heirs, male relatives' entitlement to make reproductive decisions, and the harsh social stigma against extramarital pregnancy. In the SEA Region, maternal death because of unsafe abortion is high, with rates varying from less than 1% in Bangladesh to 13% in Timor-Leste, according to the WHO. According to research, countries with restricted access to abortion perform an average of more than four times as many unsafe abortions than those with less restricted access. (1,6)

The third most common reason for maternal mortality in India is unsafe abortion, according to the United Nations Population Fund's (UNFPA) State of the World Population Report 2022. More than 8 women die every day from complications related to unsafe abortions. 67% of abortions performed in India between the years 2007 and 2011 were deemed unsafe. Every year, 47 Indian women out of 1,000 have abortions. Prenatal death occurs to one-third of all conceived children. (7,8)

Abortion was used as a technique of family planning by South Asian and British women in India during the early 19th century. The Bombay case of T. V. T. expressed the opinion

that abortion was a frequent occurrence in married life and the court learned that oral contraceptives were frequently referred to as "the wife's help" in that case. Hehir and Gribble, the authors of the treatise, claimed that married British women routinely used abortion to minimise the size of their families in India. Sex industry workers also used abortion practice. (9)

Abortion is seen from a wide range of doctrinal perspectives in South Asian religious traditions. In contrast to unintentional miscarriage, Hindu traditions forbid purposeful abortion unless it was necessary to preserve the woman's life (and with the king's consent). Beginning in the eighteenth century, the Catholic and Protestant religions strictly prohibited abortion from conception onward. This was a change from the previous century. According to Zoroastrian scripture, abortion is prohibited. Islamic law adopted the most lenient stance, permitting it prior to 120 days (the time of ensoulment) under particular circumstances and forbidding it thereafter unless it saved the woman's life. Nevertheless, despite religious bans on abortion, some women nevertheless attempted to end their pregnancies. Other cosmological beliefs may have influenced the desire for abortion in certain women. For instance, sex-selective abortion was practised long before sex-determining technologies were developed in the middle of the 20th century. Astrologers made predictions concerning the gender of the foetus, which in some circumstances resulted in abortions. In other cases, women (or couples) asked for abortions because they felt the pregnancy was in general unlucky. In Punjab, abortions allegedly happened because of the prevailing notion that every third pregnancy was unfortunate. (9) Women either performed abortions on themselves using drugs or on other people using a combination of local chemical and mechanical methods. To save the women's lives, medical experts with Western training performed legal abortions; nonetheless, the medico-legal archive only has a minimal number of specific examples of allopathic doctors executing illegal abortions in India. (9)

Regulations that restrict abortion may additionally contribute to distress and stigma. In addition to putting women and girls in financial hardship, restrictive abortion regulations have the potential to infringe their human rights, particularly their right to privacy, equality, and non-discrimination. (10)

The well-being of individuals, couples, and families, as well as the social and economic development of societies, depends on sexual and reproductive health. For both individual and community health as well as the fulfilment of human rights, access to sexual and reproductive health (SRH) information and services is crucial. (11)

## Rationale:

The current study's aim is to the secondary evidence synthesis on the abortion scenario and legal framework of abortion situation in South Asian countries. There are various literatures available in public domain in bits and pieces but there is dearth of literatures to give a holistic view of the abortion scenario in South Asian countries. Therefore, there is an utmost need to have a comprehensive study document which covers all the aspect related to abortion. With this backdrop, we have adopted the approach of documenting one comprehensive study document where we will be portraying the secondary evidence and aim to draw the inferences by analysing DHS data on abortion. By providing reliable data, the study will aid in understanding ability to access safe abortion care and its impact on the maternal mortality scenario and health complications.

## Research Questions:

What is the current situation of legal aspects of abortion in South Asian countries?

What are the secondary data and evidence available which decode the abortion situation in both restricted and non-restricted settings?

What are the preferences of women in terms of utilising the abortion care?

## Objectives:

The following are the objectives of this study:

1. To explore the legal framework of abortions in South Asian countries
2. To understand the current scenario and practices of abortion by exploring the secondary data (DHS) on abortion in South Asian countries.
3. To understand the abortion self-care situation in India by analysing the NFHS-5 (2019-21) data.

## Methodology:

**Study design:** Cross sectional observational study

**Study Data:** This exercise's main goal was to update the stakeholders on the legal status of abortion in the South Asian countries as well as the rules and regulations in place that govern the provision of abortion services. The legal status of abortion in various nations, as well as the national standards and guidelines for offering abortion services, when available, were gathered through a thorough desk analysis of the available papers. A number of search engines were used for the literature search. Technical references were

accessed through specialised websites run by organisations including the WHO, UNFPA, UNDP, and Guttmacher Institute. Peer reviewed articles and reports were accessed by typing keywords in the search engine. A comprehensive landscape analysis table of abortion situation in South Asian countries was prepared to explore the legal framework of abortions in the South Asian countries. Secondary data (DHS) on abortion in South Asian countries was explored to understand the current scenario and practices of abortion in the South Asian countries. Bivariate and univariate analysis of the unit level NFHS-5 (2019-21) recent round of data was conducted for abortion indicators to understand the abortion self-care situation in India. Following indicators were used – pregnancy consequences, place last termination performed, person performed abortion, what method was used for the abortion, age in 5-year groups, type of place of residence, highest educational level, religion, wealth index combined, total children ever born, number of living children, respondent currently working, respondent's occupation, caste, what was the main reason for the abortion, and complications from abortion. Multivariate binary logistic regression has been done to see abortion complications with background variables.

**Study setting:** South Asian countries (Afghanistan, Bangladesh, India, Nepal, Sri Lanka, Pakistan, Bhutan, and Maldives).

**Study population:** Pregnant women of reproductive age (married or unmarried).

**Study tool:** NFHS 5 and DHS factsheet & secondary data on abortion scenario and legal framework in South Asian countries.

**Data Analysis:** SPSS was used to analyse the data.

## Result:

## Objective wise finding:

1. To explore the legal framework of abortions in South Asian countries

**Table 1.1: Landscape analysis of abortion situation in South Asian countries**

| Country | Conditions and gestation limit for which abortion is permitted | | | | | | | | | Abortion-Legal Status |
|---|---|---|---|---|---|---|---|---|---|---|
| | Save woman 's life | Physical Health | Mental Health | Rape/ incest | Foetal impairment | Economic/ Social reasons | HIV/Other incurable diseases | Intellectual cognitive disability | On Request | |
| Afghanistan | ✓ | X | X | X | X | X | X | X | X | Restricted setting |
| Bangladesh | ✓ (no limit) | X | X | X | X | X | X | X | X | Abortion is not legal. MR is permitted |
| India | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | ✓ (Till 24 weeks) | X | Legal |
| Nepal | ✓ (Till 28 weeks) | ✓ (Till 28 weeks) | ✓ (Till 28 weeks) | ✓ (Till 28 weeks) | ✓ (Till 28 weeks) | X | ✓ (Till 28 weeks) | ✓ (Till 28 weeks) | ✓ (Till 12 weeks) | Legal |
| Sri Lanka | ✓ (no limit) | X | X | X | X | X | X | X | X | Restricted Setting |
| Pakistan | ✓ | X | X | X | X | X | X | X | X | Restricted Setting |
| Bhutan | ✓ (Till 180 days) | ✓ (Till 180 days) | ✓ (Till 180 days) | ✓ (Till 180 days) | ✓ (Till 180 days) | X | ✓ (Till 180 days) | ✓ (Till 180 days) | X | Not Legal |
| Maldives | ✓ (no limit) | X | X | ✓ (Till 120 days) | X | ✓ (Till 120 days) | X | X | X | Restricted Setting |

0 million women, or 59% of all women in the world that belong to the reproductive age reside in countries where abortion is generally permitted. 41% of women are subject to severe regulations even though most women reside in countries where they have permission to have abortions. The inability to seek a safe and legal abortion procedure is a barrier for 700 million women who are of reproductive age. According to the World Health Organisation, 23,000 women die from unsafe abortions annually, and several thousand more experience catastrophic health consequences. Legislative restrictions on abortion do not reduce the number of abortions; instead, they push women to seek unsafe abortion treatment, endangering their lives and health. (12)

The legal status of abortion also illustrates where women and girls are legally permitted to decide whether to carry a pregnancy to term or not. It additionally demonstrates the barriers that hinder women and girls from participating fully in public and political life, the probability that a woman will die during an unsafe abortion, and the likelihood that girls will complete their education. In other words, monitoring the legal status of abortion allows us to assess the degree to which women and girls are treated equally and given the opportunity to choose how they lead their lives. (12)

- **Afghanistan Legal Status –**

In the Islamic Republic of Afghanistan, it is against the law to induce a pregnancy to terminate. Only when there is proof that the mother's life is at risk or that the child is severely disabled, are exceptions allowed. Abortion is prohibited in all other situations and is punishable by a steep fine or even incarceration. Even rape and incest are not thought to be adequate justifications for an abortion. Asia's highest birth rate is in Afghanistan. Throughout the course of their lifetimes, Afghan women typically have six children. Many women would prefer to have fewer children or maybe none, but they do not have the knowledge required to understand the various birth control options. The

United Nations organisation for children's relief, UNICEF, reports that 79% of Afghan women do not utilise birth control, with abortion being the only method they are aware of. Since abortion is prohibited, women typically turn to traditional midwives, which is very risky. (13–15)

- **Bangladesh legal status –**

Maternal Mortality Ratio decreased at a rate of 5.6% from 322 deaths per 100 000 live births in 1998 to 2001, to 194 deaths per 100 000 live births in 2007 to 2010. Haemorrhage is the cause of about 29% of these fatalities. Less than 1% of maternal deaths, according to the 2011 Bangladesh Maternal Mortality Survey, are related to unsafe abortion. More than 80% of births are expected to be attended by untrained birth attendants, family members, or neighbours who are not medically certified to carry delivery. More than 85% of deliveries are thought to occur at home and majority of them are unaware of the potentially fatal consequences of any delay in managing obstetric problems, particularly haemorrhage following delivery. Furthermore, pregnant women in rural Bangladesh do not have easy access to emergency obstetric care. The Guttmacher study projected that in 2014, 48% (2.8 million) of all pregnancies in Bangladesh were unplanned, even though CPR (Contraceptive Prevalence Rate) for modern techniques has been rising.

Although abortion is legally restricted in Bangladesh, early menstrual regulation (MR) has been a part of the government's health and family planning initiatives since 1975 as an attempt to reduce female morbidity and death related to indigenous abortion. Only in cases where the woman's life is placed at risk is abortion legal. Menstrual regulation (MR) is permissible for no more than twelve weeks of pregnancy. In order to "regulate the menstrual cycle when menstruation is absent for a short duration," MR uses manual vacuum aspiration or a mifepristone and misoprostol combination. The term MRM refers to MR that is done while taking medication. Government regulations state that MRM

procedures can be carried out for a maximum of nine weeks after a woman's last menstrual period, whereas MR procedures can be carried out until 10–12 weeks after that (depending upon the particular kind of provider). (16–19)

- **India Legal status**

Around 8% of the MMR in the country are induced by complications associated to abortion, which are the third leading cause of maternal mortality. The MTP Act of 1971 permits medical practitioners (with specified specialisation) to terminate pregnancies on certain conditions. Depending on the opinion of one doctor, a pregnancy may be terminated up to 12 weeks, and up to 20 weeks based on the opinion of two doctors. In 2021, India amended its Medical Termination of Pregnancy Act (MTP). The amendments further liberalized access to abortion services and removed several restrictions. The amendments increased the upper gestational limit for access to abortion for minors, for women with specified disabilities, and in cases of rape and incest from 20 to 24 weeks, among others. The amendment also removed gestational limits in cases of "substantial foetal abnormalities. One doctor's opinion is necessary if the abortion takes place within 12 weeks of conception; if it is carried out between 12 and 20 weeks, two doctors' opinions are required. For certain groups of women, the bill permits abortion on the advice of one doctor up to 20 weeks and two doctors between 20 and 24 weeks. Medical Termination of Pregnancy is legal if it results from a consenting relationship with a licenced medical professional, regardless of marital status. (20–23)

- **Nepal legal status –**

In 2002, Nepal legalized abortion. It is accessible upon request up to 12 weeks' gestation, up to 18 weeks' gestation in situations of rape or incest, and whenever the woman's life,

bodily or mental health are in danger due to the pregnancy or if there is a foetal abnormality. Maternal mortality has dramatically decreased since abortion became legal, dropping from 580 maternal deaths per 100,000 live births in 1995 to 190 per 100,000 in 2013. (24)

According to a Guttmacher research, in Nepal in 2014, nearly 50% of pregnancies were unplanned (mistimed or unwanted), which is likely a direct result of the country's significant unmet need for family planning. The MMR (Maternal Mortality Ratio) has declined (from 539 in 1996 to 239 in 2016), the TFR (Total Fertility Rate) has decreased (from 4.6 in 1996 to 2.3 in 2016), and the CPR (Contraceptive Prevalence Rate) has risen (from 48% in 2006 to 53% in 2016). This increase, nevertheless, can be attributed to more people using conventional methods of contraception. CPR for modern procedures dropped from 44% in 2006 to 43% in 2011, and it stayed there in 2016. (25,26)

- **Sri Lanka legal aspect –**

Abortion is prohibited in Sri Lanka, one of the countries with the harshest abortion regulations in the world, unless the mother's life is in danger. The consent of three doctors is required, if not, the abortion is not permitted. In Sri Lanka, abortion is absolutely forbidden and those who cannot afford high-quality services, either in the country or abroad, are either forced to risk their lives to have the procedure done in unsafe conditions or are forced to carry a pregnancy that they cannot afford, manage, or desire. (27)

According to Sri Lanka's Penal Code 6, inducing an abortion is a crime that is punished by three to ten years in prison, a fine, or both. Except for the pregnant woman's permission, there are no procedural criteria in the provision of the Penal Code for the lawful termination of pregnancy. Neither the type of facilities where the procedures are to be carried out nor the requirements for individuals who are authorized to perform

abortions are specified. This is possibly because preserving life is regarded as equivalent to other obstetric procedures. (28)

Sri Lanka has one of the lowest maternal mortality ratio (MMR) among the South Asian nations, at 39 maternal deaths per 100,000 live births (FHB 2017). This has been achieved due to the participation of a health system that operates properly and allows women to quickly access emergency obstetric care services. Abortion-related cause-specific MMR has decreased recently, although it still ranks among the top 10 causes of maternal death. (28)

- **Pakistan legal status –**

Articles 338, 338A, 338B, and 338C of Pakistan's Penal Code refer to abortion as "Isqat-e-Haml" and "Isqat-e-Janin." Isqat-e-haml is a term for discontinuing a pregnancy before the child's organs have formed. The termination of a pregnancy while parts of the child's limbs and organs have formed is known as Isqat-e-Janin. According to articles 338 and 338(B), termination of a pregnancy is a punishable crime, unless it is caused under ‘good faith’, or to save the life of the woman through the ‘necessary treatment’ to her. Abortion is punishable by three years or more in prison in all other circumstances, depending on whether the woman provided her consent or not. (29,30)

- **Bhutan legal status –**

The Bhutan Penal Code's Section 146 permits abortion in three situations: where it is necessary to preserve the woman's life; when there has been rape or incest; and when the mother is suffering from a mental illness. Additionally, the Standard Guideline for the Health Workers on Management of Complications of Abortion, which outlines additional requirements for medical termination of pregnancy to preserve the woman's health, and

in cases of foetal impairment, defines gestational limits and describes methods to be used, serves as a general guide for abortions in Bhutan.

Intensive programme efforts have resulted in decline in MMR to 86/100 000 live births in 2017. With a case fatality rate of 1.4%, abortion complications are one of the most common obstetric morbidity causes. (31,32)

- **Maldives legal status –**

Abortion is legal in the Maldives under Section 416 of the Criminal Code of 2014, provided that the woman's life is in danger and the pregnancy is the consequence of rape or incest. According to the National Reproductive Health Strategy (2014–2018) of the Ministry of Health, the Ministry of Health and Gender requested the Ministry of Islamic Affairs to revise the law regarding abortion after realising the scope and impact of unsafe abortions. In response, the Government's Council of Religious Scholars (Fiqh Academy of Maldives) issued a Fatwa in 2013 that authorised abortion under some circumstances. The academy claims that regardless of whether marriage to the male is permitted under Islamic law, if a woman is raped, abortion is permitted if it is done within the first 120 days. If an abortion is performed during the first 120 days after a man has sexually assaulted a woman whose health makes it impossible for her to carry a child, this is legal. If the doctors are certain that the infant may have a major illness, such as thalassemia, sickle cell disease, or any other significant illness that cannot be treated with medication. Abortion is only permitted after the first 120 days if the mother's health is in grave danger and doctors must rescue the baby or the mother. The Fiqh Academy also stated that while abortion is permitted in the first four circumstances if done within 120 days of pregnancy, after that point the foetus will have a soul inside and should be regarded as living. (33,34).

2. To understand the current scenario and practices of abortion by exploring the secondary data (DHS) on abortion in South Asian countries.

# Abortion Indicators (DHS Data)

## Bangladesh

According to the Bangladesh Demographic and Health Survey 2017-18, 71.3% of ever-married women in Bangladesh have heard of menstrual regulation, but only 7.4% have used it. Only 7.5% of currently married women have ever utilised menstrual regulation, even though 71.7% had heard of it. (Table 2.1). (35)

**Table 2.1:** Abortion Indicators (DHS Data) Bangladesh

| Indicators | Percentage |
|---|---|
| **Knowledge and use of menstrual regulation** | |
| | |
| Ever-married women who have ever heard of menstrual regulation | 71.3 |
| Ever-married women who have ever used menstrual regulation among women who have heard of menstrual regulation | 7.4 |
| Currently married women who have ever heard of menstrual regulation | 71.7 |
| Currently married women who have ever used menstrual regulation among women who have heard of menstrual regulation | 7.5 |

# Nepal

Based the findings of the Nepal Demographic and Health Survey 2016, 40.6% of women in Nepal were aware that abortion is legal. Majority of the women (50.3%) feel abortion is legal if there are too many children while 28.8% believed abortion during pregnancy

of 18 weeks or less if stemmed from rape/incest is legal, and 22.8% of them believed abortion during pregnancy of 12 weeks or less for any woman is lawful. 48% of women were aware of a safe abortion location. 79.4% of them knew about abortion in the government sector, and 46.2% in the private sector. The most prevalent source of information on safe abortion services was friends or neighbours (66.8%). Pregnancies terminated with a live delivery in 80.6% of cases, a stillbirth in 1.4% of cases, a miscarriage in 9.1% of cases, and abortion in 9% of cases. Many women (50.3%) stated they were opposed to another kid as the primary reason for abortion, while 11.7% sought to postpone childbearing. The health of the mother was cited as the cause for the most recent abortion in 10.3% of women. Medical abortion (72.1%) was the most utilised method of abortion. 16.6% of women utilised manual vacuum aspiration, while 6.8% had dilation and evacuation/dilation and curettage. A large percentage of abortions (71.1%) were performed by a doctor/nurse/auxiliary nurse midwife, 19.0% by a pharmacist/medical store, and 5.2% by a health assistant/AHW. A large proportion of women (50.8%) had abortions at authorised sites, 30.9% went to the government sector, and 26.5% went to the private sector. Nearly one-fifth of women (27.1%) underwent abortions at home. (Table 2.2). (36)

**Table 2.2:** Abortion Indicators (DHS Data) Nepal

| Indicators | Percentage |
|---|---|
| **Knowledge that Abortion Is Legal** | |
| Women who think abortion is legal | 40.6 |
| Pregnancy of 12 weeks duration or less for any women | 22.8 |
| Pregnancy of 18 weeks duration if resulted from rape/incest | 28.8 |
| Life of mother is in danger | 13.5 |
| Mother's physical/mental health at risk | 12.2 |
| Foetus abnormality | 11.9 |
| Don't know | 16.2 |
| To space births | 0.7 |
| If foetus is a daughter | 3.0 |
| If too many children | 50.3 |
| Other | 2.9 |
| **Knowledge about Places that Provide Safe Abortions** | |
| Percentage who know a safe place for abortion | 48 |
| Government sector | 79.4 |
| Non government sector | 18.4 |
| Private sector | 46.2 |
| Other | 1.1 |
| **Source of Information on Safe Abortion Service** | |
| Health Providers/Pharmacists | 18.2 |
| Female community health volunteer | 9.0 |
| Radio | 15.8 |
| Television | 12.5 |
| Internet | 2.3 |
| Newspaper/Magazine | 5.9 |
| Friends or Neighbours | 66.8 |
| Family members | 26.7 |
| Women's group/mother's group | 3.0 |
| Course book/teacher | 3.2 |
| Poster/billboard/pamphlet/other materials | 3.8 |
| **Pregnancy Outcome** | |
| Live birth | 80.6 |
| Stillbirth | 1.4 |
| Miscarriage | 9.1 |
| Abortion | 9.0 |
| Total | 100 |

**Table 2.2:** continued

| Reason for having most recent abortion | |
|---|---|
| Health of the mother | 10.3 |
| No money to take care of the baby | 4.3 |
| Wanted to delay child bearing | 11.7 |
| Did not want more children | 50.3 |
| Wanted to space births | 9.3 |
| Husband/partner did not want a child | 3.7 |
| Sex of the child not as desired | 6.5 |
| Other | 3.9 |
| **Procedure of abortion** | |
| Medical Abortion | 72.1 |
| Manual vacuum aspiration | 16.6 |
| Dilation and evacuation/dilation and curettage | 6.8 |
| Other | 4.5 |
| **Type of health provider for abortion** | |
| Doctor/nurse/auxiliary nurse midwife | 71.1 |
| Health assistant/ AHW | 5.2 |
| MCHW/VHW/FCHV | 0.7 |
| Pharmacist/medical shop | 19.0 |
| Relatives/friends | 2.5 |
| No one | 1.5 |
| **Health Facility** | |
| Government sector | 30.9 |
| Non Government sector | 12.9 |
| Private sector | 26.5 |
| Home | 27.1 |
| Other | 4.4 |
| Authorised site for abortion | 50.8 |

## Pakistan

Based a report by the Pakistan Demographic and Health Survey 2017-18, 83% of pregnancies in Pakistan resulted in live birth, 13.3% in miscarriage, 2% in stillbirth, and 1.7% in abortion. 7.4% of pregnant women experienced violence, and 2.5% of them had an abortion, miscarriage, stillbirth, or other health problems as a result of the abuse. (Table 2.3) (37)

**Table 2.3:** Abortion Indicators (DHS Data) Pakistan

| Indicators | Percentage |
|---|---|
| **Pregnancy Outcome** | |
| Live birth | 83.0 |
| Stillbirth | 2.0 |
| Miscarriage | 13.3 |
| Abortion | 1.7 |
| Total | 100 |
| **Experience of violence during pregnancy** | |
| Percentage who experienced violence during pregnancy | 7.4 |
| Percentage who had a abortion, miscarriage, stillbirth or other health problems due to experienced violence during pregnancy | 2.5 |

3. To understand the abortion self-care situation in India by analysing the NFHS-5 (2019-21) data.

**Findings from unit level data analysis of NFHS-5 (2019-21) (**38)

Figure 3.1 presents consequences of pregnancy. Of the total pregnancies, three-fourth (65.8%) end with miscarriage, 25.9% end with abortion and 8.3% with stillbirth.

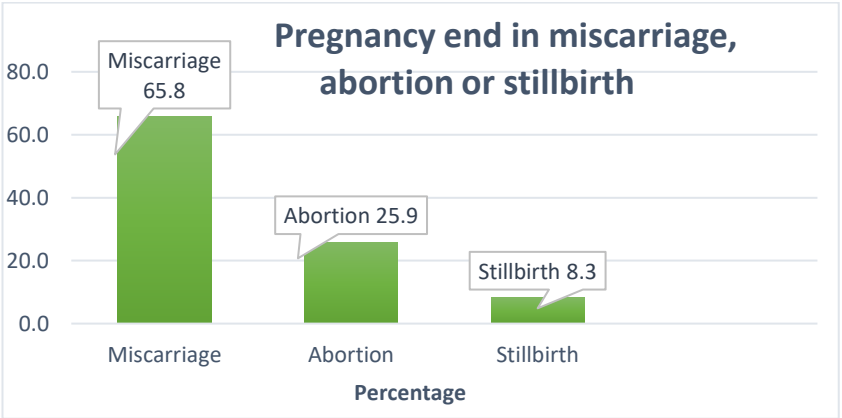


**Figure 3.1:** Pregnancy end in miscarriage, abortion or stillbirth

Figure 3.2 presents main reasons for the abortion. Out of total women, 47.6% of the women stated unplanned pregnancy as the prime reason, followed by 11.3% whose health condition did not allow them to continue pregnancy. 9.7% women highlighted about the

age of the last child was too young to have another child. While pregnancy complications (9.1%) were another stated reason. On the other hand, there were women (4.1%) forced to undergo the abortion process as their husband/mother-in-law did not permit for the pregnancy. (Figure 3.2)

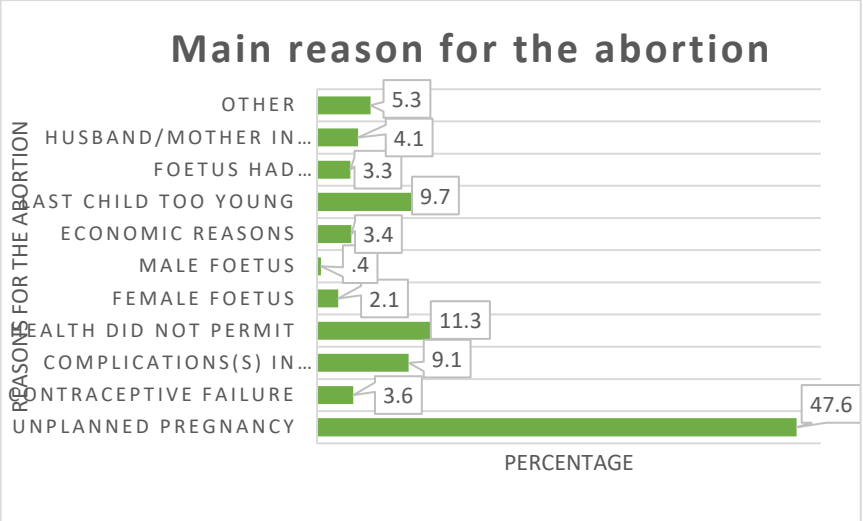


**Figure 3.2:** Main reason for the abortion

Table 3.1 represented the profile of women who had aborted their most recent pregnancy and the person who performed the abortion. Women of the Muslim religion made up the majority of those who had abortions performed by doctors (57.9%), followed by women of other religions (56.5%) and Hindus (55%). It's interesting to note that among Muslim women, 1% preferred Dai and 1% preferred Vaidya/hakim/AYUSH over doctors for abortions. 3.7% of Hindu women opted for an abortion from a family member, friend, or relative rather than visiting a doctor. As opposed to 53.9% of the younger population, 60.4% of middle-aged women preferred doctors for abortions. Surprisingly, 1.9% of young women chose a Vaidya, hakim, or homoeopath (AYUSH), 3.9% preferred a family member, relative, or acquaintance, and 29.9% performed the abortion themselves. Three-fifths (64.5%) of urban and 57.7% of rural women consulted a doctor for an abortion. Women from the richest income quintile (64.1%) preferred doctors for abortion more frequently than women from the poorest wealth quintile (41.7%), while women from the

middle class preferred 59.2%. Among women having no schooling, 42.7% chose doctor, 22.2% chose nurse/ANM/ LHV, 1% preferred Dai, and 4% chose family member/relative/friend. In contrast to this woman with higher schooling 69.5% chose doctor and 4% chose family member/relative/friend. Vaidya/hakim/Homeopath AYUSH performed abortions on 1.2% of women from the poor wealth quintile, while they were not chosen by women from the higher wealth quintile. Women without children were more likely to settle on a doctor for abortion (66.4%), followed by 12.2% who selected a nurse/ANM/LHV. For abortion, 34.4% of women with five or more children preferred a doctor, 23.8% chose a nurse/ANM/LHV, and 1.9% preferred a Vaidya/hakim/Homeopath AYUSH. Doctors were favoured for abortion by 59.2% of women who were unaware of their caste, 17.2% of scheduled caste women picked nurse/ANM/LHV, and 4% chose family member/relative/friend. Schedule tribal women had a high percentage of self-abortion (30.5%). (Table 3.1)

**Table 3.1:** Person performed abortion

| | **Person performed abortion** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Religion** | **Doctor** | **Nurse/ ANM / LHV** | **Vaidya/ Hakim/ Homeopath (Ayush)** | **DAI** | **Family member/ Relative / friend** | **Self** | **Other** | **Total** |
| Hindu | 55.0% | 13.9% | .3% | .3% | 3.7% | 26.1% | .7% | 100.0% |
| Muslim | 57.9% | 15.1% | 1.0% | 1.0% | 2.5% | 22.2% | .4% | 100.0% |
| Other | 56.5% | 16.4% | .1% | .3% | .7% | 25.4% | .4% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |
| **Age in 5-year groups** | | | | | | | | |
| 15-19 | 53.9% | 11.7% | 1.9% | 0.0% | 2.6% | 29.9% | 0.0% | 100.0% |
| 20-24 | 53.2% | 13.2% | .4% | .4% | 3.8% | 28.3% | .7% | 100.0% |
| 25-29 | 53.9% | 14.6% | .2% | .4% | 3.9% | 26.6% | .5% | 100.0% |
| 30-34 | 56.3% | 14.5% | .3% | .4% | 2.8% | 24.9% | .7% | 100.0% |
| 35-39 | 60.4% | 14.6% | .8% | .1% | 2.4% | 21.2% | .6% | 100.0% |
| 40-44 | 58.9% | 13.7% | 0.0% | .6% | 2.8% | 23.4% | .6% | 100.0% |
| 45-49 | 54.9% | 22.0% | 1.2% | 0.0% | 2.4% | 17.1% | 2.4% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |

| **Type of place of residence** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Urban | 64.5% | 9.9% | .2% | .1% | 3.1% | 21.6% | .6% | 100.0% |
| Rural | 51.7% | 16.0% | .4% | .5% | 3.4% | 27.3% | .6% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |
| **Highest educational level** | | | | | | | | |
| No education | 42.7% | 22.2% | .6% | 1.0% | 4.0% | 28.8% | .8% | 100.0% |
| Primary | 45.6% | 19.6% | .8% | .3% | 3.3% | 29.1% | 1.2% | 100.0% |
| Secondary | 56.0% | 12.9% | .3% | .3% | 3.5% | 26.4% | .6% | 100.0% |
| Higher | 69.5% | 9.1% | .2% | .2% | 2.4% | 18.5% | .1% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |
| **Wealth index combined** | | | | | | | | |
| Poorest | 41.7% | 18.1% | 1.2% | 1.2% | 4.7% | 32.2% | .8% | 100.0% |
| Poorer | 47.6% | 16.0% | .2% | .3% | 3.5% | 31.8% | .7% | 100.0% |
| Middle | 59.2% | 13.1% | .3% | .3% | 3.3% | 22.9% | .9% | 100.0% |
| Richer | 61.8% | 11.7% | .4% | .1% | 3.2% | 22.5% | .3% | 100.0% |
| Richest | 64.1% | 13.3% | 0.0% | .1% | 2.2% | 19.9% | .4% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |
| **Respondent currently working** | | | | | | | | |
| No | 52.7% | 13.3% | .4% | .3% | 3.5% | 29.0% | .8% | 100.0% |
| Yes | 54.3% | 12.8% | 0.0% | .4% | 2.8% | 28.4% | 1.4% | 100.0% |
| **Total** | 53.1% | 13.2% | .3% | .3% | 3.3% | 28.8% | .9% | 100.0% |
| **Respondent's occupation** | | | | | | | | |
| Not working | 52.8% | 13.3% | .5% | .2% | 3.5% | 29.0% | .7% | 100.0% |
| Professional / technical / managerial | 59.4% | 12.5% | 0.0% | 0.0% | 6.3% | 21.9% | 0.0% | 100.0% |
| Clerical | 83.3% | 0.0% | 0.0% | 0.0% | 0.0% | 16.7% | 0.0% | 100.0% |
| Sales | 54.2% | 4.2% | 0.0% | 4.2% | 0.0% | 33.3% | 4.2% | 100.0% |
| Services / household and domestic | 51.9% | 14.8% | 0.0% | 3.7% | 3.7% | 25.9% | 0.0% | 100.0% |
| Agricultural | 52.2% | 17.9% | 0.0% | 0.0% | 3.7% | 24.6% | 1.5% | 100.0% |
| Skilled and unskilled manual | 56.3% | 6.3% | 0.0% | 0.0% | 2.1% | 33.3% | 2.1% | 100.0% |
| Other | 36.4% | 22.7% | 0.0% | 0.0% | 0.0% | 40.9% | 0.0% | 100.0% |
| Don't know | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% |
| **Total** | 53.1% | 13.2% | .3% | .3% | 3.3% | 28.8% | .9% | 100.0% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Total Children ever born** | | | | | | | | |
| 0 Child | 66.4% | 12.2% | .2% | 0.0% | 2.7% | 17.7% | .8% | 100.0% |
| 1 Child | 63.5% | 10.1% | .2% | .3% | 2.1% | 23.1% | .7% | 100.0% |
| 2 Children | 55.9% | 13.2% | .3% | .3% | 3.7% | 26.2% | .3% | 100.0% |
| 3 Children | 46.4% | 18.6% | .3% | .6% | 4.3% | 28.9% | .8% | 100.0% |
| 4 Children | 40.1% | 24.4% | .8% | .4% | 5.5% | 28.0% | .6% | 100.0% |
| 5 and above Children | 34.4% | 23.8% | 1.9% | .5% | 2.6% | 35.4% | 1.3% | 100.0% |
| **Total** | 55.4% | 14.3% | .4% | .4% | 3.3% | 25.6% | .6% | 100.0% |
| **Number of living children** | | | | | | | | |
| 0 Child | 66.3% | 13.2% | .2% | .2% | 2.6% | 16.9% | .8% | 100.0% |
| 1 Child | 63.2% | 9.9% | .2% | .3% | 2.3% | 23.5% | .6% | 100.0% |
| 2 Children | 55.6% | 13.3% | .3% | .3% | 3.9% | 26.3% | .4% | 100.0% |
| 3 Children | 44.4% | 19.6% | .5% | .7% | 4.1% | 29.8% | .9% | 100.0% |
| 4 Children and above | 37.5% | 25.1% | 1.3% | .4% | 3.7% | 31.1% | .9% | 100.0% |
| **Total** | 66.4% | 12.2% | .2% | 0.0% | 2.7% | 17.7% | .8% | 100.0% |
| **Caste** | | | | | | | | |
| Schedule caste | 50.9% | 17.2% | .2% | .4% | 4.0% | 26.6% | .9% | 100.0% |
| Schedule tribe | 53.9% | 11.0% | .5% | .5% | 3.0% | 30.5% | .5% | 100.0% |
| OBC | 55.7% | 14.7% | .3% | .2% | 3.6% | 25.0% | .6% | 100.0% |
| None of them | 58.6% | 13.2% | .4% | .3% | 2.8% | 24.3% | .3% | 100.0% |
| Don't know | 59.2% | 14.1% | 0.0% | 0.0% | 1.4% | 22.5% | 2.8% | 100.0% |
| **Total** | 55.1% | 14.4% | .3% | .3% | 3.4% | 25.8% | .6% | 100.0% |

Table 3.2 shows the characteristics of women who had abortions as well as the method of abortion. Medicines were used to induce abortion more frequently, by around two-thirds (66.7%) of women belonging to Hindu religion, followed by women of Muslim religion (65.2 Younger women (70.8%) favoured medicines over other means of abortion, whereas 53.7% older women preferred medications over other techniques. Other surgical procedures were utilised more frequently among older women (22%) than among younger women (14.9%). MVA was the procedure of choice for abortion for 19.5 elderly women. Around three-fifths (63.8%) of women with higher education opted medicine and 21.2% opted for other surgical methods, whereas 66.3% of women with no education

took medicine and 15.7 went for other surgical methods. Lowest income bracket women (68.5%) were more inclined to favour medications than the wealthiest percentile women (61.5%). Surgical techniques were favoured more by women in the upper wealth quintile (23.1%) than by women in the lower wealth quintile (16.1%). Women who have never had child favoured surgical techniques more than women who had five or more children (12.4%). Medications were used for abortion by 68.8% of women who had 5 or more children and 61.6% of women who did not have a child.

**Table 3.2:** Method used for the abortion

| | **Method used for the abortion?** | | | | | |
|---|---|---|---|---|---|---|
| **Religion** | **Medicines** | **MVA** | **Other surgical** | **Any other (specify)** | **Don't know** | **Total** |
| Hindu | 66.7% | 11.9% | 17.5% | 1.1% | 2.6% | 100.0% |
| Muslim | 65.2% | 13.1% | 17.8% | 1.3% | 2.6% | 100.0% |
| Other | 61.6% | 13.6% | 20.3% | 1.5% | 3.0% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Age in 5-year groups** | | | | | | |
| 15-19 | 70.8% | 11.7% | 14.9% | 1.3% | 1.3% | 100.0% |
| 20-24 | 69.7% | 11.4% | 15.7% | 1.1% | 2.1% | 100.0% |
| 25-29 | 67.1% | 11.5% | 17.7% | 1.1% | 2.6% | 100.0% |
| 30-34 | 64.9% | 12.3% | 18.5% | 1.0% | 3.3% | 100.0% |
| 35-39 | 61.6% | 13.9% | 19.8% | 1.6% | 3.1% | 100.0% |
| 40-44 | 63.2% | 14.3% | 19.0% | 1.9% | 1.6% | 100.0% |
| 45-49 | 53.7% | 19.5% | 22.0% | 1.2% | 3.7% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Type of place of residence** | | | | | | |
| Urban | 66.2% | 11.7% | 18.2% | 1.4% | 2.5% | 100.0% |
| Rural | 66.1% | 12.4% | 17.6% | 1.1% | 2.7% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Highest educational level** | | | | | | |
| No education | 66.3% | 12.5% | 15.7% | 1.3% | 4.1% | 100.0% |
| Primary | 67.3% | 14.2% | 15.3% | .8% | 2.5% | 100.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Secondary | 66.6% | 11.8% | 17.8% | 1.2% | 2.6% | 100.0% |
| Higher | 63.8% | 11.9% | 21.1% | 1.4% | 1.8% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Wealth index combined** | | | | | | |
| Poorest | 68.5% | 10.0% | 16.1% | 1.4% | 4.1% | 100.0% |
| Poorer | 67.3% | 12.9% | 16.4% | 1.0% | 2.3% | 100.0% |
| Middle | 67.0% | 12.4% | 16.8% | 1.0% | 2.8% | 100.0% |
| Richer | 66.6% | 12.6% | 16.7% | 1.4% | 2.7% | 100.0% |
| Richest | 61.4% | 12.6% | 23.1% | 1.2% | 1.8% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Respondent currently working** | | | | | | |
| No | 64.7% | 11.1% | 19.9% | 1.5% | 2.7% | 100.0% |
| Yes | 64.9% | 12.1% | 18.1% | 1.8% | 3.2% | 100.0% |
| **Total** | 64.8% | 11.3% | 19.5% | 1.6% | 2.8% | 100.0% |
| **Respondent's occupation** | | | | | | |
| Not working | 65.3% | 11.2% | 19.5% | 1.5% | 2.6% | 100.0% |
| Professional / technical / managerial | 68.8% | 9.4% | 21.9% | 0.0% | 0.0% | 100.0% |
| Clerical | 66.7% | 16.7% | 16.7% | 0.0% | 0.0% | 100.0% |
| Sales | 62.5% | 16.7% | 12.5% | 0.0% | 8.3% | 100.0% |
| Services / household and domestic | 74.1% | 14.8% | 11.1% | 0.0% | 0.0% | 100.0% |
| Agricultural | 62.7% | 11.9% | 16.4% | 4.5% | 4.5% | 100.0% |
| Skilled and unskilled manual | 59.4% | 9.4% | 30.2% | 0.0% | 1.0% | 100.0% |
| Other | 63.6% | 13.6% | 9.1% | 0.0% | 13.6% | 100.0% |
| Don't know | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% |
| **Total** | 64.8% | 11.3% | 19.5% | 1.6% | 2.8% | 100.0% |
| **Total Children ever born** | | | | | | |
| 0 Child | 61.6% | 12.9% | 20.1% | 2.1% | 3.4% | 100.0% |
| 1 Child | 64.2% | 11.6% | 20.5% | 1.3% | 2.3% | 100.0% |
| 2 Children | 68.4% | 12.2% | 15.8% | .9% | 2.6% | 100.0% |
| 3 Children | 66.1% | 12.1% | 18.0% | 1.3% | 2.5% | 100.0% |
| 4 Children | 65.0% | 12.7% | 18.5% | .8% | 3.0% | 100.0% |
| 5 and above Children | 68.8% | 14.0% | 12.4% | 1.1% | 3.7% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Number of living children** | | | | | | |
| 0 Child | 61.6% | 12.9% | 20.3% | 2.0% | 3.3% | 100.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 Child | 64.2% | 11.8% | 20.3% | 1.3% | 2.3% | 100.0% |
| 2 Children | 68.4% | 11.9% | 16.1% | .9% | 2.8% | 100.0% |
| 3 Children | 66.6% | 12.2% | 17.6% | 1.6% | 2.1% | 100.0% |
| 4 Children and above | 66.2% | 14.2% | 15.2% | .7% | 3.7% | 100.0% |
| **Total** | 66.1% | 12.2% | 17.8% | 1.2% | 2.7% | 100.0% |
| **Caste** | | | | | | |
| Schedule caste | 68.8% | 11.9% | 15.6% | 1.1% | 2.6% | 100.0% |
| Schedule tribe | 65.8% | 11.3% | 17.5% | 1.7% | 3.7% | 100.0% |
| OBC | 67.2% | 11.9% | 17.0% | 1.1% | 2.8% | 100.0% |
| None of them | 63.3% | 13.3% | 20.3% | 1.2% | 1.8% | 100.0% |
| Don't know | 62.0% | 14.1% | 15.5% | 2.8% | 5.6% | 100.0% |
| **Total** | 66.4% | 12.2% | 17.5% | 1.2% | 2.7% | 100.0% |

Table 3.3 shows the characteristics of women who had abortions as well as the location of the most recent termination. Women of Muslim faith (37.1%) were the most likely to use public health facilities for abortion, followed by women of other faiths (35.4%) and 23.3% of Hindu women. About half (49.4%) of Hindu women had abortions in private health facilities, while 40% of Muslim women had abortions in private health facilities. In the young age group, half of the women (51.9%) visited a private health facility for abortion, compared to 46.3% in the senior age group. It is worth noting that abortion was conducted at home more frequently among the young age group (28.3%). Older women (36.6%) visit public health facilities more frequently than younger women (18.2%). Abortion was performed at a private health facility by 56% of urban women and 44.3 percent of rural women. Women with no education (27.4%) used public health facilities more than women with higher education (16.9%). Similarly, women with a higher level of education (64.9%) utilised private health facilities more frequently than women with little education (42.5%). Working women (27%) accessed public health facilities more frequently than non-working women (25.6%). For abortion, 58.4% of women with no children and 43.9% of women with 5 or more children preferred a private health facility. In comparison, 37.7% of schedule tribal women, while 19.7% women who were

uninformed of their caste accessed a public health centre for abortion. For abortion, 53.3% of OBC women selected private health facilities, whereas 1.4% preferred NGO/Trust hospitals/clinics.

**Table 3.3:** Place last termination performed

| | **Place last termination performed** | | | | | |
|---|---|---|---|---|---|---|
| **Religion** | **Public Health** | **NGO or Trust Hospital/clinic** | **Private** | **At Home** | **Elsewhere** | **Total** |
| Hindu | 23.3% | .4% | 49.4% | 26.4% | .5% | 100.0% |
| Muslim | 37.1% | .5% | 40.0% | 22.0% | .5% | 100.0% |
| Other | 35.4% | .1% | 41.3% | 22.3% | .9% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Age in 5-year groups** | | | | | | |
| 15-19 | 18.2% | .6% | 51.9% | 27.9% | 1.3% | 100.0% |
| 20-24 | 22.8% | .4% | 47.9% | 28.3% | .6% | 100.0% |
| 25-29 | 24.8% | .4% | 47.1% | 27.2% | .5% | 100.0% |
| 30-34 | 26.6% | .3% | 48.3% | 24.2% | .6% | 100.0% |
| 35-39 | 31.1% | .4% | 48.0% | 20.4% | .1% | 100.0% |
| 40-44 | 30.2% | .6% | 45.5% | 22.7% | .9% | 100.0% |
| 45-49 | 36.6% | 0.0% | 46.3% | 17.1% | 0.0% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Table 3.3: continued** | | | | | | |
| **Type of place of residence** | | | | | | |
| Urban | 21.7% | .6% | 56.0% | 21.3% | .4% | 100.0% |
| Rural | 27.6% | .3% | 44.3% | 27.2% | .6% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Highest educational level** | | | | | | |
| No education | 27.4% | .2% | 42.5% | 29.3% | .5% | 100.0% |
| Primary | 33.1% | .3% | 36.8% | 29.0% | .8% | 100.0% |
| Secondary | 26.8% | .4% | 45.8% | 26.4% | .6% | 100.0% |
| Higher | 16.9% | .4% | 64.9% | 17.6% | .2% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Wealth index combined** | | | | | | |
| Poorest | 33.7% | .2% | 31.4% | 34.1% | .7% | 100.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Poorer | 30.8% | .2% | 37.7% | 30.5% | .7% | 100.0% |
| Middle | 28.0% | .2% | 48.1% | 23.2% | .5% | 100.0% |
| Richer | 22.5% | .6% | 53.9% | 22.5% | .6% | 100.0% |
| Richest | 15.4% | .7% | 64.8% | 18.9% | .2% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Respondent currently working** | | | | | | |
| No | 25.6% | .5% | 44.7% | 28.6% | .5% | 100.0% |
| Yes | 27.0% | .4% | 41.8% | 30.5% | .4% | 100.0% |
| **Total** | 25.9% | .5% | 44.0% | 29.1% | .5% | 100.0% |
| **Respondent's occupation** | | | | | | |
| Not working | 25.4% | .6% | 45.0% | 28.6% | .5% | 100.0% |
| Professional / technical / managerial | 15.6% | 3.1% | 53.1% | 28.1% | 0.0% | 100.0% |
| Clerical | 33.3% | 0.0% | 50.0% | 16.7% | 0.0% | 100.0% |
| Sales | 29.2% | 0.0% | 37.5% | 29.2% | 4.2% | 100.0% |
| Services / household and domestic | 22.2% | 0.0% | 48.1% | 29.6% | 0.0% | 100.0% |
| Agricultural | 30.6% | 0.0% | 43.3% | 26.1% | 0.0% | 100.0% |
| Skilled and unskilled manual | 26.0% | 0.0% | 39.6% | 34.4% | 0.0% | 100.0% |
| Other | 27.3% | 0.0% | 18.2% | 50.0% | 4.5% | 100.0% |
| Don't know | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% |
| | | | | | | |
| **Total** | 25.9% | .5% | 44.0% | 29.1% | .5% | 100.0% |
| **Total Children ever born** | | | | | | |
| 0 Child | 24.0% | .5% | 58.4% | 16.7% | .5% | 100.0% |
| 1 Child | 26.2% | .5% | 50.5% | 22.4% | .4% | 100.0% |
| 2 Children | 26.1% | .3% | 46.8% | 26.4% | .5% | 100.0% |
| 3 Children | 25.9% | .5% | 43.8% | 29.0% | .8% | 100.0% |
| 4 Children | 29.3% | .2% | 39.3% | 30.1% | 1.1% | 100.0% |
| 5 and above Children | 21.2% | .3% | 43.9% | 34.7% | 0.0% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Number of living children** | | | | | | |
| 0 Child | 24.7% | .5% | 58.5% | 15.9% | .5% | 100.0% |
| 1 Child | 26.3% | .5% | 50.0% | 22.8% | .4% | 100.0% |
| 2 Children | 26.0% | .3% | 46.6% | 26.6% | .5% | 100.0% |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3 Children | 25.0% | .5% | 43.2% | 30.3% | .9% | 100.0% |
| 4 Children and above | 26.5% | .1% | 41.7% | 31.0% | .6% | 100.0% |
| **Total** | 25.9% | .4% | 47.7% | 25.5% | .5% | 100.0% |
| **Caste** | | | | | | |
| Schedule caste | 26.8% | .3% | 45.2% | 27.3% | .5% | 100.0% |
| Schedule tribe | 37.7% | .2% | 32.4% | 29.1% | .5% | 100.0% |
| OBC | 21.1% | .3% | 53.3% | 24.9% | .4% | 100.0% |
| None of them | 23.3% | .7% | 51.5% | 23.7% | .7% | 100.0% |
| Don't know | 19.7% | 1.4% | 50.7% | 25.4% | 2.8% | 100.0% |
| **Total** | 24.9% | .4% | 48.5% | 25.7% | .5% | 100.0% |

The objective of this analysis is to explore the complication situation from abortion with the type of method used for abortion. The findings revealed that the women those who underwent abortion with any other methods rather than surgical or medical abortion methods faced more complications (18.5%) followed by those who used surgical methods (17%) and 13.9% of those who chose medication for abortion. (Table 3.4)

**Table 3.4:** Method used for the abortion* Complication from abortion

| | **Method used for the abortion* Complication from abortion** | | |
|---|---|---|---|
| **Method used for the abortion** | **Complication from abortion** | | |
| | **No** | **Yes** | **Total** |
| Medicines | 86.1% | 13.9% | 100.0% |
| MVA | 84.5% | 15.5% | 100.0% |
| Other surgical | 83.0% | 17.0% | 100.0% |
| Any other (specify) | 81.5% | 18.5% | 100.0% |
| Don't know | 89.8% | 10.2% | 100.0% |
| Total | 85.4% | 14.6% | 100.0% |

The data in Table 3.5 presents complications associated with person performed abortion. 21.4% of women who underwent an abortion by Dai, 20.7% through Vaidya/Hakim/Homeopath (Ayush), and 17.5% through Nurse / ANM / LHV experienced complications. 14.9% of women who had doctor-assisted abortions experienced complications.

**Table 3.5:** Person performed abortion * Complication from abortion

| | **Person performed abortion * Complication from abortion** | | |
|---|---|---|---|
| **Person performed abortion** | **Complication from abortion** | | |
| | **No** | **Yes** | **Total** |
| Doctor | 85.1% | 14.9% | 100.0% |
| Nurse / ANM / LHV | 82.5% | 17.5% | 100.0% |
| Vaidya/Hakim/Homeopath (Ayush) | 79.3% | 20.7% | 100.0% |
| DAI | 78.6% | 21.4% | 100.0% |
| Family member / relative / friend | 85.2% | 14.8% | 100.0% |
| Self | 87.7% | 12.3% | 100.0% |
| Other | 89.4% | 10.6% | 100.0% |
| Total | 85.4% | 14.6% | 100.0% |

Post-abortion complications associated with background variables are outlined in Table 3.6. Of all the religions, Muslim women were more likely to experience post-abortion complications (18.8%), followed by women of other religions (14.2%), and Hindu women (14.1%). More than one-fifth (29.3%) of women in the older age group, 16.9% of women in the younger age group, and 15.7% of women in the middle age group experienced problems with their abortions. Compared to women from urban regions (13.5%), women from rural areas (15.0%) reported more abortion complications. Post-abortion difficulties were more common (16.6%) for women with no formal schooling than for those with secondary education and basic school (14.6% and 14.2%, respectively). Contrary to 14.1% of women in the richest economic group, problems with abortion affected 15.3% of women in the medium wealth quintile and 15.2% of women in the poorest wealth quintile. Complications were reported by 13.1% of working women and 12.6% of non-working women. Abortion complications were more common for women without children than for those who did (21.2%), had at least one child (14.7%), or had five or more (16.9%). Complications affected 21.3% of women with no living children more than 14.7% of women with one living child, and 16.2% of women with

four or more living children. Making up a quarter (22.5%) of those who were uninformed of their caste, 15.4% of women who were part of the schedule caste and 13.6% of the population belonging to schedule tribe, experienced problems after an abortion.

**Table 3.6:** Complication from abortion

| **Background Variables** | | | |
|---|---|---|---|
| | **Complication from abortion** | | |
| **Religion** | **No** | **Yes** | **Total** |
| Hindu | 85.9% | 14.1% | 100.0% |
| Muslim | 81.2% | 18.8% | 100.0% |
| Other | 85.8% | 14.2% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Age in 5-year groups** | | | |
| 15-19 | 83.1% | 16.9% | 100.0% |
| 20-24 | 85.4% | 14.6% | 100.0% |
| 25-29 | 86.8% | 13.2% | 100.0% |
| 30-34 | 84.3% | 15.7% | 100.0% |
| 35-39 | 85.7% | 14.3% | 100.0% |
| 40-44 | 84.1% | 15.9% | 100.0% |
| 45-49 | 70.7% | 29.3% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Type of place of residence** | | | |
| Urban | 86.5% | 13.5% | 100.0% |
| Rural | 85.0% | 15.0% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Highest educational level** | | | |
| No education | 83.4% | 16.6% | 100.0% |
| Primary | 85.8% | 14.2% | 100.0% |
| Secondary | 85.4% | 14.6% | 100.0% |
| Higher | 86.7% | 13.3% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Wealth index combined** | | | |
| Poorest | 85.6% | 14.4% | 100.0% |
| Poorer | 84.8% | 15.2% | 100.0% |

| | | | |
|---|---|---|---|
| Middle | 84.7% | 15.3% | 100.0% |
| Richer | 86.1% | 13.9% | 100.0% |
| Richest | 85.9% | 14.1% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Respondent currently working** | | | |
| No | 87.4% | 12.6% | 100.0% |
| Yes | 86.9% | 13.1% | 100.0% |
| **Total** | 87.3% | 12.8% | 100.0% |
| **Respondent's occupation** | | | |
| Not working | 87.1% | 12.9% | 100.0% |
| Professional / technical / managerial | 84.4% | 15.6% | 100.0% |
| Clerical | 66.7% | 33.3% | 100.0% |
| Sales | 91.7% | 8.3% | 100.0% |
| Services / household and domestic | 88.9% | 11.1% | 100.0% |
| Agricultural | 88.1% | 11.9% | 100.0% |
| Skilled and unskilled manual | 87.5% | 12.5% | 100.0% |
| Other | 90.9% | 9.1% | 100.0% |
| Don't know | 100.0 % | 0.0% | 100.0% |
| **Total** | 87.3% | 12.8% | 100.0% |
| **Total Children ever born** | | | |
| 0 Child | 78.8% | 21.2% | 100.0% |
| 1 Child | 85.3% | 14.7% | 100.0% |
| 2 Children | 86.4% | 13.6% | 100.0% |
| 3 Children | 86.8% | 13.2% | 100.0% |
| 4 Children | 86.6% | 13.4% | 100.0% |
| 5 and above Children | 83.1% | 16.9% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Number of living children** | | | |
| 0 Child | 78.7% | 21.3% | 100.0% |
| 1 Child | 85.3% | 14.7% | 100.0% |
| 2 Children | 86.3% | 13.7% | 100.0% |
| 3 Children | 87.9% | 12.1% | 100.0% |

| | | | |
|---|---|---|---|
| 4 Children and above | 83.8% | 16.2% | 100.0% |
| **Total** | 85.4% | 14.6% | 100.0% |
| **Caste** | | | |
| Schedule caste | 84.6% | 15.4% | 100.0% |
| Schedule tribe | 86.4% | 13.6% | 100.0% |
| OBC | 86.8% | 13.2% | 100.0% |
| None of them | 84.6% | 15.4% | 100.0% |
| Don't know | 77.5% | 22.5% | 100.0% |
| **Total** | 85.7% | 14.3% | 100.0% |

Table 3.7 lists the background variables together with self-performed abortions with "Else" being defined as "Doctor, nurse/ANM/ LHV, Dai, Vaidya/hakim/Homeopath AYUSH, family member/relative, and other person." Hindu women (26.1%) had the highest rate of self-abortion among all religious groups, followed by women of other religions (25.4%) and Muslims (22.2%). Interestingly, more than a fifth of women in the younger age group (29.9%) and (24.9%) of women in the middle age group in contrast to 17.1% of women in the older age group report having self-abortions. Self-abortion was more common among women in rural areas (27.3%) than in urban areas (21.6%). Self-abortion was most prevalent among women with primary education (29.1%), followed by women without a formal education (28.8%), and women with secondary education (18.5%). The number of self-abortions among women was higher in the lowest quintile of wealth (32.2%) than in the middle quintile (22.9%) and lowest among the richest economic group (19.9%). Women who were employed (29.0%) self-aborted more frequently than unemployed (28.4%). Nearly one-third (35.4%) of women with five or more children self-abort, compared to 23.1% of women with a single child and 17.7% of women without children. One in five (30.5%) of those who belonged to a schedule tribe, one in six (26.6%) of those who belonged to a schedule caste, and one in twenty (22.5%) of the women who were unaware of their caste had self-aborted.

**Table 3.7:** Person performed abortion

| **Background Variables** | | | |
|---|---|---|---|
| | **Person performed abortion** | | |
| **Religion** | **Else** | **Self-Care** | **Total** |
| Hindu | 73.9% | 26.1% | 100.0% |
| Muslim | 77.8% | 22.2% | 100.0% |
| Other | 74.6% | 25.4% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Age in 5-year groups** | | | |
| 15-19 | 70.1% | 29.9% | 100.0% |
| 20-24 | 71.7% | 28.3% | 100.0% |
| 25-29 | 73.4% | 26.6% | 100.0% |
| 30-34 | 75.1% | 24.9% | 100.0% |
| 35-39 | 78.8% | 21.2% | 100.0% |
| 40-44 | 76.6% | 23.4% | 100.0% |
| 45-49 | 82.9% | 17.1% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Type of place of residence** | | | |
| Urban | 78.4% | 21.6% | 100.0% |
| Rural | 72.7% | 27.3% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Highest educational level** | | | |
| No education | 71.2% | 28.8% | 100.0% |
| Primary | 70.9% | 29.1% | 100.0% |
| Secondary | 73.6% | 26.4% | 100.0% |
| Higher | 81.5% | 18.5% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Wealth index combined** | | | |
| Poorest | 67.8% | 32.2% | 100.0% |
| Poorer | 68.2% | 31.8% | 100.0% |
| Middle | 77.1% | 22.9% | 100.0% |
| Richer | 77.5% | 22.5% | 100.0% |
| Richest | 80.1% | 19.9% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Respondent currently working** | | | |
| No | 71.0% | 29.0% | 100.0% |

| | | | |
|---|---|---|---|
| Yes | 71.6% | 28.4% | 100.0% |
| **Total** | 71.2% | 28.8% | 100.0% |
| **Respondent's occupation** | | | |
| Not working | 71.0% | 29.0% | 100.0% |
| Professional / technical / managerial | 78.1% | 21.9% | 100.0% |
| Clerical | 83.3% | 16.7% | 100.0% |
| Sales | 66.7% | 33.3% | 100.0% |
| Services / household and domestic | 74.1% | 25.9% | 100.0% |
| Agricultural | 75.4% | 24.6% | 100.0% |
| Skilled and unskilled manual | 66.7% | 33.3% | 100.0% |
| Other | 59.1% | 40.9% | 100.0% |
| Don't know | 100.0% | 0.0% | 100.0% |
| **Total** | 71.2% | 28.8% | 100.0% |
| **Total Children ever born** | | | |
| 0 Child | 82.3% | 17.7% | 100.0% |
| 1 Child | 76.9% | 23.1% | 100.0% |
| 2 Children | 73.8% | 26.2% | 100.0% |
| 3 Children | 71.1% | 28.9% | 100.0% |
| 4 Children | 72.0% | 28.0% | 100.0% |
| 5 and above Children | 64.6% | 35.4% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Number of living children** | | | |
| 0 Child | 83.1% | 16.9% | 100.0% |
| 1 Child | 76.5% | 23.5% | 100.0% |
| 2 Children | 73.7% | 26.3% | 100.0% |
| 3 Children | 70.2% | 29.8% | 100.0% |
| 4 Children and above | 68.9% | 31.1% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |
| **Caste** | | | |
| Schedule caste | 73.4% | 26.6% | 100.0% |
| Schedule tribe | 69.5% | 30.5% | 100.0% |
| OBC | 75.0% | 25.0% | 100.0% |
| None of them | 75.7% | 24.3% | 100.0% |
| Don't know | 77.5% | 22.5% | 100.0% |
| **Total** | 74.2% | 25.8% | 100.0% |

Table 3.8 data illustrates background variables of women together with place of abortions at home versus elsewhere, which is defined as ‘public health, NGO/Trust hospitals/clinics, private, and elsewhere’. A home abortion was carried out by more than

one-fifth (26.4%) of Hindu, 22% of Muslim, and 22.3% of other religious women. Surprisingly, younger women (28.3%) preferred to abort at home more often than older women (17.1%). More women from rural than urban areas (27.2%) have abortions performed at home than do women from urban areas (21.3%). In comparison to women with higher education (17.6%), those without any formal education had more abortions performed at home (29.3%). Compared to the highest income quintile (18.9%), more women from the poorest wealth quintile (34.4%) had an abortion at home. Employed women (30.5%) were more likely than empty-handed women (28.6%) to have an abortion at home. In comparison to 16.7% of women without children, over one-third (34.7%) of mothers with five or more children aborted at home.

**Table 3.8:** Place of termination

| **Background Variables** | | | |
|---|---|---|---|
| | **Place of termination** | | |
| **Religion** | **Else** | **At Home** | **Total** |
| Hindu | 73.6% | 26.4% | 100.0% |
| Muslim | 78.0% | 22.0% | 100.0% |
| Other | 77.7% | 22.3% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Age in 5-year groups** | | | |
| 15-19 | 72.1% | 27.9% | 100.0% |
| 20-24 | 71.7% | 28.3% | 100.0% |
| 25-29 | 72.8% | 27.2% | 100.0% |
| 30-34 | 75.8% | 24.2% | 100.0% |
| 35-39 | 79.6% | 20.4% | 100.0% |
| 40-44 | 77.3% | 22.7% | 100.0% |
| 45-49 | 82.9% | 17.1% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Type of place of residence** | | | |
| Urban | 78.7% | 21.3% | 100.0% |
| Rural | 72.8% | 27.2% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Highest educational level** | | | |
| No education | 70.7% | 29.3% | 100.0% |

| | | | |
|---|---|---|---|
| Primary | 71.0% | 29.0% | 100.0% |
| Secondary | 73.6% | 26.4% | 100.0% |
| Higher | 82.4% | 17.6% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Wealth index combined** | | | |
| Poorest | 65.9% | 34.1% | 100.0% |
| Poorer | 69.5% | 30.5% | 100.0% |
| Middle | 76.8% | 23.2% | 100.0% |
| Richer | 77.5% | 22.5% | 100.0% |
| Richest | 81.1% | 18.9% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Respondent currently working** | | | |
| No | 71.4% | 28.6% | 100.0% |
| Yes | 69.5% | 30.5% | 100.0% |
| **Total** | 70.9% | 29.1% | 100.0% |
| **Respondent's occupation** | | | |
| Not working | 71.4% | 28.6% | 100.0% |
| Professional / technical / managerial | 71.9% | 28.1% | 100.0% |
| Clerical | 83.3% | 16.7% | 100.0% |
| Sales | 70.8% | 29.2% | 100.0% |
| Services / household and domestic | 70.4% | 29.6% | 100.0% |
| Agricultural | 73.9% | 26.1% | 100.0% |
| Skilled and unskilled manual | 65.6% | 34.4% | 100.0% |
| Other | 50.0% | 50.0% | 100.0% |
| Don't know | 100.0% | 0.0% | 100.0% |
| **Total** | 70.9% | 29.1% | 100.0% |
| **Total Children ever born** | | | |
| 0 Child | 83.3% | 16.7% | 100.0% |
| 1 Child | 77.6% | 22.4% | 100.0% |
| 2 Children | 73.6% | 26.4% | 100.0% |
| 3 Children | 71.0% | 29.0% | 100.0% |
| 4 Children | 69.9% | 30.1% | 100.0% |
| 5 and above Children | 65.3% | 34.7% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Number of living children** | | | |
| 0 Child | 84.1% | 15.9% | 100.0% |
| 1 Child | 77.2% | 22.8% | 100.0% |
| 2 Children | 73.4% | 26.6% | 100.0% |
| 3 Children | 69.7% | 30.3% | 100.0% |

| | | | |
|---|---|---|---|
| 4 Children and above | 69.0% | 31.0% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |
| **Caste** | | | |
| Schedule caste | 72.7% | 27.3% | 100.0% |
| Schedule tribe | 70.9% | 29.1% | 100.0% |
| OBC | 75.1% | 24.9% | 100.0% |
| None of them | 76.3% | 23.7% | 100.0% |
| Don't know | 74.6% | 25.4% | 100.0% |
| **Total** | 74.3% | 25.7% | 100.0% |

Table 3.9 shows the distribution of self-performed abortions by state, with "Else" being defined as "Doctor, nurse/ANM/ LHV, Dai, Vaidya/hakim/Homeopath AYUSH, family member/relative, and other person." Self-abortion was more prevalent in Sikkim, where 50% of abortions were carried out by the woman herself, followed by Odisha (47.3%). Self-abortion accounted for more than two-fifths (43.7%) of abortions in Tripura, 40.9% in Arunachal Pradesh, 39.2% in Chhattisgarh, 39.2% in Bihar, and 37.3% in Jharkhand. It's interesting to take into account both Ladakh and Lakshadweep recorded zero percent of self-abortions. In Kerala and Jammu & Kashmir, self-abortion rates were at 3.8% and 3.8%, respectively. Self-abortion rates were 5% in Goa, 5.1% in Telangana, and 6.1% in Andhra Pradesh.

**Table 3.9:** Person performed abortion

| **Background Variables** | | | |
|---|---|---|---|
| **STATE** | **Person performed abortion** | | |
| | **Else** | **Self-Care** | **Total** |
| **Jammu & Kashmir** | 96.2% | 3.8% | 100.0% |
| **Himachal Pradesh** | 66.3% | 33.7% | 100.0% |
| **Punjab** | 76.3% | 23.7% | 100.0% |
| **Chandigarh** | 84.6% | 15.4% | 100.0% |
| **Uttarakhand** | 66.1% | 33.9% | 100.0% |
| **Haryana** | 83.6% | 16.4% | 100.0% |
| **Nct Of Delhi** | 65.3% | 34.7% | 100.0% |
| **Rajasthan** | 72.5% | 27.5% | 100.0% |

| | | | |
|---|---|---|---|
| **Uttar Pradesh** | 67.2% | 32.8% | 100.0% |
| **Bihar** | 60.8% | 39.2% | 100.0% |
| **Sikkim** | 50.0% | 50.0% | 100.0% |
| **Arunachal Pradesh** | 59.1% | 40.9% | 100.0% |
| **Nagaland** | 77.1% | 22.9% | 100.0% |
| **Manipur** | 76.2% | 23.8% | 100.0% |
| **Mizoram** | 100.0% | 0.0% | 100.0% |
| **Tripura** | 56.3% | 43.7% | 100.0% |
| **Meghalaya** | 73.3% | 26.7% | 100.0% |
| **Assam** | 72.4% | 27.6% | 100.0% |
| **West Bengal** | 74.4% | 25.6% | 100.0% |
| **Jharkhand** | 62.7% | 37.3% | 100.0% |
| **Odisha** | 52.7% | 47.3% | 100.0% |
| **Chhattisgarh** | 60.5% | 39.5% | 100.0% |
| **Madhya Pradesh** | 73.6% | 26.4% | 100.0% |
| **Gujarat** | 85.2% | 14.8% | 100.0% |
| **Dadra & Nagar Haveli And Daman & Diu** | 85.0% | 15.0% | 100.0% |
| **Maharashtra** | 93.7% | 6.3% | 100.0% |
| **Andhra Pradesh** | 93.9% | 6.1% | 100.0% |
| **Karnataka** | 91.8% | 8.2% | 100.0% |
| **Goa** | 95.0% | 5.0% | 100.0% |
| **Lakshadweep** | 100.0% | 0.0% | 100.0% |
| **Kerala** | 96.2% | 3.8% | 100.0% |
| **Tamil Nadu** | 88.4% | 11.6% | 100.0% |
| **Puducherry** | 92.1% | 7.9% | 100.0% |
| **Andaman & Nicobar Islands** | 88.2% | 11.8% | 100.0% |
| **Telangana** | 94.9% | 5.1% | 100.0% |
| **Ladakh** | 100.0% | 0.0% | 100.0% |
| **Total** | 74.4% | 25.6% | 100.0% |

Table 3.10 shows the breakdown by state of women who had abortions at home versus elsewhere, which is defined as ‘public health, NGO/Trust hospitals/clinics, private, and elsewhere’. The vast majority of abortions (50% of them) were carried out at home in Sikkim, followed by 49.3% in Odisha. Abortions were carried out at home almost half of the time (48.7%) in Chhattisgarh, compared to 46.7% in Meghalaya, 43.7% in Tripura, 39% in Bihar, and 35.7% in Jharkhand. It's important to note that Ladakh, Mizoram, and Lakshadweep did not report any home abortions (0%). Abortions were only carried out

at home 1% of the time in Kerala and 4.9% of the time in Jammu and Kashmir. Goa reported 5% abortion at home while Telangana and Andaman & Nicobar Islands reported 5.9% abortion performed at home.

**Table 3.10:** Place of termination

| Background Variables | | | |
|---|---|---|---|
| **STATE** | **Place of termination** | | |
| | **Else** | **At Home** | **Total** |
| **Jammu & Kashmir** | 95.1% | 4.9% | 100.0% |
| **Himachal Pradesh** | 67.4% | 32.6% | 100.0% |
| **Punjab** | 76.3% | 23.7% | 100.0% |
| **Chandigarh** | 76.9% | 23.1% | 100.0% |
| **Uttarakhand** | 65.4% | 34.6% | 100.0% |
| **Haryana** | 82.7% | 17.3% | 100.0% |
| **Nct Of Delhi** | 67.1% | 32.9% | 100.0% |
| **Rajasthan** | 71.3% | 28.7% | 100.0% |
| **Uttar Pradesh** | 67.3% | 32.7% | 100.0% |
| **Bihar** | 61.0% | 39.0% | 100.0% |
| **Sikkim** | 50.0% | 50.0% | 100.0% |
| **Arunachal Pradesh** | 68.9% | 31.1% | 100.0% |
| **Nagaland** | 89.6% | 10.4% | 100.0% |
| **Manipur** | 75.6% | 24.4% | 100.0% |
| **Mizoram** | 100.0% | 0.0% | 100.0% |
| **Tripura** | 56.3% | 43.7% | 100.0% |
| **Meghalaya** | 53.3% | 46.7% | 100.0% |
| **Assam** | 73.6% | 26.4% | 100.0% |
| **West Bengal** | 78.6% | 21.4% | 100.0% |
| **Jharkhand** | 64.3% | 35.7% | 100.0% |
| **Odisha** | 50.7% | 49.3% | 100.0% |
| **Chhattisgarh** | 51.3% | 48.7% | 100.0% |
| **Madhya Pradesh** | 69.0% | 31.0% | 100.0% |
| **Gujarat** | 85.7% | 14.3% | 100.0% |
| **Dadra & Nagar Haveli And Daman & Diu** | 80.0% | 20.0% | 100.0% |
| **Maharashtra** | 92.0% | 8.0% | 100.0% |
| **Andhra Pradesh** | 93.2% | 6.8% | 100.0% |
| **Karnataka** | 90.5% | 9.5% | 100.0% |
| **Goa** | 95.0% | 5.0% | 100.0% |
| **Lakshadweep** | 100.0% | 0.0% | 100.0% |

| | | | |
|---|---|---|---|
| **Kerala** | 99.0% | 1.0% | 100.0% |
| **Tamil Nadu** | 92.0% | 8.0% | 100.0% |
| **Puducherry** | 92.1% | 7.9% | 100.0% |
| **Andaman & Nicobar Islands** | 94.1% | 5.9% | 100.0% |
| **Telangana** | 94.1% | 5.9% | 100.0% |
| **Ladakh** | 100.0% | 0.0% | 100.0% |
| **Total** | 74.5% | 25.5% | 100.0% |

**Table 3.11:** Multivariate Binary logistic regression

| **Variables in the Equation** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | B | S.E. | Wald | df | Sig. | Exp(B) |
| **Step 1a** | Age in 5-year groups | | | 2.103 | 6 | 0.91 | |
| | 20-24 | -0.517 | 0.854 | 0.366 | 1 | 0.545 | 0.596 |
| | 25-29 | -0.643 | 0.701 | 0.842 | 1 | 0.359 | 0.526 |
| | 30-34 | -0.574 | 0.677 | 0.718 | 1 | 0.397 | 0.563 |
| | 35-39 | -0.357 | 0.677 | 0.278 | 1 | 0.598 | 0.7 |
| | 40-44 | -0.319 | 0.698 | 0.208 | 1 | 0.648 | 0.727 |
| | 45-49 | -0.493 | 0.774 | 0.407 | 1 | 0.524 | 0.611 |
| | Type of place of residence (Urban) | -0.339 | 0.219 | 2.398 | 1 | 0.121 | 0.712 |
| | Highest educational level | | | 0.901 | 3 | 0.825 | |
| | Primary | -0.169 | 0.369 | 0.209 | 1 | 0.647 | 0.845 |
| | Secondary | 0.091 | 0.352 | 0.068 | 1 | 0.795 | 1.096 |
| | Higher | -0.128 | 0.243 | 0.28 | 1 | 0.597 | 0.879 |
| | Wealth index | | | 4.941 | 4 | 0.293 | |
| | Poorer | -0.818 | 0.374 | 4.793 | 1 | 0.029 | 0.441 |
| | Middle | -0.392 | 0.307 | 1.633 | 1 | 0.201 | 0.676 |
| | Richer | -0.273 | 0.282 | 0.938 | 1 | 0.333 | 0.761 |
| | Richest | -0.311 | 0.269 | 1.338 | 1 | 0.247 | 0.733 |
| | Respondent currently working | -0.083 | 0.21 | 0.157 | 1 | 0.692 | 0.92 |
| | Religion | | | 5.472 | 2 | 0.065 | |
| | Muslim | 0.355 | 0.338 | 1.104 | 1 | 0.293 | 1.426 |
| | Other religion | 0.883 | 0.409 | 4.652 | 1 | 0.031 | 2.417 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Place of Termination- At home | 0.343 | 0.337 | 1.034 | 1 | 0.309 | 1.409 |
| | Abortion performed by self | 0.101 | 0.334 | 0.092 | 1 | 0.762 | 1.107 |
| | Number of living children | | | 0.612 | 2 | 0.736 | |
| | 1 Child | 0.914 | 1.404 | 0.424 | 1 | 0.515 | 2.494 |
| | 2 and above children | 0.584 | 0.801 | 0.531 | 1 | 0.466 | 1.792 |
| | Total children ever born | | | 0.134 | 2 | 0.935 | |
| | 1 Child | -0.321 | 1.428 | 0.05 | 1 | 0.822 | 0.726 |
| | 2 and above children | -0.296 | 0.808 | 0.134 | 1 | 0.715 | 0.744 |
| | Constant | -1.752 | 0.805 | 4.74 | 1 | 0.029 | 0.173 |

## Discussion:

Afghanistan, Sri Lanka, Pakistan and Maldives are restricted settings. Although abortion is legally restricted in Bangladesh, early menstrual regulation (MR) is permitted since 1975 to prevent female morbidity and death due to indigenous abortion. It is against the law in the Islamic Republic of Afghanistan to induce a pregnancy termination, except where there is evidence that the mother's life is at risk or the child has a significant disability. Abortion is restricted in Sri Lanka, one of the countries with the strictest abortion laws in the world, unless the mother's life is jeopardised. Abortion ranks among the top 10 causes of maternal death in Sri Lanka. Abortion complications are one of the most common obstetric morbidity causes in Bhutan, with a case fatality rate of 1.4%.

According to the Bangladesh Demographic and Health Survey 2017-18, 71.3% of ever-married women are aware of menstruation regulation, but only 7.4% use it. According to the Nepal Demographic and Health Survey 2016, 40.6% of women were aware that abortion is permitted.

- According to the findings from unit level data analysis of NFHS-5 (2019-21), three-fourths (65.8%) of total pregnancies end in miscarriage, 25.9% in abortion, and 8.3% in stillbirth. Unplanned pregnancies were cited as the main reason by 47.6% of the women, followed by health issues that prevented 11.3% of them from carrying the pregnancy to term. It is interestingly enough to note that 1.9% of young women chose a Vaidya, hakim, or homoeopath (AYUSH) while 3.9% preferred a family member, relative, or acquaintance for abortion. Women with no offspring were more likely to opt for a doctor for abortion (66.4%), followed by 12.2% who chose a nurse/ANM/LHV. Younger women (70.8%) utilised medications over other

means of abortion, more frequently than older women (53.7%). Women in the upper wealth quintile (23.1%) preferred surgical techniques higher than women in the lower wealth quintile (16.1%). The majority of women who had abortions in public health institutions were Muslim (37.1%), followed by women of other faiths (35.4%) and 23.3% of Hindu women. Further complications were experienced by women who underwent abortions using any other technique than surgical or medical means (18.5%), followed by those who utilised surgical methods (17%) and 13.9% of those who used medicine for the procedure. Abortion complications were high among women who had abortions performed by Dai (21.4%). Remarkably, compared to 17.1% of women in the older age group, more than a fifth of younger women (29.9%) and nearly a quarter of middle-aged women (24.9%) report having self-abortions. Unexpectedly, younger women (28.3%) favoured home abortions more frequently than older women (17.1%). Self-abortion was more common among working women (29.0%) than it was among jobless women (28.4%). More abortions were performed at home by women who had five or more children (34.7%) than by women without children (16.7%). The state with the highest rate of self-abortion was Sikkim, where 50% of abortions were carried out by the woman herself, followed by Odisha (47.3%). The fact that there were no self-abortions in Ladakh or Lakshadweep is captivating to consider. Self-abortion rates were 3.8% and 3.8%, respectively, in Kerala and Jammu & Kashmir. In Sikkim, home abortions were performed in an overwhelming majority (50%) of cases. It's crucial to note that there were zero reported home abortions in Ladakh, Mizoram, and Lakshadweep.

## Conclusion and way forward:

- To ensure that women have access to safe abortion care in restricted settings, increased advocacy and engagement with stakeholders is essential.
- Abortion research is needed to understand women's perspectives and needs so that appropriate strategies can be devised. It is necessary to comprehend why other individuals are preferred over doctors.
- Initiatives have to be implemented to ascertain that women have access to comprehensive reproductive healthcare services, such as family planning, contraception, and safe abortion services. This entails expanding the pool of qualified healthcare professionals and ensuring services are both affordable and readily available.
- Reducing stigma and empowering women to make knowledgeable decisions about their reproductive options can be accomplished through disseminating accurate and unbiased information about reproductive health, contraception, and safe abortion options.
- By addressing these issues, nations can attempt to reduce the number of unsafe abortions and enhance women's overall reproductive health and well-being.

## Ethical Consideration:

As we are using the secondary evidences and data which is available in public domain therefore no direct ethical approval is required for this assignment.

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