A STUDY ON ABORTION PRACTICES IN KERALA

Submitted to

Kerala Women's Commission, Government of Kerala

By

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CHAPTER-1

Introduction

Abortion is the termination of pregnancy before the fetus becomes viable. Viability is usually reached at 28 weeks when the fetus weights slightly more than 1,000 g.

It is the most common serious complication of pregnancy and it is not notifiable, it is difficult to get the accurate incidence. In general, the incidence varies from 10-15 per cent. Abortion, in its most common usage, refers to the voluntary, or induced, termination of pregnancy. Pregnancy is the process by which a mammalian female carries a live offspring from conception until it develops to the point where the offspring is capable of living outside the womb. It starts with conception, the process of fertilization to form a zygote, and ends in childbirth, miscarriage, or abortion.

In humans, pregnancy takes approximately 40 weeks between the time of the last menstrual cycle and delivery (38 weeks from fertilization). It is divided into three trimesters. The first trimester carries the highest risk of miscarriage, the unintentional abortion of a fetus. It is often a result of defects in the fetus, its parent, or damage caused after conception.

Medically, the term also refers to the early termination of a pregnancy by natural causes ("spontaneous abortion" or miscarriage). "Miscarriage" is the lay term for the natural or accidental termination of a pregnancy at a stage where the fetus is incapable of surviving. The medical term for it is "abortion"; when the

abortion is not deliberately induced, it is termed a "spontaneous abortion," so that is a synonym for "miscarriage." Miscarriages can occur for many reasons, not all of which can be identified. While miscarriage can result from physical trauma, like exposure to certain chemicals, diseases, or physical blows, they are rarely the cause. A miscarriage usually results from biological defects in the mother or genetic defects in the developing fetus.

Etiological Factors

The etiology of abortion is often complex, and, in many, obscure. Investigations have shown that in many cases abortions occur primarily as a result of the ovum, which is not viable, and in others as a result of abnormal uterine activity. Various maternal, paternal and fetal causes are said to be responsible for abortion.

Fetal Factors

Intrinsic defects of varying degrees in the fertilized ovum result in clinical abortion. In over 60 per cent of early abortions, such a defect has been discovered on microscopical examination of the aborted mass. Recent experimental works point to unsatisfactory uterine environment as being an important factor in the production of embryonic defects and faulty implantation. Chromosomal aberrations have been demonstrated in 25-40 per cent of cases of spontaneous abortion.

Cystic degeneration of the chronic villi (hydatidiform mole) is a common cause producing primary death of the fertilized ovum and abortion, and it is met with, according to some, in about 20 per cent of the abortus examined.

Hemorrhage into the deciduas has been identified as an etiological factor in a large percentage of spontaneous abortions. These are commonly seen in patients who start the abortion with painless bleeding. Infection of the placenta is another potent factor in producing abortion.

The importance of the sperm factor in relation to abortion should be remembered. A sub-fertile male can be responsible for abortion by failing to produce an embryo with sufficient urge to live. Placenta praevia is another cause of abortion. A low-lying placenta in the early and mid-trimester very often produces an abortion. Rarely, multiple pregnancy, and hydramnios in the early months may cause abortion. More often, they result in premature labor. Umblical cord anomalies occasionally produce fetal death and abortion.

Maternal Factors

Maternal systemic diseases may cause the death of the fetus. Of these, the important ones are acute infections, fevers, hypertension and chronic pyelonephritis. Hyperpyrexia in the mother can destroy the fetus. Viral infections, especially rubella,n herpes simplex and cytomegalovirus infection, lysteriosis and toxoplasmosis are factors implicated in abortion.

Trauma in the early weeks of pregnancy often results in abortion. More often, this trauma is in the form of an attempt at illegal or induced abortion. Severe hard labor, violent exercises and excessive sexual intercourse in the early weeks of pregnancy may bring about abortion.

Stress is laid on the importance of the instability of the autonomic nervous system in the causation of abortion. Psychogenic trauma in such cases may precipitate an abortion. Emphasis is now laid on emotional factors as well.

Uterine Causes

Congenital malformations of the uterus play an important role in the causation of abortion, especially repeated abortion. While milder degrees of malformations may not interfere with pregnancy and very severe degrees may result in sterility, certain degrees and types of malformations of the uterus (separate uterus or bicornuate uterus) result in repeated abortions.

Fibroid tumours of the uterus, especially if they are sub-mucous, may not only interfere with conception but may cause abortion. In quite a large number, however, the pregnancy may not be interfered with.

Cervical incompetence, either congenital or acquired as a result of obsteric or surgical trauma, is an important factor in repeated abortions. Retroversion of the uterus is very common and in a quite large number it does not give rise to trouble during pregnancy. But in some it may bring about abortion.

Ovarian tumours complicating early pregnancy may produce abortion, especially when torsion of the tumour occurs in the early months.

Endocrine Factors

Hormonal imbalance may be the cause of fetal death in a small number of cases. Maternal diabetes hypo- and hyperthyrodism, inadequate luteal phase and inadequate production of progesterone by the placenta may lead to abortion.

Incompatibility of the Blood of Husband and Wife

When the mother's blood group is Rh negative and that of of the father is Rh positive, the fetal blood group may be Rh positive and therefore hemolyse on account of the immune iso-antibodies formed in the maternal blood. The hemolysis may cause fetal death and late abortion or it may lead to the development of erythroblatosis foetals in some. ABO incompatibility may also be an etiological factor.

The following types of abortions have been recognized.

1.Threatened Abortion

In this condition, after a period of ammenorrhoea, the patient complains of slight colicky pains in the lower abdomen associated perhaps with backache, frequency of micturition and slight bleeding per vaginum. If a careful bimanual examination is made, the cervix will be found softened, the uterus enlarged and more or less globular, the size depending on the period of pregnancy. The os is

generally closed or may in some cases be slightly patulous. Where there is no actual sign suggestive of death or expulsion of portion of the ovum, the condition is known as threatened abortion.

2.Inevitable or Incomplete Abortion

This term denotes that the ovum has practically separated from the uterine wall and is , therefore, dead and bound to be expelled. In such cases the pain is more severe, the bleeding more profuse, the cervix is dialated, and occasionally a portion of the ovum may be felt protruding through the cervical canal. When only a part of the products of conception has been expelled, it is termed incomplete abortion.

3.Complete Abortion

This term is used when the entire ovum has been expelled. Once this has occurred, the pain subsides and bleeding decreases and may have stopped by the time the patient is seen. The uterus is empty and is accordingly smaller in size than the perod of amenorrhoea would suggest and the cervical canal may be closed, as it contracts very rapidly after the complete expulsion of the uterine contents.

4.Cervical Abortion

This is somewhat rare form and is due to the expulsion of the products of conception from the uterus into the cervical canal where they are retained because the external os remains closed. There is certain amount of pain associated with hemorrhage. After sometime the bleeding may stop. On a vaginal examination the external os is found closed, but the cervical canal is ballooned out and is like an inverted cone due to the presence of the ovum therein.

5.Missed Abortion

In this condition, symptoms of abortion occur but subside later, without any part of the ovum being expelled. The ovum dies but is retained in the uterus. The patient gradually recovers from the attack of pain and the vaginal hemorrhage

subsides. The hemorrhage that has occurred in utero forms a clot round the dead ovum and changes take place subsequently in and around the ovum. In the early stages the clotted blood, with the ovum init, presents a peculiar condition, which is known as a blood mole. Later, when the blood clot becomes organized, the appearance changes. In the course of a few weeks, the whole of the uterine contents are changed into a dark red or brownish, shaggy mass known as a carneous mole. Occasionally, in these changes, owing to the formation of hematoma of varying sizes between the amniotic and the chorionic membranes, a further change takes place resulting in the formation of what is known as a tuberose mole. Where a mole has developed, the fetus may not be present, or even if it does exist, it is of very small size. This is due to the fact that in the large majority of cases the mole formation takes place in the early weeks of pregnancy. Consequent on the long lapse of time before the mole is expelled, the fetus may be absorbed or in some cases it may be found as a rudimentary vestigial structure. Where mole formation has taken place, the amenorrhoea may persist but none of the progressive signs of pregnancy are present. Thus the uterus does not continue to enlarge in size, the breast changes cease, and the patient may not feel any of the subjective symptoms of pregnancy, and generally presents herself for the persistent amenorrhoea. A bimanual examination will reveal that the uterus, though enlarged, never corresponds to the period of amenorrhoea, and is smaller. The cervical softening does not persist, and the uterus itself has the soft feel of a normal pregnancy. If a pregnancy test is done at this stage, the result will be negative. Where the uterus is of a fairly large size, a roentgenogram may reveal the absence of a fetal skeleton or if present will show radiological evidence of fetal death.

6.Febrile Abortion

In febrile abortion, signs and symptoms of abortion exist, with a rise of temperature. This may be due to two distinct factors:

a. In one set of cases the rise of temperature may precede the signs and symptoms of abortion and may be the causative factor or at least one of the causative factors. In such cases, the temperature is the cause and not the result of abortion.

b. In other cases, the rise in temperature may be due to sepsis, and the patient, besides presenting the usual symptoms of pain and hemorrhage, will also have an offensive discharge per vaginum. This is called septic abortion.

7.Therapeutic Abortion

Where abortion is induced as a therapeutic measure for the sake of the mother, it is spoken of as therapeutic abortion. In modern obstetrics, there are a few indications for therapeutic abortion. Pulmonary tuberculosis in pregnant women is no longer considered an indication for therapeutic abortion. Cardiac disease (Grades III and IV) and decompensation in a previous pregnancy are justifiable indications for termination of pregnancy in the first trimester. It is necessary that optimum compensation be established prior to termination. Epilepsy and other forms of psychosis in the mother who has had a number of children may justify a therapeutic abortion. Intractable hyperemesis gravidarum will necessitate termination of pregnancy. If the mother contracts German measles in the early weeks of pregnancy, induction of abortion is advocated by some on the plea of a malformed fetus being born. Chronic glomerulo-nephritis, malignant hypertension, pregnancy following soon after a radical mastectomy for carcinoma of the breast, is other indications. In India abortion is legalized by a liberal act called **Medical Termination of Pregnancy (MTP) Act.**

Chromosomal and enzyme abnormalities have now been identified as factors responsible for the transmission of certain inherited disorders. Some of these disorder may also be sex linked. It is possible to determine by examination of the liquor amnii whether the intra-uterine fetus will be affected or not. If investigations yield a positive result, it is now the practice to induce abortion. Sex linked diseases like hemophilia, progressive muscular atrophy and chromosomal abnormalities

resulting in various genetically induced diseases as also iatrogenic disorders can now be diagnosed early and therapeutic abortion performed.

8.Criminal Illegal Abortion

Abortion other than therapeutic carried out against the laws of the land is termed criminal or illegal. Criminal abortion, unfortunately, is practiced in most countries and is one of the potent factors in the causation of maternal mortality and morbidity. (Dutta, D.C., 1995)

Reasons for Induced and Spontaneous Abortions

Various reasons are cited for abortion. One of the main reasons is for postponing childbearing. Some women do not want children immediately after marriage. During this period if the women become pregnant they usually opt for abortion. Studies have shown that a good number of women do abortion for this reason. Another reason for abortion is to avoid more children. After getting adequate number the couples do not prefer more children and if the woman becomes pregnant they go for abortion usually. Sometime the couples are not able to afford a baby may go for abortion. Some women think that a child may disrupt education or job will also do abortion, which is another reason. Relationship problem or partner doesn't want pregnancy also opt for abortion. Too young, parents or others object pregnancy and risk to maternal and fetal health are also other reasons for abortion.

Induced abortion-both legal and illegal- has important public health and demographic implications that are often overlooked. For epidemiologists and health planners concerned with maternal health, information on abortion is important in designing and implementing programmes to reduce the adverse effects of unsafe abortions. Demographers are interested in the effects of induced abortion on fertility and population growth, while family planning programme specialists use abortion rates as one way of ganging the need for contraceptive services and measuring programme impacts.

Spontaneous abortions are due to various gynecological problems.

A study conducted in 27 countries pointed out that the following are the main reasons for induced abortion.

Wants to postpone childbearing: 25.5%

Wants no (more) children: 7.9%

Cannot afford a baby: 21.3%

Having a child will disrupt education or job: 10.8%

Has relationship problem or partner does not want pregnancy: 14.1%

Too young; parent(s) or other(s) object to pregnancy: 12.2%

Risk to maternal health: 2.8%

Risk to fetal health: 3.3%

Other: 2.1%

[Bankole, Akinrinola; Singh, Susheela; Haas, Taylor, 1998]

Methods of abortion

Depending on the stage of pregnancy, an abortion is performed by a number of different methods. Chemical abortion A chemical abortion is a type of abortion in which a drug is used to induce the abortion, rather than a surgical procedure. Chemical abortions occur after the embryo has implanted itself in the uterus. The implantation in the uterus is when a fertilized egg becomes a pregnancy. The most common drug, called RU-486, blocks progesterone, which is a hormone required for a pregnancy to continue. Administered correctly, it has a high rate of success. Advocates of chemical abortion claim that it is easier emotionally for the women and that it is safe. However, some critics believe that chemical abortions are unsafe, and might even cause death. While available in most European countries, chemical abortion has met great controversy in Canada and the United States.

Medical Abortion as opposed to Surgical Abortion is the usual method when it is induced before the first nine weeks. The procedure consists of administering either methotrexate Methotrexate (abbreviated MTX; formerly known as amethopterin) is an antimetabolite drug used in treatment of cancer and autoimmune disease. It acts by inhibiting the metabolism of folic acid.

Possible side effects

In 1967, the World Health Assembly in resolution WHA 20.41 recognized that abortion constituted an important health problem for women in many countries. The consequences of unsafely performed abortion account for a large share of maternal mortality and those who survive may suffer long term sequelae including infertility.

National authorities are responsible for deciding whether and under what circumstances to provide services for the medical termination of pregnancy. WHO takes no position on the matter. However, it subscribes to the view, as recommended at the International Conference on Better health for women and Children through Family Planning, Nairobi, October 1987, that, "Regardless of the legal status, humane treatment of septic and incomplete abortion and post-abortion contraceptive advice and services should be made available".

As noted in the principles of the World Population Plan of Action, reaffirmed and expanded at the International Conference on Population in Mexico City in 1984, the medical termination of pregnancy is not considered by WHO to be a family planning method. However, the level of induced abortion or of abortion-related mortality is a clear indication of unmet needs for family planning.

WHO estimates that throughout the world approximately 500 000 women die every year from pregnancy related causes. A large proportion of these deaths are attributable to complications of abortion. Further, 98% of maternal deaths occur in developing countries, where the greater number of pregnancies compounds a woman's lifetime risk of pregnancy-related death experienced by

each woman, as well as by socio-economic conditions and the limited availability of maternal health services in these countries (WHO, 1991). A maternal death is defined by WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

The Role of Abortion in Maternal Mortality and Morbidity

Induced abortion is the oldest, and probably still the most widely used method of fertility control. Yet because it touches on some of the most profound religious and moral issues, few societies have been able to look dispassionately at the health aspects of abortion as it affects the woman (Royston & Amstrong, 1989).

The tragedy of maternal death is that virtually all are preventable with proper management (WHO, 1986). Globally, around 15% of maternal mortality results from unsafe abortion, and the proportion is high as 50% in some areas. The high level of mortality worldwide that results from unsafe abortion could be prevented by providing ready access to treatment of abortion complications, safe abortion procedures and contraceptive services (Mahler, 1987).

Unsafe abortion, i.e., the termination of pregnancy performed or treated by untrained or unskilled persons and its complications are a major direct cause of death among women of reproductive age (WHO, 1986). Recent estimates suggest that around 155 of the more than 500 000 pregnancy related deaths in developing countries each year may result from complications of unsafely induced abortion (WHO,1993) and some experts put the figure considerably higher (WHO,1991).

Regardless of whether an abortion is spontaneous or induced, subsequent events and the care received determine whether the abortion is safe or unsafe. Estimates based on death certificates from 20 countries reveal that between 6%

and 46% of all reported maternal deaths can be attributed to complications of all types of abortion (Liskin, 1980).Data from 67 studies in 17 countries indicate that, in some areas, up to 50% of maternal deaths occurring in hospital are due to complications of unsafely induced abortion. In many countries this proportion averages about one-quarter of all maternal deaths in hospital(WHO,1991).

Spontaneous abortion, or the unprovoked interruption of pregnancy (also called miscarriage), affects approximately 10-15% of all known or suspected pregnancies. While spontaneous abortion often requires treatment or hospitalization, it is less often fatal than unsafely induced abortion.

Complications of all types of abortion are also a leading cause of morbidity for women in developing countries. When restrictions on abortion are lessened, the number of deaths related to induced abortion is reduced, presumably owing to the greater safely of the procedures performed by trained health professionals. For example, in the United States of America, death rates due to abortion fell by 85% in the five years following legalization (Tietze, 1981).

Post abortion psychological issues

Research has been carried out on the question of whether abortion is associated with increased risk of clinical depression, but the results are mixed. According to a study of 1,884 women conducted by the National Longitudinal Survey of Youth, women who did not carry their first pregnancies to term are 65% more likely to be diagnosed with clinical depression around eight years later. However, other studies did not support a conclusion that depression may be caused by abortion. For example, a study of 2,525 women revealed that women who had an abortion were more likely to report depression or lower satisfaction with their lives. However, they also often reported rape, childhood physical and sexual abuse, and violent partners. After controlling for the history of abuse, partner characteristics, and background variables, abortion was not related to poorer mental health (Denious, J. & Russo, N. F. (2000)).

A study in the Medical Science Monitorsaid that "Consistent with previous research, the data here suggest abortion can increase stress and decrease coping abilities, particularly for those women who have a history of adverse childhood events and prior traumata." In the study 65% of post-abortive American women and 13.1% of Russian women experienced multiple symptoms of increased arousal, re-experiencing, and avoidance associated with posttraumatic stress disorder (PTSD). According to the study, 14.3% of American and 0.9% of Russian women met the full diagnostic criteria for PTSD. (Vincent Rue, Priscilla Coleman, James Rue, David Reardon (2004).

In keeping with the paper, it should however be noted that many day to day tasks cause problems for sufferers of PTSD, especially as a result of child abuse. Visits to dentists are often a problem, but women often still try to get to them and to avoid all events in life that might lead to re-traumatization.

Post abortion physical issues

The exact risk and type of complications depend on the abortion method as well as the clinical and hygienic conditions. Studies found that the risk of serious physical complications of an abortion is less than 1%. In countries where abortion is illegal and women are forced to go to back-street abortionists serious physical complications such as infections, bleeding, and even fatal injuries are much higher.

The Abortion-Breast Cancer (ABC) debate centers on the fact that during early pregnancy hormone levels increase significantly. This initiates cellular differentiation (growth) in the breast preparing for lactation. The ABC theory is if the pregnancy is aborted prior to full differentiation in the third trimester this could leave more "vulnerable" cells than prior to the pregnancy; resulting in an elevated risk of breast cancer. A meta-analysis of 53 epidemiological studies undertaken in 16 countries did not find evidence of a relationship between abortion and breast cancer (The Lancet, 2004). Nevertheless this remains a hot issue in anti-abortion circles.

Induction of Abortion

Deliberate termination of pregnancy before the viability of the fetus is called induction of abortion. The induced abortion may be legal or illegal (criminal). There are many countries in the globe where the abortion is not yet legalized.

Abortion law

Abortion has been a controversial subject throughout history due to the moral and ethical issues that surround it. It has been regularly banned and otherwise limited, though abortions have continued to be commonplace in many areas where it is illegal. Almost 2/3 of the world's women currently reside in countries where abortion may be obtained on request or for a broad range of social, economic or personal reasons. Abortion laws vary widely by country, with some countries allowing nearly total liberalization, and others banning abortion under any circumstances. There are also countries that do not have any laws restricting abortion, such as Canada. In the United States, abortions are legal in all 50 states up to the time of birth, although many physicians are reluctant to perform extreme late-term procedures from fear of litigation.

Medical Termination of Pregnancy (MTP)

In India, the abortion became legalized as "Medical Termination of Pregnancy Act" of 1971, which became enforced in the year April 1972. The provisions of the Act have been revised in 1975.

- Since legalization of abortion in India, deliberate induction of abortion by a registered medical practitioner in the interest of mother's health and life is protected under the MTP act. The following provisions are laid down:
- The continuation of pregnancy would involve serious risk of life or grave injury to the physical and mental health of the pregnant woman.

- There is a substantial risk of the child being born with serious physical and mental abnormalities so as to handicapped in life.
- When the pregnancy is caused by rape both in cases of major and minor girl and in mentally imbalanced woman.
- Pregnancy caused as a result of failure of a contraceptive used by any married woman or by her husband.

In practice, the following are the indications for termination under the MTP Act.

- To save the life of the mother (Therapeutic or Medical termination): The indications are limited and scarcely justifiable now a days except in the following cases: a) Pulmonary tuberculosis, when superimposed pregnancy deteriorates the condition. b) Cardiac diseases (Grade-III & IV) with history of decomposition in the previous pregnancy or in between the pregnancies are justifiable indications for termination in the first trimester. c) Chronic glomurelonephritis. d) Malignant hypertension. e) Intractable hypermesis gravidarum. f) Cervical or breast malignancy. g) Diabetes mellitus with retinopathy. h) Epilepsy or psychiatric illness with the advice of a psychiatrist.
- Social indications: This is almost the sole indication and is covered under the provision "to prevent grave injury to the physical and mental health of the pregnant woman". In about 80% it is limited to parous women having unplanned pregnancy with low socioeconomic status. Pregnancy caused by rape or unwanted pregnancy caused due to failure of any contraceptive device also falls in this category (20%).
- Eugenic: This is done under the provision of " substantial risk of the child being born with serious physical and mental abnormalities so as to be handicapped in life". The indication is rare.

i) Chromosomal and enzymatic abnormalities of the foetus, which are identified as factors responsible for transmission of certain, inherited disorders.

ii) When the foetus is likely to be deformed due to action of teratogenic drugs or radiation exposure in early pregnancy. Taking hormones eother in the form of tablets or injections for diagnosis of pregnancy or accidental pelvic X-ray (having less than 10 rad) is not a justifiable indication especially in first pregnancy, for temination.

iii) Rubella, a viral infection affecting in the first trimester, is an indication for termination.

iv) History of one or both parents being mentally defective or previous children being malformed can be a reason for termination in consultation with a geneticist.

Recommendations

- In the revised rules, a registered medical practitioner is qualified to perform a MTP provided: a) One has assisted in at least 25 MTP in an authorized center and having a certificate. b) One has got six months house surgeon training in obstetrics and gynaecology. c) One has got diploma or degree in obstetrics and gynaecology.
- Termination can only be performed in hospitals, established or maintained by the government or places approved by the government.
- Pregnancy can only be terminated on the written consent of the woman. Husband's consent is not required
- Pregnancy in a minor girl (below the age of 18 years) or lunatic cannot terminated without written consent of the parents or legal guardians.
- Termination is permitted up to 20 weeks of pregnancy. When the pregnancy exceeds 12 weeks, opinion of two medical practitioners is required.
- The abortion has to be performed confidentially and to be reported to the Director of Health Services of the State in the prescribed form.

Abortion as a political issue

Abortion has sometimes been a bitterly fought battle in politics, especially in the United States. Opponents of abortion are usually termed Pro-Life, while proponents of abortion rights are usually termed Pro-Choice. The United States Supreme Court is largely considered the gatekeeper of abortion rights in the United States, and as a result, the possibility of the balance of the Court shifting towards a more conservative body became an issue in the 2004 US Presidential Election.

In many other countries, the issue of abortion is less of a political issue. None of the main political parties in the UK, for instance, are challenging the basis of the currently permissive laws on abortion, and abortion is available free through the National Health Service. Abortion is no longer considered to be a mainstream political issue in the UK.

Abortion and Feminism

The cornerstone of the pro-choice feminist movement is reproductive rights, freedom from the interference of men, the state or the church in the decision over whether to have an abortion.

It stresses heavily the right of a woman to choose an abortion for her own protection and life, as well as for her happiness, her career, her education or her personal fulfillment. Most of the arguments tend to characterize abortion as a form of birth control, freeing women from the physical and emotional burden of sex. They charge that men are already free of pregnancy and do not have to carry children at all, so abortion is merely an equalizer in this regard. Further, the perspective tends to view any encroachment by male pro-life advocates as chauvinism.

Most feminist groups tend to be heavily pro-choice or pro-choice leaning. Groups like NOW and others have a definite bias toward abortion, but similar pro-choice feminist views are defended and advanced by non-feminist groups ranging

from the American Civil Liberties Union to Planned Parenthood. Abortion rights is often a measuring stick for support of feminism, and the two are used interchangeably by many on both sides of the debate.

The pro-life feminist movement connects abortion to war and characterizes it as a male-dominated institution of violence against both women and children. Early feminists took the view that abortion was a horrible tragedy, a disastrous crime, and a male-supported instrument to further power over women.

Elizabeth Cady Stanton termed abortion infanticide, while Emma Goldman bemoaned the high rate of abortion as "appalling" and "beyond belief." Mattie Brinkerhoff characterized abortion as destroying the life of an unborn child, and evidence that a woman "has been greatly wronged." Victoria Woodhull, the first female US presidential candidate, affirmed "the rights of children as individuals begin while yet they remain the fetus." Caroline Elizabeth Sarah Norton wrote of "infant butcheries" and "ante-natal child murder," describing abortion as interfering with "the right of the unborn to be born." Mary Wollstonecraft suggested outright that abortion violated the laws of nature and Matilda Joslyn Gage suggested it was one of the greatest wrongs against women and that men committed it. Alice Paul, author of the first Equal Rights Amendment in 1923, said simply "Abortion is the ultimate exploitation of women." Susan B. Anthony referred to it as child murder. Today the pro-life feminist view is taken by few groups. Although some groups are neutral on abortion, the Feminists For Life are the primary group explicitly and aggressively advocating both for feminism and against abortion.

CHAPTER-2

Review of Past Studies

Several attempts have been made in different parts of the world to study abortion. In this chapter a brief summary of some of the related studies are present.

Sudev (1983) studies the reason for the acceptance of induced abortion in Trivandrum. It tries to determine the reason for the abortion for all marital status groups. Important reasons for the out-of-wed lock conceptions were false promises of security given by the man, promises of marriage and lack of knowledge about the consequences of sexual intercourse. The major reason for umwanted conception among married women who were exposed to the risk of conception was contraceptive failure. The general finding of the study is that the better-educated women had benefited from the programme of legalized abortion better than the less educated.

Lauvie Schbim Zabim et al (1989) studied the consequences of abortion among adolescents with respect to education and their psychological status in Maryland. It founded that those who obtained abortions were adversely affected by their abortion experience. The study pointed that those who had obtained abortion were better off economically and the analysis of psychological stress showed that those who terminate their pregnancy had experienced no greater levels of stress and they were no more likely to have psychological problems two years later

Sarkar (1993) conducted a study "Legally Induced Abortion in India" re-evaluated the legally induced abortion in the perspective of the national family planning prrogramme. A large proportion of their acceptors were in their twenties. Acceptors of legally induced abortion by a large number of young women have shown that the concept of a small family is gaining importance.

Sureendar et al (1993) made an attempt to find out the prevalence of abortion during the period 1976-77 and 1988-89 in the major states of India. The results revealed that the incidence of abortion has been declining over the years and there has been a decline in the percentage of those opting formation at their late duration of pregnancy. The failure of contraception has been the major reason given by those who opted for abortion in both 1976-77 and 1988-89.

The paper "Adolescent Premarital Childbearing" of Lundberg et al (1995) pointed out that welfare, abortion and family planning policy variables do not explain premarital childbearing.

Miller (1995) makes an analysis of the risk factors for adolescent non-marital childbearing. The author as a high-risk population views teenagers, because 72 per cent of teenage births in 1992 were non-marital which is an increase from 15 percent in 1960 (US). It is concluded that there is not only any single factor responsible for teenage non-marital childbearing, but adolescents from disadvantaged families and communities are at great risk.

Based on the data obtained from eleven European countries Creatsan(1995) analyses the Pattern of adolescent pregnancy in Europe. Findings indicate that adolescent pregnancy rates during 1985-89 remained stable or declined. Germany had the highest rates of adolescent pregnancy, followed by United Kingdom. And the Netherlands had the lowest adolescent abortion rate with 0.4 percent in 1987.

The paper by DeClerque (1995) which summarizes findings from the rural Adolescent Pregnancy Project, analyses secondary data on rural adolescent pregnancy and fertility during 1985-94 in the southern States of the US. It is found that in 1990, birth rates for rural teens aged 18-19 years, birth rates fro rural teens aged 18-19 years for all the states were 17 percent higher than for teen in urban areas.

The Center for Health Services Research University of North Corolina (1995), conducted a comprehensive analysis of adolescent pregnancy and its prevention in

some states of US. The study's major finding was the adolescent pregnancy and birth rates for 15-19 year olds at least as high in rural as in urban areas, while the abortion rate was substantially lower in rural areas. And 84 percent of programmes that serve rural youth are located in an urban or suburban area.

Goldenberg et al (1995) analyse adolescent pregnancy in US with a different perspective. It is reported that in 1992, more than 9 million pregnancies in women under the age 20 years resulted in 12.7 percent of all live births. Fourteen percent of the pregnancies ended in miscarriage and 35 percent in induced abortion.

A survey of 167 pregnant adolescent from Devon, England, representing to NHS climes in 1992-94 for induced abortion or prenatal care, Pearson et al (1995) revealed important information about the special family planning needs of this population. About 71 percent of the teenagers were using contraception at the time of conception and 98.2 percent of teens had heard of family planning clinics. A high rate of contraceptive failure in this groups suggest the need for school-based sex education programmes to increase knowledge of the proper used of methods such as condoms and greater promotion of more effective contraceptive methods.

The health facility to examine pregnancy outcomes and incidence of pregnancy complications among adolescents are also studied by Unger et al (1995). The study is conducted in the selected hospitals in Rome between 1984and 1993.It is found that adolescents were likely to have had a spontaneous abortion. Fetal distress was more common in adolescents than in the 20-24 year old group. It is also found that the average birth weight for infants born to adolescent mothers was lower than that for those born to controls and it was especially low for 14-15 year olds.

In a study by Kosumen et al (1996) population register was used to examine regional patterns of adolescent pregnancy and abortion in Finland's provinces during 1976-'93. Findings revealed that pregnancies among girls aged 15-19 years and adolescent abortion decline during 12975-1993. During the study

period, induced abortion was more frequent than childbirths among young adolescents. Older –adolescent childbirths and abortions varied in the early 1990s between southern and northern provinces.

Esiet NO(1996), using date from the Nigerian country Report for the ICPD< indicate that 25 percent of sexually active teenage females in Nigeria have had at least one complication arising from usage induced abortion and it is the leading cause of death among adolescent female students in the country. The author supports the recent approval of National Council on Health regarding National Policy on Adolescent Health.

Montessora (1996) studies public policy and adolescent pregnancy in United States. The Study reveals that in the US 45 percent of female adolescent engage in premarital sex, 40 percent will become pregnant before reaching the age of 20, and 4/5th of these pregnancies will be unintended. Another study by American Academy of Pediatrics Committee on Adolescence (1996) reveals that adolescents have the right to confidential care when they are considering an abortion.

Scommegna (1996) studied "Teens Risk of Aids" and founded that approximately 1.6 million of the world's population are 10-24 years old. The proportion of teen births to unwed mothers has risen by 50 percent in the US since 1980 and by almost 70 percent in Kenya during the 1980s. Approximately 2 million adolescent women in developing countries have illegal, unsafe abortions each year, with at least 10 percent of all abortions worldwide occurring among ages 15-19.

In a study "Abortion in Context: Women's Experience in two Villages in Tahi Binh, Vietnam, Annila Johensson (1996) explored that the circumstances of abortions from women's Perspectives. The study results that most abortions among women in the study villages were performed quite early in the pregnancy, and none were reported after the 12th week. Only 9 percent of the women undergoing abortion in this study were younger than 2.5. As a conclusion the authors suggest that the rapid increase in abortions recent years is the combined effect of stricter

population policies and a wish for smaller families while contraceptive services are still inadequate.

Eutwisie et al (1997) describes findings from a new source of data for estimating the incidence of induced abortion in the Russian Federation. According to him the abortion rate in 1994 was 56 per 1000 women an estimate that varies from the advanced by official sources and other studies. The sensitivity of this estimate to survey design under reporting of abortion and potential confusion about miniabortions is considered. Consistency of abortion estimates with patterns of contraceptive use is also evaluated. A significant advantage of the present data is the ability to estimate abortion rates specific torespondentcharacteristics.

Extent of Abortion

Approximately 26 million legal and 20 million illegal abortions were performed worldwide in 1995, resulting in a worldwide abortion rate of 35 per 1,000 women aged 15–44. Among the subregions of the world, Eastern Europe had the highest abortion rate (90 per 1,000) and Western Europe the lowest rate (11 per 1,000). Among countries where abortion is legal without restriction as to reason, the highest abortion rate, 83 per 1,000, was reported for Vietnam and the lowest, seven per 1,000, for Belgium and the Netherlands. Abortion rates are no lower overall in areas where abortion is generally restricted by law (and where many abortions are performed under unsafe conditions) than in areas where abortion is legally permitted.

Both developed and developing countries can have low abortion rates. Most countries, however, have moderate to high abortion rates, reflecting lower prevalence and effectiveness of contraceptive use. Stringent legal restrictions do not guarantee a low abortion rate. (International Family Planning Perspectives, 1999, 25(Supplement):S30–S38)Approximately 46 million abortions were performed worldwide in 1995 .Of these, about 26 million were legal and 20 million illegal.‡ The abortion rate worldwide was about 35 per 1,000 women aged 15–44.

Of all pregnancies (excluding miscarriages and stillbirths), 26% were terminated by abortion.

The number of abortions taking place in Kerala is high (total of 33920 abortions during 1996). This shows that unwanted pregnancies are occurring which creates physiological and psychological stress to women (Dr.A.K.Jayasree, Challenges to reproductive Health Care in Kerala, Foundation for Integrated Research in Mental Health, Trivandrum). There is no clear and accurate statistics on the extent of abortion in Kerala as a good number of abortions are done in Private hospitals, which are secret.

CHAPTER-3

Methodology

Abortion is the termination of a pregnancy before the fetus is capable of extra uterine life. Further refinements of the term depend on the cause of the abortion. Spontaneous abortions (sometimes called miscarriages) are those in which the termination is not provoked, whereas induced abortions are those caused by deliberate interference. Induced abortions include those performed in accordance with legal sanctions and those performed outside the law. The term therapeutic abortion, strictly defined, refers to medically indicated abortion for women whose life or health is threatened by continuation of pregnancy or when the health of the fetus is threatened by congenital or genetic factors.

Ever since the liberalization of abortion many studies have been conducted on different aspects of medical termination of pregnancy by demographers, sociologists and physicians. However little is known about the awareness of laywomen on abortion and various aspects of aborted women. Kerala is the most advanced state in India demographically and it has the lowest fertility level in the country. Abortion rate has great influence on fertility regulation because one of the main reasons for terminating pregnancy is spacing between births. In the context of changing value system, erosion of family kinship ties, media explosion on sex provocative themes, availability of MTP services almost on request and existing threat of HIV/AIDS spread it is significant a study like this.

Objectives

1.To find out the attitude of women towards and of knowledge on abortion.

2.To assess the extent of abortion in Kerala.

3.To find out the causes of abortion.

4.To investigate the after effects – social, economic and familial- of abortion.

5.To find out ways of abortion among women.

Types of Data Collected

The following types of data were collected for the study.

1. Documentary evidence mainly from published materials from libraries, government reports etc

2. Interview data from the respondents.

3. Field notes by the researcher through observation and discussion with knowledgeable persons in the concerned field.

Tools of Data Collection

Data for the empirical study was collected mainly through interview schedules. The schedules elicited information needed to understand the objectives of the study. Most of the questions in the schedule were precoded for easy tabulation and analysis. The interview schedule consists of closed questions and only very few are open-ended.

Piolet Study and Pre-test

With the intention of forecasting flaws and problems and plausibility of the research, a piolet study was conducted in Trivandrum district. The researcher had discussions with the knowledgeable persons in the field that has helped a lot in understanding situations and problems. The interview schedule was administered on 10 respondents to find out whether the questions were simple enough for them, and whether the data collected through them were adequate, reliable and valid. With the use of simple statistics, analysis was also be done. In the light of piolet study, the hypotheses were modified and finalized.

Pre-test

A pre-test was conducted with some of the respondents and found that some of the questions were unnecessary and were not understood by the respondents mainly among the less educated. The unreliable, ambiguous, suggestive and repetitive questions were suitably modified or discarded. The questions were then modified and finalized.

Sampling Design

Two types of samples were selected via. general women population and women who have undergone abortion. There were 40 general women – 20 rural and 20 urban and 10 women who has undergone abortion from each district of Trivandrum, Pathanamthitta and Thrissur have been selected for the study. Thus total 120 general women and 30 women who has undergone abortion were selected and interviewed.

Data Collection

The field study was conducted in the month of April, 2005. The researcher and investigator stayed for a week each in the three districts. The area of study is a sensitive one it was difficult to get proper answers in the beginning but after making good rapport the investigators could collect data effectively. Some of the respondents were reluctant to provide correct answers and expose their identity. Anyway these difficulties could be overcome by using various techniques of interview.

Quantitative Techniques.

An interview schedule consisting of questions related to the different types of variables to measure attitude and awareness and another schedule for measuring various aspects of women who has undergone abortion with a four-point scale attached to each question (nil/low/average/high) were used for

collecting data from the selected respondents. There were also questions to collect information about various aspects to understand the objectives given in this study.

The data collected by the survey was computerised and analysed using SPSS Ver. 7.00 software. The Performa was edited by the project Director and obvious inaccuracies were rectified before data entry. The errors in the data entry was eliminated by suitable programme validation and consistency checks. Quality control was maintained by cross checking the data input with the original Performa randomly. The analysis was done to review various aspects given in the schedule and objectives. Based on available data, various hypotheses about the population was tested. The statistical analysis methods included computing the frequency tables. After identifying the distribution of data, cross-tabulation studies with correlated variable and multivariable analysis were done to establish possible causes of problems and the consequent effect on the population. Pearson's coefficient of correlation and regression index were evaluated to confirm the statistical significance of the result. Based on the trend of population behaviour the hypotheses made were subject to chi-square or students T-Test wherever applicable and p-values determined to validate the inferences of the study. ANOVA and Factor Analysis were also be done. The Project Director correlated the statistical results with the observation during the survey and possible reasons were identified.

CHAPTER-4

ANALYSIS OF DATA

The data for the present study was collected from three districts of Kerala during the period April, 2005. Thiruvananthapuram, Pathanamthitta and Thrissur were the districts from which data were collected. The sample for the study consisted of 120 women, 40 each from the three districts. Of the 40 from each district, 20 samples were from rural and 20 from urban areas. 10 samples were women who had undergone abortion. Great care was taken while selecting the sample, so as to provide adequate representation to all related and pertinent variables like age, spread among the different areas in the districts selected for study, etc. Due to sensitivities involved, great care was taken by the investigators not to antagonize the respondents. The services of Anganwadi workers were utilized wherever it was available. This helped in gaining the confidence of the respondents and they responded in a free and fair manner.

Random sampling method has been used to select the sample for investigation. This method was chosen due to the sensitivities involved with respect to the subject under study. A random sample from a population is a sample which is formed in such a way that every member of the population has an equal chance of being selected and the selection of an individual does not influence the selection of the other.

The breakup of sample taken for the study is presented in Table 1.

Table 1

District wise Break-up of the Sample Selected

Sl. No	District	Particulars	Number
1.	Thiruvananthapuram	Urban	20
		Rural	20
		Aborted	10
2.	Pathanamthitta	Urban	20
		Rural	20
		Aborted	10
3.	Thrissur	Urban	20
		Rural	20
		Aborted	10
Total			**150**

Description of the Tool Used of Data Collection:

Data were collected using two types of Interview Schedule – one for Women not undergone abortion (Annexure I) and another of Aborted Women (Annexure II). The Interview schedule prepared for the present study was that of a structured type with choices provided in the schedule itself, and the interviewee had to choose only form the options provided therein. However, the respondents were provided with option to respond regarding other related aspects which they had knowledge about abortion. Both the Schedules had two Sections. The first section entitled 'Personal Data' had 11 questions which elicited information like

age, marital status, qualification, religion, occupation, income, number of children, etc. The details of the data pertaining to the first section are presented below.

The demographic breakup of the sample is presented in Table 2.

Table 2.

Demographic Breakup of the Sample

Sl. No	Details	Particulars	Number
1.	Age	15-25 Years	22
		26-35 Years	28
		36-45 Years	22
		Above 45 Years	48
2.	Marital status	Married	81
		Unmarried	17
		Separated	2
		Divorced	8
		Widow	20
3.	Education	Illiterate	12
		Literate	3
		Primary	16
		Upper Primary	48
		SSLC	13
		Plus Two	13
		Graduate	13
		Post Graduate	2
4.	Religion	Hindu	67
		Christian	37
		Muslim	16

5.	Occupation	Employee	16
		Student	13
		Business	3
		Farmer	8
		Unemployed	86
		Labourer	2
7.	Number of children	Nil	23
		1	21
		2	49
		3	18
		4	3
		Above 4	6

From the above table, it may be observed that 22 respondents belonged to the age bracket 15 to 25, 28 to the age bracket 26 to 35, 22 to 36-45, and 48 were above 45 years of age. The sample consisted of 81, 17, 2, 8, and 20 married, unmarried, separated, divorced and widows respectively. Their educational qualifications varied from illiterates to Post graduates. There were 67 Hindus, 37 Christians and 16 Muslims in the sample. Employees constituted 16 numbers of the data while 13 were students, three were doing business, eight of them farming, two were laborers and the balance of 86 was unemployed. As regards the number of children, there were 21 respondents with one child, 49 with two children, 18 with three children, three with four children, six had above four children, and the balance of 23 were without any children.

The statistical data pertaining to those women undergone abortion is worth noting and the same is presented in Table 3.

Table 3.

Data pertaining to Women who had Undergone Abortion

Sl. No	Details	Particulars	Number
1.	Age	15-25 Years	7
		26-35 Years	20
		36-45 Years	3
2.	Marital status	Married	29
		Unmarried	0
		Separated	0
		Divorced	0
		Widow	1
3.	Education	Illiterate	0
		Literate	2
		Primary	1
		Upper Primary	11
		SSLC	11
		Plus Two	2
		Graduate	1
		Post Graduate	2
4.	Religion	Hindu	18
		Christian	12
		Muslim	0
5.	Occupation	Employee	4
		Student	0
		Business	0
		Farmer	0
		Unemployed	24

		Labourer	2
7.	Number of children	Nil	12
		1	10
		2	5
		3	2
		4	1
		Above 4	0

Thus, it may be observed that the respondents of the present study pertain to the cross section of women and can thus be established to be representative of the population.

The second section for the interview schedule for women who had not undergone abortion had 19 structured questions. The possible response for these questions were Very Well, Well, Average, Little. The respondents were expected to choose only from any of the said responses. However, they were allowed to present other related information they had about the current topic, which was also recorded appropriately by the interviewer.

As mentioned elsewhere, one among the objectives of the present study was to find out the attitude of women towards and their knowledge about abortion, and abortion processes. The analysis of the data collected for the study is presented in the following sections.

1. KNOWLEDGE ABOUT THE TERM 'ABORTION':

The respondents were interviewed about their knowledge about Abortion, and the findings are presented below.

Table 4

Data Regarding the Knowledge about the Term 'Abortion'

No	Response	No of Responses	Percent
1.	Very Well	**46**	**38.33**
2.	Well	**18**	**15.00**
3.	Average	**53**	**44.17**
4.	Little	**3**	**2.50**
Total		**120**	**100.00**

It can be observed that majority of the respondents had fairly good knowledge about the term abortion, general. Over 97.5 per cent of the total respondents had knowledge about the term abortion. This indeed is a matter of grate importance, denoting heightened knowledge about topics that matter to women.

An attempt was also made to find out as to whether other demographic variables had any influence on the knowledge level of the respondents. The same is presented in the following table.

Table 5

Data Regarding the Knowledge about the Term 'Abortion' With Respect to Place of Residence

	Response	Urban		Rural	
		No	Per cent	No	Per cent
1.	Very Well	**33**	**55.00**	**13**	**21.67**
2.	Well	**6**	**10.00**	**12**	**20.00**
3.	Average	**19**	**31.67**	**34**	**56.66**
4.	Little	**2**	**3.33**	**1**	**1.67**
Total		**60**	**100**	**60**	**100**

From the above data it is evident that the women resident in the urban area had better knowledge about abortion. While 65 per cent of the urban respondents had above average knowledge regarding the term 'abortion' the same was only 41.67 among the women of rural areas. The high level of knowledge in the urban areas may be due to the availability of media and other means of information dissemination, which is scant as regarding the rural areas of our state.

1.1. Result of ANOVA: Comparison with respect to Age:

The different age groups as presented in Table 2 were compared with the knowledge about the term abortion and the result is presented in Table 6

Table 6

Data and Result of Comparison with respect to Age

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	11.679	3	3.893	4.612**
Within Groups	97.913	116	.844	
Total	109.592	119		

Note ** indicate significance at 0.01 level

It can be observed that there existed significant difference between the respondents of varying ages groups regarding the knowledge about the term

1.2. Result of ANOVA: Comparison with respect to Marital Status:

Respondents of varying marital status were compared to find out if there existed any difference among them of the knowledge about the term abortion. It cam be found from the following table that there existed significant difference at 0.01 level in this factor.

Table 7

Data and Result of Comparison with respect to Marital Status

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	19.583	3	6.528	8.412**
Within Groups	90.009	116	.776	
Total	109.592	119		

Note ** indicate significance at 0.01 level

1.3. Result of ANOVA: Comparison with respect to Educational Qualification:

The comparison of the respondents with respect to their educational qualification, as per table 2, is presented below, which is worth noting.

Table 8

Data and Result of Comparison with respect to Educational Qualification

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	20.925	7	2.989	3.776**
Within Groups	88.667	112	.792	
Total	109.592	119		

Note ** indicate significance at 0.05 level

1.4. Result of ANOVA: Comparison with respect to Occupation:

The knowledge of the term of the respondents were compared with respect to their occupation, and it is observed that in this factor too there existed significant difference. The results are presented in the table below:

Table 9

Data and Result of Comparison with respect to Occupation

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	20.377	4	5.094	6.567**
Within Groups	89.215	115	.776	
Total	109.592	119		

Note ** indicate significance at 0.05 level

1.4. Result of ANOVA: Comparison with respect to Number of Children:

A comparison was also made to find out if there existed any difference with respect to the number of children, the result of which is presented in the following Table.

Table 10

Data and Result of Comparison with respect to Number of Children

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	8.273	5	1.655	1.862**
Within Groups	101.318	114	.889	
Total	109.592	119		

Note ** indicate not significant

It can be observed that there did not exist any significance with respect to respondents having varying number of children with respect to their knowledge about the term abortion, which is worth noting.

2. Data Regarding the Origin of the Information about Abortion

With an intention of knowing the origin of information about abortion a question was provided to elicit their knowledge in this area too. The respondents were asked to denote the origin of the information about abortion. They were

asked to pick from among the choices of 'parents, teachers, friends and relatives'. The data pertaining to this is presented in Table 11

Table 11

Data Regarding the Origin of the Information about Abortion

No	Response	No of Responses	Percent
1.	Parents	**4**	**3.33**
2.	Teachers	**26**	**21.67**
3.	Friends	**44**	**36.67**
4.	Relatives	**46**	**38.33**
Total		**120**	**100.00**

From the above table it can be noted that only four respondents (3.33%) came to know about abortion from their parents. This is an indication of the fact that our society is still in its conservative mode. 26 respondents obtained information from their teachers, which is in fact a matter of great importance. It is worth noting that 44 and 46 respondents obtained information from friends and relatives respectively.

An attempt was also made to find out as to whether other demographic variables had any influence on the origin of information about abortion, among the respondents who were chosen for the study. A comparison was also made among the rural and urban population regarding this aspect. The results of the same are presented in the following table.

Table 12

Data Regarding the Origin of the Information about Abortion With Respect to Place of Residence

	Response	Urban		Rural	
		No	Per cent	No	Per cent
1.	Parents	**8**	**13.33**	**3**	**5.00**
2.	Teachers	**11**	**18.33**	**8**	**13.33**
3.	Friends	**22**	**36.67**	**22**	**36.67**
4.	Relatives	**19**	**31.67**	**27**	**45.00**
Total		**60**	**100**	**60**	**100**

From the table it can be observed that while 13.33 per cent from the urban areas knew about abortion from the parents, only five per cent knew from rural areas knew from their parents. Information from teachers was 18.33 and 13.33 for urban and rural respectively. It can be noted the influence of friends were same for both rural and urban residents. Relatives constituted 45 percent for rural and at the same time it was 31.67 for residents of urban area. Thus the composition of persons resident in urban and rural areas with respect to the origin about the information is on a different manner.

3. Data Regarding the Knowledge about Spontaneous Abortion:

Respondents were also asked at to whether they have heard about spontaneous abortion. Spontaneous abortion is 'the involuntary loss of products of consumption prior to 24 weeks gestation'. In such instances the fetus is said to be viable or capable of sustaining life outside the uterus. The data pertaining to the said question is presented in Table 13

Table13

Data Regarding the Knowledge about Spontaneous Abortion

No	Response	No of Responses	Percent
1.	Very Well	**25**	**20.83**
2.	Well	**38**	**31.67**
3.	Average	**44**	**36.67**
4.	Little	**13**	**10.83**
Total		**120**	**100.00**

From the above table it is seen that about 52 per cent of the sample population had above average information about spontaneous abortion. However 36 per cent had average information and about 11 per cent of the population had only little information. This is an area where health authorities and the concerned policy makers are to provide their attention.

As in the earlier variables a comparison with respect to the difference in knowledge level of the urban and rural population was also compared, so as to establish difference levels if any. The finding is of importance and is consistent with the preceding ones and is presented in the following section.

Table 14

Data Regarding the Knowledge about Spontaneous Abortion

	Response	Urban		Rural	
		No	Per cent	No	Per cent
1.	Very Well	**20**	**33.33**	**9**	**15.00**
2.	Well	**14**	**23.33**	**18**	**30.00**
3.	Average	**23**	**38.34**	**24**	**40.00**
4.	Little	**3**	**5.00**	**9**	**15.00**
Total		**60**	**100**	**60**	**100**

An analysis of the above table brings to light the fact that the Urban population had far more knowledge about the variable under study. Further, more than 50 per cent of the urban population, studies had above average information about spontaneous abortion against 45 per cent in the rural population.

3.1. Result of ANOVA: Comparison with respect to Age:

The different age groups as presented in Table 2 were compared with the knowledge about spontaneous abortion and the result is presented in Table 15

Table 15

Data and Result of Comparison with respect to Age

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	10.854	3	3.618	4.499**
Within Groups	93.271	116	.804	
Total	104.125	119		

Note ** indicate significance at 0.01 level

It is observed that significant difference existed at 0.01 level, with respect to the knowledge about spontaneous abortion among respondents of varying age groups.

3.2. Result of ANOVA: Comparison with respect to Marital Status:

Respondents of varying marital status were compared to find out if there existed any difference among them regarding their knowledge about spontaneous abortion. It cam be found from the following table that there existed significant difference at 0.05 level in this factor.

Table 16

Data and Result of Comparison with respect to Marital Status

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	9.149	3	3.050	3.725**
Within Groups	94.976	116	.819	
Total	104.125	119		

Note ** indicate significance at 0.05 level

3.3. Result of ANOVA: Comparison with respect to Educational Qualification:

The knowledge about spontaneous abortion of respondents with respect to their educational qualification, as per table 2, was compared and is presented below.

Table 17

Data and Result of Comparison with respect to Educational Qualification

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	19.952	7	2.850	3.793**
Within Groups	84.173	112	.752	
Total	104.125	119		

Note ** indicate significance at 0.05 level

As in the earlier case, it is observed that there existed significant difference among the respondents having different educational qualifications, at 0.05 level, with respect to their knowledge about spontaneous abortion.

3.4. Result of ANOVA: Comparison with respect to Occupation:

A comparison made to find out if there existed any difference among respondents having different occupations, about the knowledge of spontaneous abortion, showed significance at 0.01 level. The result is presented in the following Table.

Table 18

Data and Result of Comparison with respect to Occupation

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	16.202	4	4.051	5.298**
Within Groups	87.923	115	.756	
Total	109.592	119		

Note ** indicate significance at 0.01 level

3.5. Result of ANOVA: Comparison with respect to Number of Children:

A comparison was also made to find out if there existed any difference among respondents having varying number of children, about the knowledge of spontaneous abortion, the result of which is presented Table 19

Table 19

Data and Result of Comparison with respect to Number of Children

Source of Variation	Sum of Squares	Df	Mean Squares	F
Between Groups	5.041	5	1.008	1.160**
Within Groups	99.084	114	.869	
Total	109.592	119		

Note ** Not Significant.

As in the earlier case there did not exist any significant difference in the knowledge about spontaneous abortion among respondents having varying number of children.

4. Data Regarding the Knowledge about Health Conditions Leading to Abortion:

Questions were also provided to see if the respondents had any information about certain problems like infertility, bleeding, infection, difference in menstrual cycle and hormonal imbalance are associated with abortion. It was also asked if they had any information about certain diseases like Diabetes, Hyper/Hypo Tension, Heart diseases, etc. could lead to abortion. The data pertaining to the said questions are presented below.

Table 20

Data Regarding the Knowledge about Health Conditions Leading to Abortion

	Response	**I**		**II**	
		No	**Per cent**	**No**	**Per cent**
1.	Very Well	**18**	**15.00**	**22**	**18.33**
2.	Well	**29**	**24.17**	**25**	**20.83**
3.	Average	**53**	**44.17**	**50**	**41.67**
4.	Little	**20**	**16.66**	**23**	**19.17**
Total		**120**	**100**	**120**	**100**

Notes:

I : Response regarding information about certain problems like infertility, bleeding, infection, difference in menstrual cycle and hormonal imbalance.

II : Response regarding information about certain diseases like Diabetes, Hyper/Hypo Tension, Heart diseases, etc.

From the above table it is observed that majority of the respondents had average or below average knowledge that problems like infertility, bleeding, infection, difference in menstrual cycle and hormonal imbalance (over 60%); and diseases like Diabetes, Hyper/Hypo Tension, Heart diseases, etc. (over 60%) could lead to spontaneous abortion. This should also be a cause of concern for the authorities as it is established that only few persons are aware of the health conditions that could lead to spontaneous abortion.

5. Data Regarding the Knowledge about Psychological Problems being a Causative Factor for Abortion:

It is an established fact that psychological problems of expectant mother can be a causative factor for abortion. Though medical science has grown considerably, lot more needs to be done in this area. The medicines used for patients with psychological problems may also lead to abortions. The psychological problems can have a direct bearing on the general health conditions of the mother leading to further complications too in the future. Medical practitioners in this area have vouched this. Attempt was also made to know the knowledge level of respondents about psychological problems leading to abortion. The results obtained are significant and is presented in the following Table.

Table 21

Data Regarding the Knowledge about Psychological Problems being a Causative Factor for Abortion

No	Response	No of Responses	Percent
1.	Very Well	**23**	**19.17**
2.	Well	**22**	**18.33**
3.	Average	**62**	**51.67**
4.	Little	**13**	**10.83**
Total		**120**	**100.00**

This finding is also in line with the earlier findings. In this particular case also over 62% of the respondents had only average and below average knowledge that psychological problems are causative factor of abortion. This is also to be viewed with caution by the health authorities and the policy makers, and they should think of ways to disseminate the required information to the required persons.

Since it was expected that the results of rural and urban population will differ with respect to their knowledge about psychological problems being a causative factor for abortion, a comparison was done among the respondents based on their locale. The results are presented below:

Table 22

Data Regarding the Knowledge about Psychological Problems being a Causative Factor for Abortion With Respect to Place of Residence

	Response	Urban		Rural	
		No	Per cent	No	Per cent
1.	Very Well	**17**	**28.33**	**6**	**10.00**
2.	Well	**15**	**25.00**	**7**	**11.67**
3.	Average	**26**	**43.33**	**36**	**60.00**
4.	Little	**2**	**3.33**	**11**	**18.33**
Total		**60**	**100**	**60**	**100**

It is evident that the rural people lag behind in the knowledge about psychological problems being causative factor for abortion. Majority (over 78 per cent) had either Average or Little information about this, while the urban population had better information.

6. Data Regarding the Knowledge about MTP Act

The Medical Termination of Pregnancy Act (MTP Act) was passed by the Government of India to regulate the abortion and its conduct. The Act of 1971 was enforced in April 1972, and was revised in 1975. As per the provisions of the Act induction of abortion by a registered medical practitioner, in the interest of mother's health and life is protected. Further, it can also be done if there is substantial risk of the child being born with serious physical and mental abnormalities so as to be handicapped in life.

A question was also provided to study about the knowledge about MTP Act among the respondents. This aspect was provided in the interview schedule, as Kerala is a highly literate state, and taking into consideration the fact that our state has progressed considerably in the field of health and family welfare. The knowledge of the respondents are worth examining, which is provided in Table 23

Table 23

Data Regarding the Knowledge about MTP Act

No	Response	No of Responses	Percent
1.	Very Well	**16**	**13.33**
2.	Well	**10**	**8.33**
3.	Average	**28**	**23.34**
4.	Little	**66**	**55.00**
Total		**120**	**100.00**

It is evident from the above table that only about 21 per cent of the respondents who were surveyed had any knowledge about MTP Act. It is a matter of concern that 55 per cent had no information about this particular piece of legislation, which is of vital importance with regard to abortion. Further, about 23 per cent had only average information about the Act. This is another area of

concern and all out efforts should be taken by those related like health workers, people of legal fraternity, policy designers, social workers, and people engaged in similar professions.

7. Data Regarding the Opinion about Induced Abortion:

Induced abortion is the deliberate termination of pregnancy before the viability of the foetus. This is far more serious than forms of abortions discussed earlier as it may, at times lead to damaging effects on the health and general physical conditions of the woman. Induced abortion can be either legal or illegal, and the illegal one is of criminal in nature. This is governed by provisions of MTP Act, and can be done only by medical practitioners who have the stipulated qualifications and experience. Respondents were also interviewed on their opinion as to whether they favour induced abortion, which is as per the following table:

Table 24

Data Regarding the Opinion about Induced Abortion

No	Response	No of Responses	Percent
1.	Very Well	**10**	**8.33**
2.	Well	**19**	**15.83**
3.	Average	**40**	**34.17**
4.	Little	**50**	**41.67**
Total		**120**	**100.00**

From the about table is evident that only a minority (about 24 per cent) favoured induced abortion, with around 75 per cent not in favour of abortion which is induced in nature.

Attempt was also made to know if there is difference in the knowledge level about the variable under study among women resident in urban and rural areas. The results are which are in line with the earlier investigation provided in the

following table. It can be observed that there is marked difference in the knowledge level of the rural population, with only 13 per cent having opinion which favoured induced abortion. The variations in the social background that is prevalent in the rural areas may be the reason for the variation in the variable under study.

Table 25

Data Regarding the Opinion about Induced Abortion With Respect to Place of Residence

	Response	Urban		Rural	
		No	Per cent	No	Per cent
1.	Very Well	**8**	**13.33**	**2**	**3.33**
2.	Well	**13**	**21.67**	**6**	**10.00**
3.	Average	**17**	**28.33**	**24**	**40.00**
4.	Little	**22**	**36.67**	**28**	**46.67**
Total		**60**	**100**	**60**	**100**

8. Data Regarding the Knowledge about Methods of Abortion

Another important information that was elicited was whether the respondents were aware of the methods adopted for abortion. The data collected with respect to the question pertaining to this section is presented in Table 26

Table 26

Data Regarding the Knowledge about Methods of Abortion

No	Response	No of Responses	Percent
1.	Very Well	**20**	**16.67**
2.	Well	**31**	**25.83**
3.	Average	**57**	**47.50**
4.	Little	**12**	**10.00**
Total		**120**	**100.00**

An attempt was made to find out the reasons behind the cause of abortion. The data is present in the following table.

Table 27

Data Regarding Reason for Induced Abortion

Reason	Response			
	Very Well	**Well**	**Average**	**Little**
Avoiding Loss of Prestige	4	6	7	13
Avoiding Danger to Life (Mother)	8	9	3	10
Threat to Health of Child	1	6	13	10
Physiological/Gynecological	27	2	0	1
Psychological	5	6	9	10
Lack of Care	6	8	13	3

The above data helps to fulfill one of the objectives of the study, mainly to find out the causes of abortion. Though the number of samples was 30, of which 10 were from each district selected for study, if throws light on the causes, which led to the person performing, induced abortion. One of the main reasons of performing induced abortion by the persons was due to the physiological or gynecological problems faced by the mother.

Further, the respondents were also asked as to whether 'it was for avoiding more children'. It is worth noting that only 16 respondents provided answers to the particular question. However, the investigator did not compel the respondents to answer the questing taking into consideration the sensitivities involved in asking such a question. Similarly, to the question, 'who influenced the induced abortion' only eight persons responded. Of this eight, two persons said that they were not influenced by anybody and they did the same. One said that her husband influenced her. Two persons said that themselves and their husband influenced them. Three persons were influenced by their parents to perform induced abortion.

21 of the 30 respondents had only one abortion in their lifetime while the rest (nine) had performed more than one induced abortion. 26 respondents said that they suffered bleeding and infection, which seems to be a matter of concern, and should be noted by the concerned authorities. Only 4 persons were free from such difficulties.

Table 28

Data Regarding Problems after Induced Abortion

Problems	**Response**			
	Very Well	**Well**	**Average**	**Little**
Psychological	8	3	17	2
Interpersonal relations - family	2	5	17	6
Interpersonal relations – society	1	1	17	11

Though data has been obtained to throw adequate light on the reasons for abortion, the data was limited to 30 respondents, due to the peculiar nature of the study. It may not be in order to generalize the findings based on such population. However, the investigator has succeeded in presenting the reasons and problems faced by those who undergo induced abortion. A more intense study with a larger sample and having more questions would be ideal for finding out the reasons for

induced abortion, and the problems faced by those persons, before, during and after performance of induced abortion. There is all scope and necessity for such a study, especially in a state like Kerala were women enjoy better position in all walks of life, as compared to their counterparts of the other parts of the country.

CHAPTER-5

FINDINGS AND CONCLUSIONS AND SUGGESTIONS

The purpose of the study undertaken in three districts of Kerala, viz. Thiruvananthapuram, Pathanamthitta and Thrissurm, was to find out the attitude of women towards Abortion. 40 respondents were selected from each district in which the study was undertaken. The 40 from each district included 20 from rural background and the same number from urban background. Care was taken to see that the sample chosen is representative of the population. The respondents belonged to diverse socio-economic conditions having varying backgrounds with respect to marital status, number of children, income levels, occupations, etc.

10 respondents who had undergone abortion were selected from each district, so as to know their attitude about abortion. Collecting data from these respondents was a cumbersome process, as they were reluctant to face such a type of interview. This was all the more difficult in rural areas, as the respondents are found to be conservative in nature. Services of Anganwady workers and lady interviewers were utilized to collect data from respondents who had undergone abortion.

Knowledge of the respondents with respect to various aspects of abortion like type, methods, etc. was studied. Specific importance was provided to abortions like Spontaneous Abortion, Induced Abortion, etc. The impact of Physical and health conditions, Psychological conditions of the women on abortion was also studied. The main methods used for the study-included review of literature, interviews/workshops with the respondents, data processing and analyzing and final reporting.

FINDINGS:

This study has established the following, which the investigation humbly hopes will be of great importance to the policy makers, medical practitioners, heath workers, hospital staff, and other researchers in the field. It would be a matter of joy to the investigator if the findings of the study is made used for the betterment of the women, on whom the very existence and development of the society rests.

The main findings of the study are presented in the following table for easy reference.

Table 29

Findings of The Study

Particulars (Knowledge About)	**Responses (%)**			
	Very well	**Well**	**Average**	**Little**
The Term Abortion	**38.33**	**15.00**	**44.17**	**2.50**
Spontaneous Abortion	**20.83**	**31.67**	**36.67**	**10.83**
Imbalances Leading to Abortion	**15.00**	**24.17**	**44.17**	**16.66**
Diseases Leading to Abortion	**18.33**	**20.83**	**41.67**	**19.17**
Psychological Conditions	**19.17**	**18.33**	**51.67**	**10.83**
MTP Act	**13.33**	**8.33**	**23.34**	**55.00**
Induced Abortion	**8.33**	**15.83**	**34.17**	**41.67**
Methods of Abortion	**16.67**	**25.83**	**47.50**	**10.00**

From the above table, which provides a bird's eye view of the overall findings of the study, it can be established that though a majority of the respondents knew about the term abortion, with respect to all the other variables under study, this is not the case. For all the other variables, majority opinion was average and below, denoting less knowledge about the variables and factors studied.

There was also found to be wide variation in the knowledge levels of women resident in urban areas and rural areas. While the respondents who were resident in urban areas had better levels of information and knowledge about the various aspects, almost the opposite was the case of respondents of rural areas. The rural women had less information about various aspects concerning abortion. This may be due to the better communication, access to better health care and information available in the urban areas. Though our rural areas have developed considerably as compared to the rural population of the rest of the county, still more needs to be done, with respect to information dissemination in these areas.

There was also found to be difference in the knowledge level among the respondents in all the variables studied with respect to the different demographical variables like age, marital status, educational qualifications, occupations, etc. The only variable for which no significant difference was found was with respect to the number of children of the respondents.

This can be very well tackled if the services of Anganvadies and Ayalkoottoms can be solicited and utilized. The ayalkoottoms have been instant successes as regards micro finances are concerned and can be termed as revolution in this area. It has won accolades from many sources, and is considered strong and stable. These institutions can be used with great success for information dissemination regarding health care, prevention of HIV, etc. Further since Abortion is a matter that is highly sensitive in nature, women health workers should be trained in all aspects with respect to this, and should be in a position to tackle the related problems.

CONCLUSIONS:

Based on the study, the investigator intends to place a few suggestions and conclusions regarding the matter investigated, which can be of importance to persons related to the topic. They are presented below:

- The women of rural areas should be provided with more information regarding abortion and its related aspects. For this seminars and study classes should be conducted near their place of residence and according to their convenience. Duly qualified persons, who will be in a position to clarify their doubts and apprehensions, should conduct the classes.
- Awareness among the women that the general health conditions including psychological conditions may lead to abortion is not up to the mark. The women, residing both in rural and urban areas are to the presented about facts and remedies regarding the health conditions.
- The respondents, in general, are ignorant about induced abortion and the problems it may lead to. The women should be made aware of the drawbacks and the legal implications of induced abortion.
- The knowledge level of women about Medical Termination of Pregnancy Act is not satisfactory. This is a marvelous piece of legislation indented for the protection and welfare of women. For the legislation to be a success the letter and spirit should be passed down to those for whom it is intended to. As such seminars, study classes and pamphlets should be provided to women at possible places so as to acquaint them of the important provisions of the Act, which has been enacted for the sake of their protection and well being.
- A few respondents were reluctant to answer a few questions due to the sensitivity of the problem. This is quite natural and provides scope for further investigation and action.

SUGGESTIONS

1. The government should conduct awareness programmes regarding various aspects of abortion so that the women section particularly in

rural areas and less educated will get certain information, which will be highly useful for these sections.

2. It is highly essential to conduct classes and seminars for teenage girls particularly in the school atmosphere so that this section will be informed with various aspects of abortion. They are the main venerable group, which help them to take care and caution.
3. Besides they will be informed with modern family planning methods, which help them not to relapse into unwanted pregnancies and consequent abortions.
4. Generally, the laywomen who are usually unaware of the consequences of abortion particularly in rural settings, which emphasizes the need for education and the health personnel concerned, can contribute a lot to reduce the unnecessary incidences of abortion.
5. Anganwadi is a better center for disseminating information on abortion needed for the general less educated section of women population. So these centers should be equipped with necessary information dissemination resources.
6. School authorities could do a lot in this regard by appointing a counselor for eradicating the doubts of the girl students on abortion and its consequences.
7. It is very important to note that the most women do not aware of the MTP Act, which should be disseminated among women population through seminars and classes.
8. It is also appreciable to start a separate counseling center attached to PHCs, Angawadis and other government hospitals for women who need help in the process of doing abortion which will reduce the dangers of abortion. Most of the women in rural areas are unaware of the methods and ways of abortion and its possible side effects.

9. Distribution of pamphlets on details of abortion and MTP Act among families in rural as well as urban centers that will help them to know the details of abortion. This will help to reduce the abortions due to ignorance and contact specialized doctors if abortion becomes a necessary.
10. Mass Media could do a lot in this regard and boost them to provide social suggestions about abortion through their media.

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APPEDIX

Interview Schedule for Aborted Women

I.Personal Data

1. Name and Address	
2. Age	1.15-25 Years
	2.26-35 Years
	3.36-45 Years
	4.Above 45 Years
3. Marital Status	1.Married
	2.Unmarried
	3.Separated
	4.Divorced
	5.Widow
4. Education	1.Illiterate
	2.Literate
	3.Primary
	4.Upper primary
	5.Secondary
	6.SSLC
	7.+2
	8.Graduate
	9.Post-graduate
	10.Professional
	11.Technical.
5. Religion	1.Hindu
	2.Christian

	3.Muslim
6. Caste	1.forward
	2.Bacward
	3.SC/ST
7. Occupation	1.Govt/Pvt.Employee
	2.Student
	3.Businuss
	4.Farmer
	5.Unemployed
	6.Labourer
8. Personal Income	1.Below10,000/-
	2.10001-35000/-
	3.35001/-60000
	4.60001/-85000/-
	5.85001/-1,10000/-
	6.Above1,10000/-
	7.No Income
9. Family Income	1.Below10,000/-
	2.10,001/-35,000/-
	3.35,001/-60,000/-
	4.60,001/-85,000/-
	5.85,001/-1,10000/-
	6.Above 1,10000/-
	7.No Income.
10. No. of members in the family	1. 1-3
	2. 4-6
	3. 7-9
	4. Above 9
11. Number of children	1.Nil

2. 1
3. 2
4. 3
5. 4
6.Above 4

Abortion Practices

12. Do you favor abortion	1.VeryWell
	2.Well
	3.Average
	4.Little
13. Which kind of abortion did you face	1.Induced
	2.Spontanious
14. If induced, is the induction for avoiding loss of prestige and future life	1.VeryWell
	2.Well
	3.Average
	4.Little
15. Was it for avoiding danger to the life of mother	1. VeryWell
	2.Well
	3.Average
	4.Little
16.Was it serious threat to the physical or mental well being of the child	1.VeryWell
	2.Well
	3.Average
	4.Little
17. Was it for avoiding more children	1.VeryWell

2.Well

3.Average

4. Little

18. If spontaneous ,was it due to
physiological and gynecological reasons 1.Verywell

2.Well

3.Average

4.Little

19.It was due to psychological reasons 1.Verywell

2.Well

3.Average

4.Little

20.It was due to lack of proper care 1.VeryWell

2.Well

3.Average

4.Little

21. Who influenced your induced abortion 1.Self

2.Husband

3.Both

4.Parents

22. Is this first abortion 1.Yes

2.No

23. If no,then how many 1.2

2. 3

3.4

4.More than 4

24. Did you feel inferiority complex
after abortion 1.Yes

2.No

25. Did you feel hormonal imbalance after

abortion? 1.VeryWell
2.Well
3.Average
4.Little

26. Did you feel differences in menstruation after abortion?
1.VeryWell
2.Well
3.Average
4.little

27. Did you feel bleeding/infection after abortion?
1.Yes
2.No

28. Did you feel psychological problems like tension/depression etc?
1.VeryWell
2.Well
3.average
4.Little

29. Did you feel inter personal relationship in family after abortion?
1.VeryWell
2.well
3.Average
4.Little

30. Did you feel interpersonal problems in society after abortion?
1.Verywell
2.well
3.Average
4.Little

31. Did you feel that the abortion is costly?
1.VeryWell
2.Well
3.Average

4.little

32. Did you face economic problems due to abortion like loss of job etc?

1.VeryWell

2.Well

3.average

4.Little

33. What are the benefits of abortion for you?

34. If induced, what kind of method did you use? 1.Mannual

2. Medicine

35. Write here if any other than given above.

Interview Schedule for General Women

I.Personal Data

1. Name and Address	
2. Age	1.15-25 Years
	2.26-35 Years
	3.36-45 Years
	4.Above 45 Years
3. Marital Status	1.Married
	2.Unmarried
	3.Separated
	4.Divorced
	5.Widow
4. Education	1.Illiterate
	2.Literate
	3.Primary
	4.Upper primary
	5.Secondary
	6.SSLC
	7.+2
	8.Graduate
	9.Post-graduate
	10.Professional
	11.Technical.
5. Religion	1.Hindu
	2.Christian

	3.Muslim
6. Caste	1.forward
	2.Bacward
	3.SC/ST
7. Occupation	1.Govt/Pvt.Employee
	2.Student
	3.Businuss
	4.Farmer
	5.Unemployed
	6.Labourer
8. Personal Income	1.Below10,000/-
	2.10001-35000/-
	3.35001/-60000
	4.60001/-85000/-
	5.85001/-1,10000/-
	6.Above1,10000/-
	7.No Income
9. Family Income	1.Below10,000/-
	2.10,001/-35,000/-
	3.35,001/-60,000/-
	4.60,001/-85,000/-
	5.85,001/-1,10000/-
	6.Above 1,10000/-
	7.No Income.
10. No. of members	
in the family	1. 1-3
	2. 4-6
	3. 7-9
	4. Above 9
11. Number of children	1.Nil

2. 1

3. 2

4. 3

5. 4

6. Above 4

Abortion Practices

12. Have you heard about the term abortion?

1.VeryWell

2.Well

3.Average

4.little

13. If yes, where did you get the information?

1.VeryWell

2.Well

3.Average

4.little

14. Have you heard about the term spontaneous abortion?

1.VeryWell

2.Well

3.Average

4.little

15. Have you heard about the term induced abortion?

1.VeryWell

2.Well

3.Average

4.little

16. Do you accept that the termination of pregnancy before 20th week of gestation can be called as abortion?

1.VeryWell

2.Well

3.Average

4.little

17. Do you accept infertility, bleeding, insection, frequent abortion, differences in menstrual cycle and hormonal imbalance are the problems associated with the abortion?

1.VeryWell

2.Well

3.Average

4.little

18. Do you accept that B.P., diabetes, heart diseases and other gynaecological problems may cause abortion?

1.VeryWell

2.Well

3.Average

4.little

19. Do you accept that the lack of physical care, psychological problems and young and old may cause abortion?

1.VeryWell

2.Well

3.Average

4.little

20. Have you heard about the MTP Act?

1.VeryWell

2.Well

3.Average

4.little

21. Do you accept that if the parents do not want a child, pregnancy is a

threat to the mother and it is due to
rape she can abort? 1.VeryWell
2.Well
3.Average
4.little

22. Have you heard about the medicinal
and manual methods of abortion? 1.VeryWell
2.Well
3.Average
4.little

23. Do you favor induced abortion? 1.VeryWell
2.Well
3.Average
4.little

24. Do you accept induced abortion
as a last resort? 1.VeryWell
2.Well
3.Average
4.little

25. Do you think that the induced abortion
is against the ethics and codes
of religion? 1.VeryWell
2.Well
3.Average
4.little

26. Do you think that the most of the
women use manual abortion? 1.VeryWell
2.Well
3.Average
4.little

27. Do you think that the most of the
women use medicines for abortion?

1.VeryWell
2.Well
3.Average
4.little

28. Do you consider that the abortion
rate is increasing today?

1.VeryWell
2.Well
3.Average
4.little

29. If yes, whether this is more
among teenage girls?

1.VeryWell
2.Well
3.Average
4.little

30. Do you know the various contraceptive
methods to avoid pregnancy?

1.VeryWell
2.Well
3.Average
4.little