EXPERIENCE OF PREGNANCY LOSS AND HEALTH SERVICE ACCESS: A CASE STUDY OF DISTRICT KUPWARA, JAMMU AND KASHMIR

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Dedicated to

The women of the world who have, at any point, experienced pregnancy loss

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
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DECLARATION

This is to certify that the dissertation/thesis titled, "***Experience of pregnancy loss and health service access: A case study of district Kupwara, Jammu and Kashmir***" submitted by Mr/Ms.**RAFIA FAROOQ** in partial fulfilment of the requirements for award of degree of M.Phil/M.Tech/**Ph.D** of Jawaharlal Nehru University, New Delhi, has not been previously submitted in part or in full for any other degree of this university or any other university/institution.

Rafia Farooq

We recommend this thesis/dissertation be placed before the examiners for evaluation for the award of the degree of M. Phil/M. Tech/**Ph.D**.

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Date: 21st June 2022

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ACRONYMS AND ABBREVIATONS

AGI	Alan Guttmacher Institute
AIDS	Acquired Immuno-deficiency Syndrome
AMA	American Medical Association
AMA	Australian Medical Association
ANC	Ante- Natal Check-up
ANM	Auxiliary Nursing Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
ATM	Automatic Teller Machine
B.Ed.	Bachelor of Education
BPL	Below Poverty Line
BUMS	Bachelor of Unani Medicine Surgery
CEDAW	Convention on the elimination of all kinds of Discrimination Against Women
CFPB	Central Family Planning Board
CHC	Community Health Care
CPC	Criminal Procedure Code
CPR	Contraceptive Prevalence Rate
CSR	Child Sex Ratio
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
DLHS	District Level House Hold Survey
ECG	Electro Cardiogram
FMPHW	Female Multi-Purpose Health Worker
GRHS	General Reproductive Health Survey
HIV	Human Immuno Deficiency Virus
HW	Health and Wellness Centre
ICHR	International Conference on Human Rights
ICPD	International Conference on Population Development
IDHR	International Declaration of Human Rights
IIPS	International Institute of Population System
IPC	Indian Penal Code
ISM	Indian System of Medicine
IUD	Intra-Uterine Device
JKB	Jammu and Kashmir Bank
JKSRLM	Jammu and Kashmir Rural State Livelihood Mission
JSY	Janani Suraksha Yojna
LHV	Lady Health Visitor
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCH	Maternal and Child Health Services
MLA	Member of Legislative Assembly
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NHP	National Health Policy
NHS	National Health System
NITI	National Institution for Transforming India
NRHM	National Rural Health Mission
NRI	Non-Resident Indian

NRLM	National Rural Livelihood Mission
OBC	Other Backward Class
OPD	Out Patient Department
PDP	People's Democratic Party
PHC	Primary Health Centre
PMJAY	Pradhan Mantri Jan Arogya Yojna
PPF	Planned Parenthood Federation
RCH	Reproductive and Child Health
RCOG	Royal College of Obstetricians and Gynecologists
RGI	Registrar General of India
RPL	Recurrent Pregnancy Loss
RPOC	Retained Products of Conception
RTO	Regional Transport Officer
SC	Scheduled Caste
SDG	Sustainable Development Goals
SHG	Self Help Group
ST	Schedule Tribe
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
USA	United States of America
USG	Ultra-sonography
WFS	World Fertility Survey
WHO	World Health Organization
WPP	World Population Plan
ZEO	Zonal Education Officer
BRGFP	Backward Regions Grant Fund Programme

ABSTRACT

THESIS TITLE: EXPERIENCE OF PREGNANCY LOSS AND HEALTH SERVICE ACCESS: A CASE STUDY OF DISTRICT KUPWARA, JAMMU AND KASHMIR

Although the national surveys like the national family health survey provide us with quantitative data about the reproductive health status of women of Jammu and Kashmir, however, there have been no attempts in the past to comprehensively study the lived experiences of women facing pregnancy loss in any part of Jammu and Kashmir. The current study attempts to gain insight into the experiences of women facing pregnancy loss and their access to reproductive healthcare services in Drugmullah village of the frontier district of Kupwara, Jammu and Kashmir using a mixed qualitative-driven quantitative (Qual→Quan) approach. The qualitative part of the study included 30 respondents between the age of 13-45 years from whom information was collected following in-depth semi-structured interviews. The quantitative part included a General Reproductive Health Survey (GRHS) of 100 women of the village which attempted to reveal the general reproductive health status of women of the village and also evaluate their access to available healthcare facilities.

The qualitative part of the study revealed that despite the knowledge and easy availability of contraceptives, reluctance shown by men to use contraception or practice *coitus interruptus* was widely observed in the study area, which likely resulted in unwanted pregnancies that were consequently self-aborted. Most self-induced abortions had taken place using abortifacients fetched by the spouse or an acquaintance from local pharmacies. Contraception failures arising from low-quality condoms procured from village PHC and poorly installed Copper-T resulted in unintended pregnancies. Interestingly, lack of facility to dispose-off condoms was also reported as one of the reasons for their limited use. It was observed that male sterilization was not practised as a method of birth control, unlike female sterilization, which was still somewhat practised. Although the respondent mostly

decided to abort, such decisions were usually influenced by socio-economic conditions like poverty, family engagements or young children at home. However, the decisions regarding general reproductive affairs like planning a child, use of contraception, number of children, and spacing between children were mostly taken by men. The quantitative study also revealed that most abortions (66.6%) were found in women from lower-income groups (0.6 to 0.9 Lakhs of annual income). Such respondents faced a moral dilemma and a strong sense of guilt and grief before and after inducing abortion, respectively. Further, the respondents maintained secrecy around the episodes of self-induced abortion which consequently fetched them limited social support and medical care. Interestingly, a cathartic feeling was observed in women during their narration of the episodes of pregnancy loss irrespective of the type of abortion they had suffered. A strong feeling of grief followed by vivid memories of the episodes of spontaneous abortion along with the associated emotional and physical pain was also observed. Such women had often associated their pregnancy loss with the routine heavy work like fetching heavy firewood or water from long distances apart from doing household chores. More than half of the respondents who had suffered spontaneous abortion belonged to the lowest income group. Irrespective of the type of abortion, the respondents enjoyed limited social support before and after abortion. For post-abortion procedures, the healthcare facilities were reasonably accessed by women after spontaneous abortion. At the same time, most women who induced abortion had also accessed healthcare facilities after citing "spontaneous abortion" as a reason. Most respondents accessed healthcare facilities post-abortion for dilatation and curettage, intra-uterine infections, haemorrhage and abdominal pain.

The quantitative study data revealed that 64% of participants had regular menstrual cycles at the time of marriage, and 67% had conceived within one year of the consummation of marriage, indicating a relatively good reproductive health status of the women. It was observed that 60% of participants had a planned first pregnancy while 84% had an unplanned second or subsequent pregnancy. The decisions about reproductive affairs were mostly (73%) taken alone by the participants, which was in agreement with women's experiences

concerning decision-making. For ante-natal check-ups, 78% of the participants had accessed government healthcare facilities during their last pregnancy, out of which 75% had visited the village PHC four or more times. Further, four or more than four antenatal visits were observed in 67% of participants who had either never attended school or attended school up to 9th grade. It was also observed that 73.6% of participants in the scheduled tribe population had undergone either one or no ultrasonography scans during their last pregnancy compared to 51% from the general population and 31.5% from social caste. Public healthcare facilities were more or less uniformly accessed by all the social groups, likely because of the centrally-placed PHC in the village. Most of the deliveries were institutional and had been performed through a usual vaginal route which is in stark contrast to the trend observed in urban areas of Jammu and Kashmir, where most of the deliveries are performed through lower segment caesarean section. Higher percentages of stillbirth and infant/child mortality were observed in schedule tribe groups compared to other groups. Overall, the quantitative part of the study revealed that most participants possessed fairly good reproductive health status. Further, the access to general reproductive healthcare in the village was also found to be satisfactory, although a lack of some basic facilities in terms of infrastructure and human resources in the village PHC was noticed.

Overall, the current study revealed: a low contraceptive prevalence rate in the study area, limited or no social support enjoyed by women facing pregnancy loss, moral dilemmas experienced by women before inducing abortion and feelings of guilt or grief post-abortion followed by sustained and vivid memories of the events of pregnancy loss in women. The study further revealed that women fairly accessed healthcare facilities during their pre and post-partum periods, however, the number of women facing pregnancy loss was very high, which was likely because of the limited awareness about contraception and poor healthcare infrastructure.

CHAPTER 1

INTRODUCTION

Pregnancy may end in many ways: a live birth, an induced abortion, or any form of perinatal loss that could occur during or after pregnancy (Studnicki et al., 2019). Although augmentation in the quality of healthcare has considerably reduced perinatal mortalities as well as adverse outcomes of pregnancy, however, despite the medical progress made yet, nearly 20-32% of pregnancies end in miscarriages (Patki et al., 2016; Simons et al., 2006; Maconochie et al., 2006). Pregnancy is undoubtedly an unpredictable and complex biomedical process. However, its context encompassing a range of social determinants that can significantly influence the fate or emotional status of the women facing adverse pregnancy outcomes has been incomprehensively studied. Medical management of miscarriage is done with ease; however, family and friends often dismiss its emotional impact on women (Boyle et al., 2000). Previous studies have revealed that women who experience pregnancy loss go through severe psychological distress accompanied by feelings of anxiety, grief and guilt, which can consequently lead to clinically significant depression, thus affecting their mental health (Farren et al., 2019; Reardon, 2018; Collins et al., 2014; Evans et al., 2002; Lauzon et al., 2000). Although guilt and shame have been found to be associated more with the women who induce abortion, higher anxiety scores have also been found in women who induce an abortion compared to those who have had a miscarriage (Broen et al., 2005).

Knapp (1980) reports that the development of this perinatal bond through attachment and investments made by the mother occurs through a series of events, which are “(a) planning the pregnancy (b) confirming the pregnancy (c) accepting the pregnancy (d) feeling foetal movement (e) accepting the feotus as an individual (f) giving birth (g) seeing the baby (h) touching the baby (i) and giving care to the baby” (Pepppers &

Knapp, 1980, p.59). Therefore, the perinatal bond that develops between the mother and the foetus might largely depend on the investments made by the mother in her pregnancy. Consequently, the differential reaction among women to their pregnancy loss has been observed by various researchers, which, they say, considerably depends on the level of commitment of the mother to the mother-foetus attachment and the investments she makes to carry the pregnancy (Shreffler, Greil and Julia, 2011).

However, other scientific studies have revealed that the level of distress caused by a miscarriage is independent of the length of pregnancy (Jackman et al., 1991; Prettyman et al., 1993). Nevertheless, in the event of a pregnancy loss, a distressful emotional reaction from the mother is expected in terms of her experiences of investment in pregnancy which could be: treatment of in-fertility, time and efforts put in to conceive, attachment developed to the foetus, and social expectation about bearing a child (Bennet et al., 2005 in Shreffler, Greil and Julia, 2011).

Social determinants of reproductive health influence women's wellbeing in terms of their life chances and access to knowledge and power (Mc Court, 2014; Kiani et al., 2016). Due to gender bias, pregnancy loss often becomes replete with individual, social, cultural, medical and economic connotations. Such factors reportedly affect the psychological response of the women to pregnancy loss (Shreffler, Greil and McQuillan,2011) and therefore reporting experiences of women facing pregnancy loss in a specific social context not only adds to the existing experiential knowledge on perinatal losses but also help us to explore the roles of various socio-medical factors leading to the loss. The documentation of experiences of women facing pregnancy loss can assist policy-makers in devising strategies that include provisions for proper medical care and incorporation of counselling and psychological support for such women in a given healthcare system (Aydin et al., 2019).

While studying lived experiences of women of a specific geographical region who face pregnancy loss is extremely important, the availability of supporting quantitative data of the region indicating access to basic reproductive healthcare facilities (ante-natal check-ups, vaccinations of pregnant women, ultra-sonographic scans, micronutrient supplementation and delivery) can add more value to a study (Van den berg et al., 2018).

Although Jammu and Kashmir has an average reproductive health coverage compared to other states, however, Kupwara district fares low in terms of various reproductive indices and human development indices like low literacy, skewed sex ratio, low institutional deliveries, low contraceptive prevalence rate, pregnancy-related complications, post-abortion complications, according to the latest NFHS survey (IIPS,2010; Directorate of Census Operations,2011; IIPS,2016). Pregnancy loss, which is still perceived as taboo, has been documented in national family surveys; however, the experiences of women, rural in particular, facing such losses are yet to be reported from any part of Jammu and Kashmir. The presence of a relatively complex social structure, low socio-economic indices, low access to healthcare and adverse reproductive outcomes in women of the frontier district of Kupwara makes this region appropriate for studying the lived experiences of pregnancy loss faced by its women. To the best of my knowledge this is the first study of its kind in any part of Jammu and Kashmir which attempts to unravel the experiences of women who have faced pregnancy loss followed by the study of access of women of the region to reproductive healthcare.

CHAPTER II

REVIEW OF LITERATURE

Pregnancy Loss

Globally, 20-25 per cent of women experience pregnancy loss in the form of spontaneous abortions, induced abortions, stillbirths, ectopic pregnancies and neo-natal deaths (Bagchi & Friedman, 1999; Coute-Arsenault & Denato, 2007; Yilmaz & Beji, 2012; Sapra et al.,2017; Rossen,2018; Linnakaari et al., 2019). According to World Health Organisation (WHO), each year, about 210 million women become pregnant, and about 133 million among them (two-thirds) deliver live infants. The remaining one-third of pregnancies, which is 78 million, resulting in miscarriage, stillbirth, or induced abortion (WHO, 2005). According to the World Fertility Survey[1] (WFS) programme, pregnancy loss accounts for 50-80 per cent of foetal deaths the world over. 9 to 13 per cent of women experience at least one pregnancy loss, 5 per cent face at least two pregnancy losses and 1 -2 per cent face at least three pregnancy losses in their lifetime (Casterline, 1989). Most of the pregnancy losses happen only weeks after conception, making up to 70 per cent of the total pregnancy loss (Jarvis, 2017). Twenty-five per cent of the couples who plan for pregnancy will at least experience one miscarriage, according to some studies (Casikar et al., 2012; Jurkovic, Overton& Bender-Atik,2013).

The WHO classifies foetal deaths into three categories based on the gestational age of the lost foetus. *Early foetal death* where the foetal age is 20 weeks or less, *late foetal death* where the foetal age is 20-27 weeks and *stillbirth* where the foetal age is 28 weeks or more (WHO, 1970).

[1]"Estimates of levels and differentials of pregnancy loss are presented for 40 developing countries participating in the World Fertility Survey (WFS) program. Judged against agreed-upon levels of spontaneous loss in human populations, WFS surveys measured from 50 to 80 percent of recognizable losses. The coverage of induced abortions appears to be much worse. Consistent with data from other sources and settings, the probability of loss is strongly correlated with maternal demographic characteristics: age, pregnancy order, pregnancy spacing, and pregnancy loss history. Despite incomplete coverage, the WFS data on pregnancy loss provide considerable, and largely unexploited, insight on the dynamics of the reproductive career" (Casterline,1989, p,81).

Nevertheless, the exact figures for pregnancy loss are difficult to ascertain, given that many pregnancies end before implantation. Clinical studies have proved that about 60 per cent of fertilised ova will not mature into a live birth (Gray, 1983; Pinar et al.,2018; Strumpf,2021). It has been reported that 25 per cent of pregnancy loss is not recognised because there will be no monthly delay in menstrual cycles (Lerido, 1977; Jauniaux & Burton,2005). A woman cannot recognise implantation failure as the slight delay in the menstrual period gets ignored in all the studies on the incidence of pregnancy loss (WHO, 1971).

Although there has been considerable progress in the study of foetal development, the aetiology of most pregnancy losses remains uncertain. Saito et al. (2005) argue that pregnancy loss is a multifactorial condition ranging from genetic predisposition and socio-economic status to environmental factors (Saito et al., 2005). It has been established that there is a consistent association between adverse pregnancy outcomes and biological, social and environmental factors (Kebede et al., 2018). Lynch et al. (2001) opine that adverse pregnancy outcomes are also associated with demographics, socio-economic conditions, income inequality, marital status, maternal education and pregnancy intention (Lynch et al., 2001). The chances of pregnancy loss tend to increase with old age pregnancies, pregnancies of a higher order[2] and in women with a history of recurrent pregnancy loss (Casterline, 1989; Lindsay & Vitrikas,2015).

Several studies confirm a strong correlation between socio-economic disparities and pregnancy outcomes, yet this relation is understudied (Hegelund, Poulsen & Moetensen, 2019). In 2002, a study by Alan Guttmacher Institute (AGI) concluded that economically marginalised women with low income and low educational levels are more likely to go for induced abortions (Jones et al., 2002). A study involving 629 women out of whom 298 had

[2] Multiple pregnancies with two or more than two fetuses.

experienced adverse pregnancy outcomes revealed that socio-economic conditions not only affect pregnancy outcomes but there is also a significant association between the educational levels and nature of work women are involved in (Naik et al., 2016).

Spontaneous Abortion: Definition and Extent

According to the Royal College of Obstetricians and Gynaecologists (RCOG), Green-top Guideline No. 17[3], a spontaneous abortion[4] is defined as a spontaneous loss of pregnancy before the foetus has reached the gestational age of 24 weeks (RCOG, 2011). Spontaneous abortion also understood as miscarriage, is defined by Hall, Beresford and Quinones (1987) as an unexpected ending of pregnancy before the time of foetal viability (Hall, Beresford & Quinones,1987). Spontaneous abortion is also defined as a non-viable intrauterine pregnancy that lasts up to 20 weeks of gestation (Prager, 2021).

Worldwide, 15 per cent of pregnancies end in miscarriages that mostly happen in the first trimester (Cook, Dickens & Fathalla, 2003). Of all pregnancies, 1-2% of miscarriages are habitual[5]. Some studies establish that miscarriages happen in the 12th week of pregnancy (Cramer & Wise, 2000; Regan & Rai, 2000; Ford & Schust,2009). Maternal age and previous history of miscarriages are generally considered risk factors where the risk of a miscarriage ranges from 20-70 per cent (Regan & Rai, 2000). However, a rare study by Brian et al. (2019) concluded that independent of selected factors, including demographics, pregnancy intention, and maternal age, advanced paternal age might also increase the odds of spontaneous abortion (Brain et al.,2019).

As mentioned earlier, even if there has been much progress in understanding the development of pregnancy and the epidemiology of RPL, the aetiology of pregnancy loss

[3] Green top Guideline No. 17 provides guidelines on the investigation and treatment of couples with habitual first trimester pregnancy loss or more than one second trimester pregnancy loss.
[4] Spontaneous abortion and miscarriage will be used interchangeably throughout the work.
[5] "Recurrent pregnancy loss (RPL), also referred to as *recurrent miscarriage* or *habitual abortion*, is historically defined as three consecutive pregnancy losses prior to 20 weeks from the last menstrual period" (Ford & Schust,2009, p.76).

remains uncertain. A study carried out by Sonal et al. (2008) demonstrated that 300 out of 602 women miscarried with no conclusive gynaecological and hormonal reasons or karyotype condition[6] (Sonal et al., 2008). However, karyotype analysis is still considered to help confirm causes of recurrent pregnancy loss (Rajashekhar et al., 2013) because 50 per cent of pregnancy losses are attributed to a chromosomal abnormality called aneuploidy (Colley et al., 2019).

Miscarriages have been classified into three categories: Paternal as caused by the factors linked to the father's physiology, maternal as caused by the factors linked to the mother's physiology and foetal as caused by the factors linked to foetal physiology. *Maternal causes* of abortion may be classified as esoteric and exoteric causes. Among the esoteric causes (internal causes) are backward displacement of the uterus, chronic matriosis[7] or endometriosis[8] and lacerated cervix are the leading cause of spontaneous abortion. Exoteric causes (external causes) include profound sorrow, uncontrollable grief, or any other traumatic experience. Exoteric causes also include external harm faced by the mother due to physical accidents or injury. *Paternal causes* include sexually transmitted diseases like syphilis, causing a severe infection that results in miscarriage. The *foetal reasons* for miscarriage are always pathological, affecting the germ cells, foetal appendages, and placenta (Saito et al., 2005).

Other reasons for spontaneous abortion are genetic and chromosomal causes (Murugappan, 2021).Translocation[9], a genetic disorder, is another cause for miscarriage where embryo receives less or more genetic material. Hormonal Abnormalities include luteal

[6]The analysis of genome or chromosomes which are the carriers of genetic material.
[7]Inflammation of uterus
[8]Inflammation of the endometrium, the inner lining of uterus.
[9]According to Free Dictionary by Farlex, translocation is the transfer of one part of a chromosome to another part of the same or a different chromosome, resulting in rearrangement of the genes.

phase deficiency where progesterone[10] is produced at low levels. Low insulin resistance and polycystic ovarian syndrome are enumerated as metabolic abnormalities that increase the chances of miscarriage. Uterine Abnormalities include uterine distortions like double uterus, uterine septum, uterus where only one compartment is formed, a scar in the uterine cavity (Asherman's syndrome), uterine fibroids and uterine polyps. is also one of the causes of miscarriage. Thrombophilia, where blood clots are formed, is an inherited disorder causing pregnancy loss in the second trimester. Another disorder referred to as the male factor responsible for miscarriage is when male sperm DNA[11] does not remain in its original form. Dietary factors like lack of folate[12] can cause homocystiene[13] levels to increase that can lead to recurrent pregnancy loss. Foetal alcohol syndrome[14] and obesity also account for reasons for miscarriage (Saito et al., 2005). Yet causes of 50-75 per cent pregnancy loss remain unexplained (Check, 2005; ASRM, 2008; Ford & Schust,2009; Shina & Carp,2012; Shahine&Lathi,2015).

Induced Abortion: Definition and Extent

According to WHO, "induced abortions are those initiated by deliberate action undertaken with the intention of terminating a pregnancy" (WHO, 1970; p, 6). Induced abortion is also defined as the expulsion of a foetus or an embryo from the uterus before it is viable (Grimes, 2010). Abortion, both in legal and obstetric terms, is generally applied to the premature expulsion of the product of conception before the 28th week of pregnancy (Chandrasekhar, 1994; p, 1).

[10]Progesterone is a hormone which is produced by ovary after ovulation. The hormone is very important for ahealthy pregnancy.
[11]Dioxy-ribo- nucleic acid is a blue print of genetic material.
[12] Folate is a substance which is very important for the maintenance of pregnancy. Folate is found naturally in vegetables, fruits and wholesome grains. The right amount of folate keeps the pregnancy maintained in terms of production of new cells of foetus.
[13]It is a kind of amino acid (unit of protein).
[14] Child that results from alcohol exposure during the mother's pregnancy (Mayo Clinic).
at https://www.mayoclinic.org/diseases-conditions/fetal-alcohol-syndrome/symptoms-causes/syc-20352901

According to WHO, globally, fifty million, i.e., 25 per cent of pregnancies per year, end up in induced abortions. It is estimated that 35 abortions per 1000 women aged between 15 and 44 occur yearly. Sedgh et al. (2016), in their study, calculated that 56.3 million women experienced abortion between 2010 and 2014 (Sedgh et al., 2016). Between 2015-2019, worldwide, 73.3 million induced abortions have taken place. There have been 39 per thousand induced abortions in women aged 15-49 years globally (Bearak et al.,2020). Induced abortion is considered one of the significant contributors to maternal mortality. One in every 7-8 deaths is caused by abortion-related complications (WHO, 2011). Out of abortion-related deaths, induced abortion accounts for the leading cause of maternal mortality (Berer, 2000). Ninety-eight per cent of unsafe abortions occur in developing countries with low socio-economic indicators (Dastigiri et al., 2017). As a result of unsafe abortions, 400 deaths per 100000 of population occur in the developing countries, which amounts to 80,000 deaths yearly (Berer, 2000). Globally, between the years 2010-2014, 25 per cent of pregnancies ended up in induced abortions (Guttmacher Institute, 2016).

It has been observed that unintended pregnancy is one of the primary reasons behind induced abortions. Unintended pregnancies occur not only because of unsafe sex but also because of the unmet need for contraception. About 82 per cent of women of reproductive age in developing countries have been observed to have an unmet need for contraception, resulting in unintended pregnancies and consequently forcing women to undergo induced abortions (Guttmacher Institute, 2012). Globally, from 2015-2019, there have been 121.0 million unintended pregnancies each year, equal to an annual rate of 64 unintended pregnancies per 1000 women aged 15-49 years (Bearak et al., 2020). Unintended pregnancy can happen because of non-use of contraceptive methods, unawareness about contraception, inefficient use of contraception, indecision about the method of contraception, partner unwillingness, lack of knowledge about safe periods and contraception failure (Binette et

al.,2017; Loeber & Muntinga,2017; Penfold et al., 2018). The fertility regulating methods offered by planners and policymakers are sometimes ineffective in regulating fertility. These factors lead to unwanted pregnancies and consequently induced abortions (Indriso & Mundigo, 1999).

Socially speaking, induced abortion is a complex phenomenon which gives rise to contestation within a family, and it raises questions about the motherhood and sexuality of women (Keown, 1988). The social context of induced abortion varies from financial reasons, multiparity[15], sex-selective abortions, becoming pregnant after a short interbirth interval, becoming pregnant soon after marriage, failure of contraceptive method, the husband being infidel or suspecting husband's fidelity, extra-marital pregnancy, pregnancy due to rape and all other circumstances that lead to unwanted pregnancy (Barge et al., 1997; Jejeebhoy, 1998; Sinha et al., 1998 in Johnston, 1999).

Experience of Pregnancy Loss: Beyond Statistics

Van der Sijpt (2010) views pregnant women as "social bodies" embedded and enmeshed with their social relationships, more so in the arenas of gender, marriage and kinship (Van der Sijpt,2010). He further argues that seeing pregnant women as having social bodies helps us understand reproductive notions, behaviour and decisions surrounding pregnancy and its loss (Van der Sijpt,2010). Pregnancy loss is not only categorised as a biomedical condition but also as a social process where decisions made by women are contingent upon the larger social structure. Social structure and gender are intertwined so that one influences the other. Anthony Giddens (1984) conceives of social structure as created by human actions. Structures act upon humans, and humans act upon social structure reciprocally. Hence, the concept of gender is embedded in the social processes and the social institutions from which emanates the actions of individuals (Lober, 1994). Since pregnancy and childbirth are

[15] Multiparity means having given birth to more than one child.

embedded in a particular cultural value system, it is being appropriated and controlled by the patriarchal structure of the society (Symonds, 1996).

Therefore, pregnancy and coping with pregnancy loss are shaped by conditions like culture, religion, race, health status, social support and previous experience (Kerstin et al., 2007). The experience of pregnancy loss is "socially constructed and depends on the specific combination of possibilities and constraints a situation presents to a woman who finds herself pregnant or, indeed, faced with pregnancy loss" (Sijpt, 2010, p. 1775). Nevertheless, women respond differently to pregnancy loss. Some women go into social isolation, while some seek the company of their loved ones (Madden 1984). Women generally tend to remain silent about their pregnancy loss which multiplies their pain and grief. Mahan and Calica (1997) argue that pregnancy loss cannot be equated with any other loss that necessitates additional support (Mahan & Calica, 1997). A recurrent pregnancy loss can affect the mother's antenatal attachment with the foetus (Yilmaz & Beji, 2013).

Pregnancy loss is not only a medical condition; it has economic, social and psychological ramifications (Liefer, 1980; Warren & Haren, 1971; Deutsch, 1945). There is a positive association between pregnancy loss and the psychological health of women (Mota et al., 2010). Pregnancy loss makes women prone to clinically significant depression, anxiety, psychiatric disorders and experiences of grief, self-doubt, guilt and post-traumatic stress disorder (PTSD) (Bagchi & Friedman, 1999; Yilmaz & Beji, 2012; Robinson, 2014). Pregnancy loss is related to women's emotional and psychological health (Bagchi and Friedman, 1999). A study using Standard Present State Examination[16] method ascertained

[16]According to Encyclopedia.Com, Present State Examination is a test developed by psychiatrist John Wing and colleagues at the Maudsley Hospital in Britain in the 1960s. The aim was to facilitate the standardized identification of psychiatric cases and to improve psychiatric classifications, both for research and clinical purposes. The test is designed to assess the individual's present mental state (questions refer to the past month only) in order to identify any mental pathology. It involves a standard checklist of items, though some flexibility is allowed in questioning, especially in follow-up questions. Interviewers have to be trained but do not have to be psychiatrists. At http://www.encyclopedia.com/doc/1O88-PresentStateExamination.html. Accessed on 06/03/2014

that even after four weeks of pregnancy loss, women experienced depression (Friedman, 1989).

According to Frost et al. (2007), the experience of pregnancy loss is divided into three categories. The pre-modern approach attributes pregnancy loss to nature and destiny, hence embedded in religious beliefs. Second, women tend to make meaning of their pregnancy loss based on scientific and modern knowledge. Third, the post-modern approach holds modern scientific knowledge as imperfect and believes in the randomness of life. Michel Foucault calls pregnancy loss a '*triple edict of modern puritanism'*, which includes taboo, non-existence and silence. Michel Foucault claims that silences are integral to strategies that underlie and permeate discourses (Foucault, 1980; p.5).

Linda Lyne's auto ethnography connects her lived experience of miscarriage to silence (Layne, 1997). She narrates that people who came to see her on pregnancy loss behaved as if nothing significant had happened. Instead, people would tell her that non-conceiving was more of a horror than pregnancy loss which is regular and routine. Not only the social interpretation but also the biomedical event of pregnancy loss is such that the medical fraternity understands miscarriage as a mild event and does not associate emotions with it. Culturally too, pregnancy loss is taken as a mild event. As the experience of miscarriage is denied altogether, women often do not disclose their pregnancy until the first trimester (Layne, 1997).

A study in based in the UK observed that women who faced miscarriage came to the hospital during unsocial[17] hours. They were made to wait in the hospital setting as doctors treated them as routine patients, denying their traumatic experiences (Friedman, 1989). The hospital staff cannot understand the feelings of women who have undergone pregnancy loss

[17]Women were found to find time in which there was not so much rush of people in order to make themselves feel comfortable.

(Breir, 1999). The experience of pregnancy loss is taken as something from which women may recover. Moreover, professional caregivers also assume that there will not be any psychological impact on women (Freidman, 1989). The women are neither treated as grieved mothers nor patients (Linda, 1997). The biomedical intervention has created expectations that technological advancement will eliminate the chances of pregnancy loss. On the other hand, biomedicine completely ignores the pre-natal bonding between the mother and the foetus, conforming to the view that pregnancy loss is a natural protection against the adverse consequences of mistakes [genetic abnormalities] that could have taken place at the time of conception (Pizer & Palinski, 1981).

Historical Development of Attitudes Towards Induced Abortion

Religion presents one of the significant challenges to the advocates of induced abortion. The Sumerian code of 2000 BC, Assyrian code of 1500 BC, Hammurabic Code of 1300 BC, the Hindu Code of 1200, Persian Code of 600 BC not only condemned but prohibited and punished the act of induced abortion (Chandershekhar, 1994).

Catholic Church does not allow induced abortion, and Islam prohibits induced abortion. However, the four schools of Islamic jurisprudence have a different takes on the issue of abortion (Hessini, 2007; Ekmeksi,2017).

The Parliament Act of 1623 of England reversed common law presumption of stillbirth and provided that, "if a woman concealed the death of her illegitimate issue so that it might not be known whether it had been born alive, she should suffer death for murder unless she could prove stillbirth" (Keown 1988, p. 6). Abortion was punishable before the statutory publication of the offence in 1803 in England. Lord Ellenborough's Act [18], passed in 1803, had provisions to restrict abortion. The law considered abortion a social problem, and if

[18] Lord Ellenborough's Act is also called as Bloody Act. It was passed in 1803 and there were ten laws in this act one of which included law on abortion which said that after quickening the abortion performed by a woman is a punishable act (Mendelson,2012).

anybody would abort a foetus after quickening[19],that was punishable with death (Mendelson,2012).

Basing its reasons on the moral implication of abortion, declining birth rate and migration of people from adjoining countries to Australia, the Australian Medical Association (AMA) passed a resolution in 1859 making abortion a criminal offence (Keown, 1988). The rhetoric of induced abortion got mixed up with racism, and physicians called women who aborted their babies barbarians. Fear was instilled among Protestant women that American civilization (Anglo-Saxon) would be taken over by Irish Catholics if they did not stop the practice of induced abortion (D'Emilio & Freedman 1988). Therefore, procreation was not only a familial function, but a duty of women toward the republic and abortion was a crime against the state (D'Emilio & Freedman 1988).

ABORTION IN MODERN TIMES

After World War II, the International Declaration of Human Rights (IDHR) was signed. The declaration in Articles1, 3, 12 and 23 determined what an individual's course of life and child-bearing should be. In 1968, the International Conference on Human Rights (ICHR) gave parents the right to *the number* and *spacing* of children. The World Population Plan of Action (WPP) agreed to the Bucharest Conference[20] and, in 1974, reaffirmed the right to abortion and expanded it. The WPP is legally binding upon all the nations that have ratified it. The convention affirms that there should be no inequality between men and women in accessing healthcare services, including those related to family planning. It also affirms that

[19]Time when women feel the movement of foetus.

[20]'The Third World Population Conference was organized by the United Nations and held in Bucharest, Romania, from 19 to 30 August 1974. This Conference, the first of an intergovernmental nature, was attended by representatives of 135 countries. The debate focused on the relationship between population issues and development. The outcome of the Conference, the World Population Plan of Action, states, among other principles, that the essential aim is the social, economic and cultural development of countries that population variables and development are interdependent and that population policies and objectives are an integral part (constituent elements) of socio-economic development policies (UN, n.d).

parties should ensure women free and proper healthcare and nutritional services during pregnancy confinement, post-natal period and lactation (Beryl, 1999).

The United Nations passed the elimination of all Forms of Discrimination against Women (CEDAW) in 1979. CEDAW rejects abortion as a method of family planning (Amnesty International, 2005). The practice of safe abortion was emphasised at the International Conference of Population and Development (ICPD) in 1994. As ratified by many countries, ICPD succinctly declares that abortion should not be used as a method of family planning (ICPD, 1994). The rules and regulations to stop the practice of unsafe abortion[21] that was on rise, particularly in developing countries, as it immensely contributes to the maternal mortality and morbidity, were laid down. The International Conference on Better Health for Women and Children through Family Planning occurred in Nairobi in 1987. In the conference, it was ascertained that no matter the legal status of abortion in a particular country, treatment of septic, incomplete abortion and counselling about post-abortion contraceptive methods should be the minimum basic available to a patient (International Conference on Better Health for Women, 1987). The World Population Plan and Action (WPP) principles emphasized in the International Conference of Population in Mexico in 1984 that the medical termination of pregnancy is not a method to control the population. However, it maintained that the frequency of induced abortion indicates unmet needs for family planning (Jagnayak, 2005). Even though there are international treaties and declarations, in the end, the national authorities are responsible for deciding when and how abortion is required. World Health Organisation (WHO) does not take any firm position on the said matter (WHO,1991). However, WHO links the right to a safe abortion with the right to life and is regarded as a component of comprehensive health care (McGovern et al.,2020).

[21]WHO defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skill or in an environment lacking the minimal standards or both (WHO, 2004).

GLOBAL PERSPECTIVE ON ABORTION

Abortion in the USA

In the United States, abortion has been a contentious issue for decades. The pro-life and pro-choice groups have been campaigning using media and law to ascertain their positions and to win legislative and public support (Strickler & Dengelis, 2002). In the US, Christian groups contest that abortion is a murder of foetus. On the other hand, feminists contend that it is a fundamental right of women to have control over their own bodies (Wack, 2008). Central to the debate in the US is the case of *Roe Vs Wade* in which the Supreme Court of US held that the abortion law of Texas is unconstitutional and is a violation to right to life. The abortion law of Texas was criminalised as it allowed abortion only to save the life of a mother (Strickler & Dengelis, 2002). American Medical Association (AMA) in 1958 campaigned to declare abortion a criminal act at any stage of foetal development. The law was passed almost in every state. It was argued that women who abort their babies are socially dangerous and are subverting the concept of motherhood (Biesel & Kay, 2004).

Many countries are legalising abortion taking into consideration specific amount of time within which a woman can abort a foetus. The debate between pro-life and pro-choice groups in the US has informed the American social and political life to an extent that Richard Dawkins in his famous book *Selfish Gene* (2006) writes…

> *Killing people outside war is the most seriously-regarded crime ordinarily committed. The only thing more strongly forbidden by our culture is eating people (even if they are already dead). We enjoy eating members of other species, however. Many of us shrink from judicial execution of even the most horrible human criminals, while we cheerfully countenance the shooting without trial of fairly mild animal pests. Indeed, we kill members of other harmless species as a means of recreation and amusement. A human foetus, with no more human feeling than an amoeba, enjoys a*

reverence and legal protection far in excess of those granted to an adult chimpanzee. Yet the chimp feels and thinks and may even be capable of learning a form of human language. The foetus belongs to our own species, and is instantly accorded special privileges and rights because of it. The war between anti-abortion groups and their opponents is America's new version of the terrible seventeenth-century European civil wars of religion. Opposing armies march down streets or pack themselves into protests at abortion clinics, courthouses, and the White House, screaming at and spitting on and loathing one another. Abortion is tearing America apart (Dawkins, 2006; p. 10).

The new abortion law was progressive as it allowed abortion up to third trimester. The law gave women greater space and span of time to go for abortion if they wanted to. Abortion debate, which is morally weighed, there has always been a need to strike balance between life of a foetus and life of a woman (Jotkowitz & Zivotofsky, 2010; Johari& Jadhav, 2017; Svenaeus,2018).

Abortion in Europe

In Europe codifying abortion laws started in 1970s and 1980s majorly on the grounds of; danger to women's health, psychological and mental health, unwanted pregnancy as a result of rape, risk of foetal malformation, socio-economic circumstance, medical and socio-medical condition (Roger, 1998).Despite the fact that abortion is legalised across Europe, women go for unsafe abortions due to crowded health facilities, unhygienic conditions in health institutions and unfriendly health service providers. It is estimated that 500000 to 800000 women go for unsafe abortions in Europe every year (Lazdane, 2005). In Eastern Europe[22] most of the maternal deaths are related to abortions. The Russian Federation is the

[22] There were 22.3 per cent of maternal deaths in Kazakhstan in 2003; 13 percent in Tajikistan; 6 per cent in 2002; 6 per cent in Armenia and 50 per cent of maternal deaths in 2003 in Republic of Moldova (Lazdane, in Entre Nous, 2005).

most affected area in terms of women going for unsafe abortion. Figure 1 shows the rate of abortion per thousand women aged 15-45 in European region.

Today almost in all the countries in Europe like Sweden, Norway, Denmark, Ireland, Netherlands, Germany, France, Switzerland, Italy and Spain, the abortion is allowed on request and on broad social and economic conditions (Abort Report.eu,2019;CPR,2020).

In the United Kingdom abortion laws were liberalised in 1967 after a sustained struggle for the same (Jesani & Iyer, 1993). In 1929, Infant Life Preservation Act was passed that made an exception to ban on abortion on the grounds of saving life of a woman. Due to ban on access to legal abortion in 19th and 20th century Britain, backstreet abortions were on the rise. In 1923-33, almost 50 per cent of maternal deaths were as a result of abortion. In 1959, Conference of Cooperative Women campaigned for the Abortion Reform Law (Abortion Rights, 2015). The law allowed abortion up to 20 weeks of gestational age. The British Medical Association (BMA), however, demanded that abortions be allowed only up to the gestational age of twenty weeks and only on the grounds of health of a woman or malformation of the foetus (Jesani & Iyer, 1993). Legal grounds on which abortion is sought in the European region is depicted in Figure 2.

In Germany abortion laws were influenced by Prussian[23]Penal Code that was highly restrictive. It prohibited abortion even in the case of women's life being under threat. During the Nazi regime in Germany contraception and birth control was banned. In the first half of 20th century, children were looked as natural resource in the form of soldiers. So, the pro-natalist polices were reinforced in Germany (Telman, 1998). In 1965, in Germany an epidemic of measles broke that resulted in the birth of babies with serious disabilities. Also, there was a highly publicised case of a woman who had an encounter with thalidomide

[23]It is the largest part of German Empire, the Weimar Republic and Nazi Germany from 1871 to 1945.

resulting in serious abnormality in her baby. These two cases intensified the abortion debate and catapulted it to a new high (Greenhouse & Siegel, 2012).

In Spain, the abortion movement started with the democratisation of Spain in 1978. Prior to that there was a decree in Catalonia during the civil war (1936-39) that allowed abortion on the grounds of health of a woman and foetal abnormality. A strong feminist movement against the criminalisation of abortion created a cleft in the right and left-wing parties. In 1983, Socialist Party in Spain presented a bill that intended to decriminalise abortion on the grounds of therapeutic, eugenic and ethical reasons (Greenhouse and Siegel, 2012). This bill was castigated by many parties and those who performed abortion were persecuted. In 1986, a regulation was passed that accredited abortion clinics which produced data on abortion. In the same year two socialist parties tabled a bill in the parliament to legalise abortion up to the gestational age of 12 weeks and also on the grounds of socio-economic status. Later in 1999, a parliamentary bill was passed that decriminalised abortion (Greenhouse and Siegel, 2012). Figure 3 depicts years in which abortion laws were liberalised across Europe.

Feminist Discourse on Induced Abortion

In the post war period discourses on human rights, women's rights and the environmental rights were fast emerging. This phenomenon was referred as the rise in *post-material values*[24] that demanded a political space in the mainstream discourse alongside the demand for space for physical needs of safety, security and survival. Thus, the post war period saw the second wave of feminism emerge as a new social movement that tried to redefine conventional practices and attitudes towards sexuality and abortion (Rendell,1985). The second wave of feminism raised the issues of quality of life that were rooted in educational changes of 1950s and 1960s. Debate and discourse on reproductive and workplace roles of women also started figuring in the public policy (Rendell, 1985). There was an emphasis on individual liberty

[24]These are the values in terms of self –esteem, self-expression and affection.

and it was ascertained that individual body and individual autonomy is all important. Some of the Western scholars argue that "it is at the heart of liberalism that the individual liberty is being celebrated. That is what Macpherson calls "possessive individualism" (Maclachlan, 1997, p. 176).

According to Shaver (1992),

"The assertion that a woman has the right to control her own body is an unambiguous statement of her proprietorship in her person, and the 'right to choose' an expression of her free will. These claims assume an essential individualism in which the woman properly acts in the pursuit of her own needs and wishes. Her rightful action is limited only by the freedom of others to do likewise" (Shaver,1992, p.11).

These developments nevertheless faced resistance from the advocates who regarded women as part of society having the essential function of reproduction. It was further argued that extreme individualism is precipitating in women and regulating the reproductive function on their own can be detrimental to the very social fabric (Nowika, 1996; Timpson,1996; Acevedo,1979; Macleod, Beynon-Jones &Toerien,2017; Ntontis& Hopkins,2018; Tadele et al., 2019).

Physicians of the 19th century argued that the social functioning of women is fulfilled only because of their reproductive capacity (Gordon, 1990). As one physician asserted that, abortion is "*a moral and social gangrene [that] pervades the community, and threatens its life, by destroying its very roots which nature intended should cluster around the domestic hearth*" (Biesel & Kay,1974, p.16). Horatio Storer [25]who was running anti-abortion campaign contended (about woman) that "what she is in health, in character, in her charms, alike of body, mind and soul is because of her womb alone" (Biesel & Kay,1974, p, 146).

[25] Horatio Robinson Storer was a surgeon and anti-abortion activist in the 1800s who worked in the of women's reproductive health and led the Physicians' Crusade Against Abortion in the US. Historians credit Storer as being one of the first physicians to distinguish gynaecology, the study of diseases affecting women and their reproductive health, as a separate subject from obstetrics, the study of pregnancy and childbirth.

The discourse on induced abortion can be classified into liberal (pro-choice approach), conservative (pro-life approach) and moderate approaches. Their individual positions are classified in Table 1.

The pro-choice approach that believes in non-personhood of embryo throws a challenge in making meaning of pregnancy loss. On the other hand, anti-choice approach that believes in the personhood of embryo right from conception upholds the painful experience of pregnancy loss. The feminist discourse on pregnancy and pregnancy loss, therefore, needs to be formed in a way that meaning of pregnancy and experience of pregnancy loss is validated. Pregnancy that is psychologically, physiologically and socially a functional experience, no gap should remain between a woman's expectations and the expectations of society and health service providers (Warren & Hern, 1971).

As Warren & Hern (1971), opine…

"There has been a cultural lag, however, with respect to our view of pregnancy. We cling to the outmoded view of pregnancy as women's highest, most 'normal' function, even though, functionally speaking, Western medicine has begun treating pregnancy as a specialized kind of illness requiring prenatal care, obstetrical supervision and postpartum follow-up with *positive results which the patients themselves recognize and seek out. Clearly, the view that pregnancy is woman's most 'normal' state has low survival value for the individual in terms of our growing understanding of the morbidity and mortality risks inherent in pregnancy; and it has a decreasing survival value for the species" (Warren & Hern, 1971, p.6).*

INDUCED ABORTION AS A PUBLIC HEALTH PROBLEM

The serious public health and demographic implications of induced abortion is often overlooked (Jagnayak, 2005). As mentioned earlier, WHO reports that,25 per cent that is fifty million pregnancies end in induced abortions every year. Induced abortion, therefore, becomes one of the leading causes of maternal mortality world over. It is estimated that

globally 20 million abortions are being performed under dangerous conditions that involve unauthorised places and unsafe methods. Unsafe places not only exist out of the hospital setting but also within hospitals where the equipment is poor and institutions are under-staffed.

Abortion rates have remained stagnant between 2003 and 2008 at the rate of 28-29 abortions per 1000 women who were between the age group of 15-44 years. Yet the number of unsafe abortions has shown a considerable increase from 44 per cent in 1995 to 49 per cent in 2008. This is indicative that abortion being one of the major causes for maternal mortality has not been tackled well (Sedgh et al., 2012). The International Conference on Population and Development (ICPD) emphasised that abortion should be safe when it is done legally. However, Sedgh et al (2012), argue that abortion needs to be safe even in illegal conditions in order to reduce the morbidity and mortality (Sedgh et al., 2012). Morbidity and mortality due to unsafe practices of abortion remains a major public health crisis in developing countries (Johnston, 2002; Cameron,2018; Munakampe, Zulu & Michelo,2018).

INDIAN EXPERIENCE

India was considered a conservative country with highly restrictive abortion laws. During the British colonialism abortion was declared illegal under the Indian Penal Code (IPC) and the Code of Criminal Procedure (CPC). Under the IPC, enacted in 1860, induced abortion was made punishable with incarceration of three years against the couple. Section 312 of the IPC stated that, both the woman and medical practitioner who carry abortion in bad faith will be punished with imprisonment of three years and a fine. In those cases where a woman is quick with the child, she shall be punished with imprisonment that can extend up to seven years, and shall also be liable to a fine (Karkal, 1991; Mudur,2008; Datar,2015).

In 1960, abortion laws were liberalised to check back-alley abortions that were done in unauthorised and unsafe settings for the fear of severe punishment. The Planned Parenthood

Federation (PPF) estimated that huge number of maternal deaths are caused by sepsis due to unsafe abortions. As a response to increasing maternal deaths in India, in 1964, a committee was formed by Central Family Planning Board of India (CFPB) that analysed almost all the dimensions of abortion in terms of its medical, legal, social and moral implications (Hirve, 2004). In 1966, the Abortion Study Committee led by Shantilal Shah was formed that recognised that abortion laws in India are highly restrictive leading to unsafe abortions with the drastic results of high maternal mortality. The recommendations were later incorporated in the Medical Termination of Pregnancy Act, 1971(Hirve,2004). Medical termination of Pregnancy Act was a landmark legislation which allowed abortion up to twenty weeks on the grounds of risk to women's life, contraceptive failure and foetal abnormality. It decreased back-alley abortions to some extent. The Act was amended in the year 2020 and it enhanced the time period of abortion from 20 weeks to 24 weeks and the act became law on 15th of March 2021 (Arora & Verma, 2021). The law was liberalised in order that it can have a decreasing effect on the incidence of unsafe abortions (Sasi,2019).

Saha (2000) argues that Medical Termination of Pregnancy has been treated as "woman's issue" and not as a health issue worthy of significant budgetary allocation. Induced abortion therefore is a neglected public health issue (Saha,2000). Despite liberalisation of abortion laws, unsafe abortions remain a serious public health problem in India (Johnston, 1999). Adding to the problem, there are no reliable and consistent estimates about the number of induced abortions (Ganatra, 2000; Khan et al., 1998). Some of the early accounts also demonstrate the extent of the unsafe abortion. Shah Committee[26] estimated that in India 3.9 million abortions took place every year (Chhabra & Nuna, 1994). In 1970, International Planned Parenthood Foundation (IPPF) estimated that 6.5 million abortions took place that

[26]Shantilal Shah Committee was appointed by Government of India in 1964. The committee was suggested to draft laws that will govern abortion in India.

amounted to 200 abortions per 1000 live births (Mishra et al., 1996). UNICEF estimated that 5 million abortions took place in India every year out of which 4.5 million were illegal (Jeejeeboy, 1996). 6.7 million abortions were performed every year in unregistered and non-government institutions by untrained persons in unhygienic conditions (Khan et al., 1998; Hirve,2004). To reach to a certain level of consensus, it is estimated that between 5 to 7 million induced abortions were done annually that made abortion a public health problem of considerable magnitude (Chhabra, 1996).

The recent estimates point towards the extent of abortion despite a considerable improvement in the overall healthcare system. According to one estimate, 6.4 million abortions occurred in 2002 alone that amounts to 26 abortions per 1000 (Singh et al., 2018). Out of total abortions that take place in India, 67 per cent are done under unsafe conditions that mostly affects vulnerable and disadvantaged sections of population in India (Yokoe et al.,2019). Lancet Global Health estimated that 15.6 million abortions occurred in India in 2015 at the rate of 47 abortions per 1000 of women aged between 15 to 49 years. The study further concluded that out of 15.6 million abortions, 11.5 million abortions took place outside medical facilities and 0.8 million abortions were considered unsafe (Singh et al., 2018). *See Table 2*

In India, despite liberalisation of abortion laws, the dividends of such relaxation of laws have not been reaped (Pallikadavath and Stones, 2006). Still, most of the abortions that take place are illegal (Karkal, 1991). Everyday almost eight women die of complications from abortions making it the third leading cause of maternal mortality in India (Balaiah, 2008; Singh et al., 2018).

One of the reasons for unsafe abortions remains the unmet need for contraception. According to the Registrar General of India (2013), at least 12.6 per cent of currently married

women across all states do not meet their family planning requirements (RGI, 2013)[27]. The lack of availability of contraceptives clubbed with misinformation, superstition and religious beliefs about spacing methods and use of contraceptives lead to the dangerous method of discontinuing pregnancy through abortion (Parivar Seva Sanstha, 1998; Johnston,1999; Zamanian, 2016).

Medical Termination of Pregnancy Act, 1971 (MTP)

The Medical Termination of Pregnancy (MTP, 1971) allows government hospital or licensed private facility to perform abortion until twenty weeks. Under the act, the abortion can only be performed by registered obstetrician- gynaecologist or a medical practitioner who is certified. It also allows medical termination of pregnancy up to twenty weeks and requires second doctor's approval if the pregnancy extends beyond twelve weeks (Hirve, 2004). In 2002 and 2003, the Indian parliament introduced some of the amendments to the MTP Act to improve the abortion services. The amended rules were significant in sanctioning the medical abortion. The two abortion drugs *mifipristone*[28] and *misopristol* were being allowed to be used until the six weeks of pregnancy in a clinical setting. The act also allowed abortion in any setting, not necessarily a clinical setting, provided they have access to a certified site with a capacity to provide surgical abortion if there is a need (Hirve,2004). Medical management using misoprostol is the newest treatment option and also recommended by the current WHO guideline (Lemmers et al.,2016; World Health Organization, 2018). Recent randomized study showed that pre-treatment with mifepristone prior to misoprostol administration leads to better outcome and reduces the need for subsequent uterine evacuation for retained products of conception (Schreiber et al., 2018). In

[27]Annual Health Survey

[28]The drug was manufactured in France by scientists and managers in a pharmacy called Roussel Uclaf Pharmaceutical Company. The three countries to register the drug for the first time were France, UK and Sweden. The standard protocol of the drug requires 600 mg of mifepristone provided to a woman (or three 200 mg pills) provided to a woman in a licensed medical facility (Braken and Winikof,2005)

2002, Drug Controller of India (DCI) licenced the abortion drug *mifepristone.* The drug had a success rate of 95%. The *dose* of the drug was also prescribed by DCI (Boler et al., 2009).

The grounds on which the termination of pregnancy is allowed according to the Act are threat to life of a woman, contraceptive failure, pregnancy which has resulted due rape or having a sexual intercourse with a mentally challenged woman, or if there are some eugenic problems to child and if the child has mental or physical deformities. The Medical Termination of Pregnancy (MTP) Rules and Regulations also define ethical issues regarding the medical termination of pregnancy which is consent of a woman, the record keeping and its confidentiality (Hirve, 2004). The liberalisation of the law permits abortion not only to save life of a woman but also to protect her physical and mental wellbeing. Socio- economic factors like age of women, number of children, economic resources of women are also the grounds according to the Indian law for the termination of unwanted pregnancy (Centre for reproductive Rights, 2009). Although there are laws in place in India, but these laws and regulations are medicalized and bureaucratic, extend immunity to doctors and do not safeguard women's right to reproductive health. So, these laws do not favour women much (Johnston, 1999).

Not all abortions in India are illegal. There are clinics which perform abortions which may be medically safe but technically unsafe as these clinics are not registered and are run unauthorizedly. Abortions which take place by authorised or legal abortion providers and services which are provided by traditional/illegal providers go unreported (Huntington et al., 1993; Karkal,1991). Although there are various sources of abortion reporting like clinics and hospital records. The individual women surveys are also conducted but the validity of that data is questionable (Barreto et al., 1992; Mathai, 1997).

National Family Health Survey (NFHS) and District Household Level Survey (DHLS) which are community based surveys also collect data regarding abortions but there are issues

of under reporting as women do not report them to the surveyors because of the stigma attached to induced abortions (Singh et al., 2018).Though there is an underestimation of the number of abortions in India as data is collected from hospital records and about two-third of abortion in India take place outside the authorised health services (Mesce, 2011). “The completeness of reporting may change over time if circumstances that influence reporting changes” (Singh et al., 2011, p. 84).

Unsafe abortions not only take place outside the available medical health setting but also take place because of the lack of proper medical health facilities where safety of women’s health and well-being is often compromised (Hirve, 2004). It is estimated that around 20 million induced abortions are performed under dangerous conditions that involve performing the procedure at unauthorised places or performing the procedure using unsafe methods (Berer, 2000). Although in India laws for abortion have been liberalised and it is no more illegal, yet women seek abortion services which are unsafe because there is a dearth of authorised abortion service providers (Khan et al., 1999). There is also unmet need for contraception or forced use of contraception, the cost of which is related to seek abortion service. Social stigma and lack or less awareness regarding the legality of abortion stops women enjoying abortion as a right (Khan et al., 1999). In some countries the laws governing the induced abortion are restrictive or abortion is even criminalised yet in India despite legal status of abortion, unsafe abortion is rampant which contributes to maternal mortality and morbidity (Ravindran, 2002).

ABORTION DUE TO SEX SELECTION IN INDIA

In India adverse sex ratio has been a matter of concern for decades and considerable attention is being given to understand the different dimensions of female population deficit. Sex ratio in favour of male child and a great hostility towards girl child in India is a well-

established fact (Miller,1997; Mohanty & Rajbhar,2014). The practice of sex selection was most prevalent in the north of India; however, some communities from various parts of Tamil Nadu, one of the southern states of India, during the past two decades were reported to carry the practice (George et al., 1992; Chunkath and Athreya, 1997). There is a cultural preference for boys in the Indian society and undesirability for female child (Prabhat, Rajesh, Dhingra et al., 2006). Amartya Sen, an economist of great repute, in his study on declining sex ratios, assesses that in India there are 100 million missing girls. He further argues that if a girl child is allowed to be born, there is huge inequality and neglect towards her right from her birth (Sen, 1992). The astounding figure of 100 million missing girls by Amartya Sen was later calculated to 60 million (Coale,1991). "The 2011 Indian census revealed about 7·1 million fewer girls than boys aged 0–6 years, a notable increase in the gap of 6·0 million fewer girls recorded in the 2001 census and the gap of 4·2 million fewer girls recorded in the 1991 census" (Jha et al., 2011, p.2). Studies have revealed that the decline in female population is a result of widespread female foeticide, infanticide, girlhood, neglect at birth, infancy and childhood(Croll,2002). Also, with the advent of modern technology there is an epidemic of sex selective abortions (Agnihotri, 2000; Arnold, Kishor & Roy, 2002). Preference for male children, ultrasound technology and amniocentesis provide evidence for the occurrence of sex selective abortions (Arnold, Kishor & Roy,2002).

Most of the sex selective abortions take place after gestation period of twelve weeks which makes women vulnerable to complications like reproductive morbidity, infertility and even mortality (Unisa et al., 2003). In a country like India where there is a strong son preference, girls are considered a burden and a liability and sons if born can accomplish the last rites, it reinforces the notion of sons being an asset (Ahmad,2010). And when the technology is available to make such preference a reality, there is a huge likelihood of female foeticide (United Nations, 1993). "In countries where there is a combination of son

preference, a small-family culture and easy access to sex-selective technologies, very serious and unprecedented sex-ratio imbalances have emerged" (Hesketh,Lu & Xing,2011,p.1375). Still an in-depth investigation into understanding the layers of reasons for sex selective abortions is required (Bose, 2007).

There is a little public debate on this issue. Instead, discussion on induced abortion in India has mainly focussed on declining sex ratio, sex-selective abortions, and proliferation of abortion clinics in urban areas. Not much has been studied about the consequences of sex-selective abortions on general and reproductive health of women and social adjustment. Adding to the problem is that, related to reproductive health, no other issue has more controversial connotations than induced abortion (Mundigo & Indriso, 1999; Omo-Aghoja et al., 2010).

GAPS IN THE LITERATURE

Pregnancy loss is being treated as pathology (Linda, 1997). As a result, the literature on pregnancy loss has primarily focused on statistics. The literature has not taken into account the immense human suffering related to pregnancy loss. The studies taken up in the Indian context have examined pregnancy loss focusing on dimensions of access and quality of abortion services. This approach fails to capture the experiential element of pregnancy loss both in case of spontaneous and induced abortions. As a result, in India, the social and cultural context within which abortions are performed, the levels and characteristics of women resorting to abortions, and its consequences on women's health remain unknown (Agrawal, 2008). However, qualitative studies have been undertaken elsewhere that try to capture expressions of grief and pain following a pregnancy loss (Acharya,2018). Understanding all the aspects of pregnancy loss and the factors that lead to such a loss has immense policy implications (Pallikadavath & Stones, 2006; Visaria & Visaria, 1995). Some

of the studies related to pregnancy loss conducted in other countries are as following (Table 3).

ABORTION ASSESSMENT PROJECT OF INDIA

The Abortion Assessment Project of India jointly taken up by CEHAT and Health Watch in 2000 was an ambitious project to carry evidence-based studies on induced abortion. Besides many other studies being conducted under the project, eight qualitative studies were also undertaken. Under the project, the studies employed both qualitative and qualitative methods to obtain data regarding induced abortion. Both the service providers and the clients were interviewed. The range of issues covered under the project were abortion seeking behaviour, intergenerational differences in abortion perceptions and practices, studying practices of abortion service providers and the quality of care. The fields of study were small geographic areas of the states with better prosperity indicators. Therefore, these results were not generalised for the larger population. In some of these studies non-governmental organisations were also involved and worked as field investigators (Visaria, 2004a). See Table 4

The eight qualitative studies conducted by CEHAT[29] focused mainly on socio-economic factors leading to pregnancy loss. The studies did not capture the aspects of grief, pain, loss, emptiness, guilt, self-blame or such emotions post pregnancy loss (Adolfesson et al., 1999). The studies looked into the interface of pregnancy loss with health services and the experience thereof. The aspects of personal loss, socio-demography and public health concerns arising out of abortions need a rigorous analysis. There is a chasm between socio-

[29]Centre for Enquiry into Health and Allied Themes (CEHAT) is a research centre of Anusandhan Trust which deals with the issue of right to health and health care. The centre is based in Mumbai, Maharashtra, India.

economic and gender aspects of abortion and its location in a given social structure that needs to be bridged (Sutapa, 2008).

RESPONSE OF HEALTH SYSTEM

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." However, it is estimated that 500,000 women die annually due to pregnancy related causes invoking questions of justice. It is argued that the state has a moral obligation to ensure equitable health services for the whole population thereby extending the obligation to physicians and other para-medical staff (Macklin,1996). "A just distribution of reproductive health services (which includes abortion services) requires that methods be accessible to poor women as well as those who are better off, to the less educated as well as those who are better educated, to rural as well as urban residents" (Macklin, 1996, p,151-152).

In India, Reproductive and Child Health Programme (RCH) started in the backdrop of International Conference of Population Development (ICPD, 1994) held in Cairo, Egypt. The aim of RCH was to improve the Child and Maternal Health Services. Since India was also one of the participating countries in ICPD, it decided to expand the scope of family planning programme (running earlier) and make it a component of its broader reproductive programme. RCH in its ambit included pre-natal and post-natal services to women and safe abortion services in addition to the services rolled out to newborns like immunization, Vitamin A prophylaxis, Oral Rehydration Therapy, Management of Acute Respiratory Infections (ARI) etc. It included services for eligible couples like contraceptive services, fertility services, and adolescent health services. All these services would be available to women through an integrated client centered approach which would be of high quality and based on the needs of women. The program aimed at women centric approach where women

themselves can regulate their fertility with less or no adverse outcomes making the survival and wellbeing of the mother and the child paramount. Safe abortion services were also given importance in the RCH programme (RCH,1997). Maternal child health (MCH) services have also been incorporated as a part of National Population Policy 2000, National Health Policy 2002 and the Five-Year Plans (Naik, 2016). However, there is no policy which addresses element of bereavement after pregnancy loss including in the recent National Health Policy of 2017 (Acharya, 2018).

Despite all these policy efforts, abortion service provided with certain respect and dignity is still not available in the current healthcare setting. There is a need for effective sensitization so that the service providers can deliver abortion services with higher degree of responsibility and seriousness (SRS, 2018).

The concept of patient centeredness for the patients who face miscarriage or recurrent miscarriages is missing. Generally, such patients are treated like routine patients without due consideration to their emotional needs or health. The eight dimensions to "patient centered" care in cases of spontaneous or induced abortions according are enumerated in Table 5.

Besides being a social process, pregnancy loss entails interaction with the health service system. The experience and interaction may vary from across different groups in the society. During the process of pregnancy loss there is an interface with formal or informal health service sector, the quality and accessibility of which in turn depends upon factors like socio-economic condition of family, income, facilities in formal and informal sector etc. The inclusion of the bereavement services in abortion care tends to the emotional needs of women (Kobler & Limbo, 2011; Wool & Catlin;2019).

Further, lack of awareness about abortion service in terms of its legalization is pushing women to avail service that is unsafe and does not meet the minimum standard of care (Maharana, 2016; Bras et al., 2021). Social history of patients in terms of domestic violence,

coercion by partner, social issues that can impact her access to care and decision-making, family environment and marital relationship have to be considered (WHO, 2014; Yogi, Prakash & Neupane, 2018.). It is further held that the incorporation of element of 'social context to health' in both preventive and curative healthcare increases the chances of better health outcomes (Khattab,1992; Younis et al.,1993).

PROFILE OF THE STATE OF JAMMU AND KASHMIR

Jammu and Kashmir has a unique status in the entire South- Asian subcontinent because of its geographical location, disputed status and its occupation by three countries India, China and Pakistan. Jammu and Kashmir has a population of 1.25 crore with a population density of 56 persons per square km. It has an area of 222,236 square Km (District Census Handbook,2011). Majority of the part is administered by India against which there is a popular discontent in the valley of Kashmir. The region has its own cultural ethos and ethnic character. Jammu and Kashmir is divided into three regions i.e, Jammu, Kashmir and Ladakh. Jammu is a Hindu dominated region, Kashmir is a Muslim dominated region and Ladakh a Buddhist region with some percentage of the Muslim population. Jammu & Kashmir shares its border with the states like Himachal Pradesh, and Punjab and the countries like Pakistan, China and Afghanistan. The official languages[30] of Jammu and Kashmir are Kashmiri, Dogri, hindi,urdu and english . On the 5th of August, 2019 the special status (Article 370)[31] was abrogated by the Indian State and the state of Jammu and Kashmir was

[30]Lok Sabha passes Jammu and Kashmir Official Languages Bill, 2020 at https://economictimes.indiatimes.com/news/politics-and-nation/lok-sabha-passes-jammu-and-kashmir-official-languages-bill-2020/articleshow/78267144.cms?from=mdr

[31] The terms and conditions of accession of Jammu and Kashmir to India were being drafted between October 1947 and November 1949. Consequently, Jammu and Kashmir as a state became an Indian state in 1950. A special status was guaranteed to the state of Jammu and Kashmir in the form of article 370 which assured internal autonomy to the state of Jammu and Kashmir (Shah and Shah, 2020).

made a union territory which included Jammu and Kashmir as its parts and Ladakh was made a separate Union Territory.

Srinagar is the largest city in Jammu and Kashmir. It is the summer capital of Jammu and Kashmir. Jammu is winter capital of the State. The temperature of the state varies with its topography and is primarily temperate. Jhelum, Chenab, Ravi and Tapti are the important rivers that flow in the state. River Jehlum would provide a system of water transport in Kashmir in the past.

Jammu and Kashmir is an agrarian economy with 70 percent of the population dependent on agriculture and about 49 per cent of the population engaged in it (PHD Research Bureau,2018). Jammu and Kashmir is rich in flora and fauna. In Jammu, the flora is in the form of thorn bu shes, temperate and alpine forests which are mainly found in the higher regions. In Kashmir, there are forests of deodar, pine, cider and fir. Jammu and Kashmir is rich in horticulture (apples, pears, walnuts, almonds) and floriculture. Horticulture is the mainstay of the rural economy generating revenue of 11 million US dollars annually. Floriculture also generates a fair amount of wealth for the state which is equal to US 2 million dollars (India Brand Enquiry Foundation,2010).See figure 7

Disputed Region

Jammu and Kashmir is a contested territory claimed both by India and Pakistan. The two countries have fought several wars over Kashmir, including three major wars. There has been a very strong resistance from the people of Kashmir against the Indian occupation. There was discontent among people from the year 1947 which culminated into an armed struggle in the year 1989. The armed conflict was heavily crushed by the state of India which led to the killing of almost one lakh people, disappearance of thousands of young people, damage to infrastructure, economy and education system of the state. Besides armed conflict, Kashmir

valley also witnessed massive yet peaceful protests in the year 2008 turning the ongoing struggle into a people's movement. The protests were crushed leading to hundreds of deaths and injuries to young people. The mass protests continued through the year 2009, 2010, 2016 which were also crushed and these protests lead to the death of hundreds of civilians. So, Kashmir valley has remained a highly volatile zone affecting people in a variety of different ways.

SOCIO-ECONOMIC INDICATORS OF JAMMU AND KASHMIR

Wealth Index

According to National Family Health Survey (NFHS -3), Jammu and Kashmir is wealthier than the other states of India in terms of wealth index. Only 3 per cent of households live in the lowest quintile of wealth. Comparing Jammu and Kashmir with rest of the India, 16 per cent of households live in the lowest two quintiles while in India about forty per cent of households live in the lowest two quintiles. Yet there are about 38. 4 per cent of households that live below the poverty line (IIPS,2017). In terms of Gross State Domestic Product (GSDP), there has been a growth rate of 8.49 per cent from the year 2011-12 to 2017-18 in Jammu and Kashmir. The per capita income at the current prices for the year 2018-19 was Rs 94992 (Directorate of Economics and Statistics, J&K, 2017). The contribution of the primary sector to the economy is declining over the years from 17.47 per cent in 2011-2012 to 16.05 in 2017-18 and the contribution of the service sector is increasing from 54.44 per cent in 2011-22 to 56.07 in 2017-2018 (ENVIS,2011) which is an indicator of a good economic development. See figure 2.

Health Index and Health Infrastructure

The data sources in the form of National Family Health Survey (NFHS-I, II, III& IV), District level Household Survey (DLHS-I, II, III), Annual Health Survey and Census gives a picture of the health indicators in Jammu and Kashmir at a macro level. As compared to other states like Kerala, Tamil Nadu, Maharashtra, Jammu and Kashmir is one of the states of India having low socio-economic development index. The health index[32] score of Jammu and Kashmir has remained same from the base year 2015-2016 against reference year 2017-18 according to a health report published by NITI Ayog while as many states are showing improvement in terms of health index. Jammu and Kashmir is categorised as front runner state which has moderately improved health index over a period of two years from 2016-2018(Health Index, 2019). In Jammu Kashmir, like in other states of India, the health infrastructure operates at three levels i.e Primary, Secondary and Tertiary. Primary level care includes primary health centres and subcentres and secondary level care includes Community Health Centres (CHCs) and sub-district hospitals and tertiary level care includes hospitals that are more than 30 bedded. Jammu and Kashmir has 30 hospitals, 119 Community Health Centres (CHCs), 633 Primary Health Centres and 2249 sub-centres (ENVIS,2011).

Education

According to the census of 2011, the literacy rate of Jammu and Kashmir was 68.74 per cent (PHD Research Bureau,2012).89 per cent of children attend primary school (age 6-10 years) in Jammu and Kashmir. In the urban area, the percentage of such children is 92 per cent and in the rural areas, it is 88 per cent. In the age group of 6-10 years, there is no gender disparity in terms of school attendance. However, older age girls are less likely to attend school according to NFHS- 3. The reasons being not interested in studies, household work, issues with the cost of education, further education not given much importance (IIPS, 2010).

[32] Health index was developed using 23 health indicators in 2016 by NITI Ayog. It includes health outcomes,

However, according to NFHS-5, the female population aged 0-6 who have attended the school has increased from 65 per cent to 70 per cent (IIPS,2020).

Composition of Population

Overall sex ratio of the state of Jammu and Kashmir is 972 females per thousand of males according to NFHS-III. The child sex ratio (CSR) in Jammu and Kashmir is low at 917 females per thousand males according to NFHS-III. There are ten per cent of the scheduled caste (SCs) households in Jammu and Kashmir and nine per cent of households which belong to scheduled tribes and five per cent of the households belong to other backward classes (OBCs) according to NFHS-IV(IIPS,2017).

Basic Amenities

In Jammu and Kashmir, about 71 per cent of the population live in pucca houses. According to NFHS-IV, 90 per cent of households have electricity. According to the same survey, 38 per cent of households do not have toilet facility About 81 per cent have improved drinking water facility. 47 per cent have water pipes up to their dwelling places in urban areas and only 2/3rd of rural areas has such a facility (IIPS,2017).

REPRODUCTIVE HEALTH INDICATORS

Age of Marriage

According to NFHS-3, in Jammu and Kashmir 14 per cent of women got married before the legal age of marriage which is 18 years and about 15 percent of men got married before the legal marriage age which is 21 years. This means that about 14-15 per cent of men and women stay in conjugal bond for a longer number of years. The same survey concluded that the median age of women becoming mothers for the first time is 21.4 years. In an urban area,

it is 22.5 and in a rural area, it is 21.0. NFHS-II had estimated figures equal to 20.3 (IIPS,2007).

Total Fertility Rate (TFR)

Total Fertility Rate (TFR)[33] is 2.4 in Jammu and Kashmir. In rural areas, the TFR is 2.7 and in the urban areas, TFR is 1.6. Once compared with NFHS- 2, TFR was 2.7 which means the fertility rate has decreased by .3 points. Fertility among people belonging to scheduled castes is more which is equal to 2.6. Fertility rates among Muslims is .3 higher than Hindus. The greatest differentials between infertility are education and wealth. The birth interval is equal to 32 months which is one month longer than the national average (IIPS,2007). According to DLHS-III contraceptive prevalence rate for any method of contraception was 54.7. Total fertility rate (TFR) was 2.4. In rural areas the TFR was 3 and in urban areas of the state TFR was1.6. Once compared with NFHS- 2, TFR was 2.7 which means fertility rate has decreased by .3 points. Fertility among people belonging to scheduled castes is more which is equal to 2.6. Fertility rates among Muslims is .3 higher than that of Hindus. The greatest differentials in fertility are by education and wealth. Birth interval is equal to 32 months which is one month longer than the national average. According to NFHS-4 total fertility rate (TFR) is 2 just below replacement level fertility[34]. From NFHS-3, TFR has declined by .4 in a period of ten years. TFR in urban areas of the state is 1.6 and in rural areas it is 2.2. There is a marked difference in the TFR between rural and urban areas of J&K aaccording to DLHS-III (IIPS, 2010).

Son Preference

[33] Total number of children per woman

[34] Total fertility rate (TFR) equal to 2.1 is called as replacement level fertility. This number is such at which the population growth will be stabilised. Neither will it increase and nor will it decrease. It will remain stagnant.

Son preference is very much ingrained in the kashmiri society. Contraception prevalence rate in high in those couples who have sons. And those couples who have daughters do not use regular contraception in the hope that they may conceive a son. 12-month discontinuation rate of all methods of contraception is 47 per cent according to NFHS-IV. 20 per cent of women and 26 per cent of men prefer sons over daughters (IIPS,2016).74 per cent of women and 68 per cent of men do not want to have more children or are already sterilised or have a husband who is already sterilized. One in four women and men want more sons than daughters. Only 2-3 per cent want more daughters than sons according to NFHS-3(IIPS,2007).

Unmet Need for Contraception and Spacing

According to NFHS-3, the exposure to the family planning messages is limited. Less than half of women were given family planning messages. According to DLHS-III contraceptive prevalence rate for any method is 54.7 per cent. It has shown a bit of improvement from NFHS-III and DLHS-III in which it was recorded at 53 per cent. 46 per cent of the women use modern method of contraception[35]. The unmet need for contraception is 20.4 per cent according to DLHS-III (IIPS, 2010).

The unmet need for reproduction is one of the main causes of unwanted pregnancies which leads to induced abortions. In some of the settings where access to family planning and health infrastructure is low, women see abortion as one of the methods of limiting the number of children. There are unmet needs not only among those who do not use any method of family planning but for those as well who use it. The family planning services are not free of coercion and force. There is a fair amount of literature indicating that. The methods are not user friendly and respectful of the informational needs (Ross and Frankenberg, 1993).

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Use of method of contraception

In Jammu and Kashmir, the most common method of contraception is use of condoms (11 per cent), withdrawal method (9.8 per cent), followed by pills (6 per cent). The rate of sterilization among women is 43 percent according to NFHS-IV. In NFHS-III it was 50. It has shown a decrease of 7 percentage points. For the purpose of sterilizations and insertions of IUDs, majority of the people have accessed public health sector. Though the knowledge about contraception is universal in Jammu and Kashmir. However, the use of contraception is limited (IIPS,2017). See Figure 10

Mean Ever Children Born (MCEB)

Mean children ever born to a female aged 15-45 is 3. In rural Jammu and Kashmir, it is 3.6 and in urban areas it is 3.1. Non-literate women have 3.6 MCEB and those who have at least ten years of formal education MCEB is 1.9 (IIPS,2017).

Abortion Scenario in Jammu and Kashmir

In rural areas of Jammu and Kashmir there was about 90 percent of live births as compared to urban where live birth was 87. 3, five years preceding the survey. According to NFHS-IV, out of the total pregnancies, 11 percent of pregnancies were wasted (foetal wastage). They were terminated in abortions (4%), miscarriages (6%) or still births (1%).The rate of abortion for rural was 3.1 as compared to urban where it was 4.8. Rate of miscarriage in the urban areas of Jammu and Kashmir was 7.4 as compared to 6.0 in the rural areas. In urban areas 40.3 accessed public health sector for abortions as compared to rural area where 61.7 accessed public health sector. In urban areas 58.5 per cent of women accessed private healthcare as compared to rural area where only 27. 8 accessed private health sector for abortion. In urban J&K, 1.2 executed abortions at home and in rural areas 10. 5 did so at their homes. In urban areas of J&K 85. 4 per cent of doctors performed abortion as compared to

rural areas where only 66.4 performed abortion. In rural area 20.7 per cent of nurses /ANM/LHV while as 7.1 per cent of nurses /ANM/LHV performed abortion in urban area. Dai (midwife) performed abortion in 1.1 percentage of cases in rural area. 7.4 self -induced abortion in rural areas and 7.1 in urban areas have self- induced abortion. In urban areas family/relative friend performed induced abortion and in rural areas 4.4 percent of abortions were performed by family member/relative and a friend (IIPS, 2010). There were 4 per cent of spontaneous abortions in the same period with highest number of abortions in Srinagar (7.5) and lowest in Kargil (.5) (IIPS,2017).

PROFILE OF DISTRICT KUPWARA, J&K

District Kupwara is one of the frontier districts of Jammu and Kashmir. It is located on the extreme north-west of the state. It is very often called "the crown of Kashmir". Kupwara has been carved out from district Baramulla in1979. The district consists of three tehsils i.e Kupwara, Handwara and Karnah. (District Administration,2009). The district has one municipal council i.e Kupwara and two municipal committees i.e Handwara and Langate (District Statistics and Evaluation Officer, 2020). The northern and the western borders of the district form the actual line of control between India and Pakistan. Its eastern and southern borders touch Sopore, Bandipora and Baramullah tehsils. It has Ladakh in its north. The famous river called Kishen Ganga separates Azad Kashmir (Pakistan) from Jammu and Kashmir (India) in Machil, Teetwal and Karnah sectors (District Administration, 2009). See figure 11.

The Name

Though there is not any proper historical account of the district, it is said that Kupwara is named after a hut that was constructed in a forest. That hut was called Kopar which means "in shambles". It is said that the hut would very often be attacked by animals of the area.

Another legend says that there was a saint called Zaiti Shah Wali who called Kupwara, Kofar (people of bad reputation) because children of the habitation would throw stones at him once he would venture out. Syed Mohammad Gaibi Shah called Kupwara Kufer-waer (the land of non-believers). He converted the people of Kupwara to Islam. That is the reason Kupwara has been named so. The tomb of Syed Mohammad Gaibi is still located in Kupwara (District Administration, 2009).

Location and Areas

Kupwara is located between 34.17 to 34.21 North Latitude and 73.10 to 73.16 East Longitude. It is situated at a height of 5300 feet above sea level with a geographical area of 2379 square kilometres (District Administration, 2009). It is about 90 kilometres from the city of Srinagar. It is one of the socio-economically backward districts which consists of 377 census villages. Among 377 villages 8 are uninhabited. It comprises of two Municipal Committees, three tehsils and eleven community developments blocks like Sogam, Tangdar, Ramhal, Kupwara, Rajwara, Kralpora, Langate, Wavoora, Trehgam and Kalaroos. There are 224 panchayats in Kupwara. It has five assembly constituencies (District Administration,2009). The district consists of two urban units that is Handwara and Kupwara (District Census handbook,1981).

Demographic Profile

According to the census of 2011, the total population of the district was 87,0354 lakhs consisting of 47,4190 males and 39,6164 females (Directorate of Census Operations,2011). The population density was 366 per square kilometres. The decadal population growth from 2001-2011 was recorded at 33.82 per cent (Directorate of Census Operations,2011). The sex ratio for the year 2001 was 906 females per thousand males and for the year 2011, the sex ratio was a record low of 835 females per thousand males and it attracted a lot of social and

political attention. Among all the districts in J&K, in Kupwara sex ratio showed the highest decline. In urban Kupwara, the sex ratio is 685 per thousand males according to the census of 2011. The sex ratio in rural areas is about 858 females per thousand males. The child sex ratio (CSR) in urban Kupwara is 879 according to the census of 2011. The child population comprises about 20.09 per cent of Kupwara's population and the overall child sex ratio in district Kupwara is 858 per thousand males (Directorate of Census Operations, 2011).

Composition

According to the census of 2011, the percentage population of scheduled tribes was 8 per cent and scheduled castes was .001 per cent. As compared to the population of 1991, the population growth recorded for the year 2001 was 40.84 per cent as compared to the state level population growth of 29.98 per cent (District Census Handbook, 2001). 2011 census showed that 87.97% of the population lives in rural areas. According to the census of 2011, population density of district Kupwara is 366 persons per square kilometre as compared to 273 in 2001(Directorate of Census Operations, 2011). See figure 12.

Conflict and Kupwara

Kupwara is one of the most affected districts of Jammu and Kashmir in terms of conflict which started in 1989. The district saw a huge participation of people in the freedom movement. The region also saw a rise in militancy. Many operations have been conducted so far to curb militancy in the region by the state of India. Although, various developmental schemes were initiated by the Government of India to rehabilitate militants who have surrendered like Integrated Social Security Scheme (Bhayana,2019), yet militancy is still seen in the district.

The district is heavily militarized. Some barracks have been there for many decades. While moving from Sopore to Kupwara one can see the military and the army bunkers

dotting the highway on both the sides. In Kunan and Poshpora, the villages in Kupwara, 53 women were raped in a single night by the Indian Security Forces. The issue attracted a lot of media attention. Kunan Poshpora is considered one of the brutal and violent episodes in the history of Kashmir. Since in Jammu and Kashmir, Armed Force Special Power Act (AFSPA) is in place so the security forces who raped the women were not tried which has left the people of Kupwara alienated.

Dardpora, another village in the district, which is 50 km away from the town of Kupwara is called a village of half-widows. The village has suffered the most in the ongoing conflict. There are about 300 widows and half-widows (women whose husbands have faced enforced disappearances) in the village. The famous Machil fake encounter in 2010 which took place in one of the sectors of Kupwara triggered protests for about two months in Kashmir. District Kupwara forms one of the most important districts in terms of the partition of 1947. The partition left many families separated. The bordering villages of the area have divided families on each side of river kishenganga. The most affected area in terms of partition is Karnah. Karnah tehsil of Kupwara was also one of the areas severely hit by the earthquake of 2005.

SOCIO-ECONOMIC INDICATORS

Ministry of Panchayati Raj has declared Kupwara as one of the backward districts in the country. The district is receiving funds from Backward Regions Grant Fund Programme (BRGFP)(MoPR, 2009). The per capita income of the district is equal to 16360 as compared to 24398 in the state of Jammu and Kashmir. Almost 31.82 percent of the population live below the poverty line as compared to 21.63 in the state of Jammu and Kashmir (Directorate of Economics and Statistics, 2008). Kupwara being one of the socio-economically backward districts is not performing well on human development indicators. According to the census of

2011, literacy rate of Kupwara is about 64.51 per cent in which male literacy is 75.68 per cent and female literacy is just 50. 95 per cent (Directorate of Census Operations,2011).

Agriculture

Agriculture is the backbone of economy of the district which includes rice, wheat, oilseeds and walnuts. The total area of the district is about 2379 square kilometres. The net sown area in district Kupwara is about .46 lac hectares. The grazing land is equal to .07 lac hectares. Pastures are about .01 lac hectares (District Administration,2009). 17505 hectares of land are under paddy cultivation, 18905 are under maize, 38 hectares under millets and 9538 is under fruit and vegetable cultivation (Directorate of Economics and Statistics, 2020).

Kupwara as a Tourist Resort

District Kupwara is also one of the most beautiful tourist resorts in Kashmir. The district is located between Pir Panjal and Shamsbari mountains. The most famous tourist destinations are Lolab Valley, Bungus valley, Chandigam, Reswari and Nazinag. The meadows of Bedi Behak, Bungus and Lolab are very famous. These valleys are cut by rocky streams. Upon reaching Keran , one can observe a beautiful valley called Neelam valley. This way Kupwara has a huge potential of becoming a tourist hub in Kashmir. So far Kupwara has not come on the tourist map of Jammu and Kashmir. Due to tough mountainous terrain, the district witnesses harsh winters. Some of the areas in Kupwara like Machil, Karnah, Keran, Badnamal, remain closed for six months. Summers are pleasant due to the presence of forests. Kupwara having a forest cover of about 70 per cent is a rich heaven for herbs and medicinal plants which are yet to be exploited. Economists say once they are exploited the district will be benefited in a huge way (District Administration,2009).

Climate

Kupwara has Temperate cum Mediterranean type of climate. The higher reaches have always a very low temperature. Average minimum and maximum temperature range between –5°C to 32°C. The winter season commences from the middle of November and a severe winter condition continues till the middle of February/March. The average precipitation of the district ranges is about 700 mm (CGWB, 2013).

Livestock

The district has a rich livestock population. The number of cattle in the district is 256160 which includes cows and buffaloes. The goat population in the district is in about 56000. The goats are mostly reared by Gujjars and Bakerwals residing in the mountainous region (District Administration,2009).

Connectivity

The state highway according to the census of 2010-2011 is about 80 kilometres. The main district highway is about 70 kilometres. Other rural and district roads are about 1300 kilometres. Kacha roads are about 150 kilometres. There are four thousand telephone connections in the district. The telephone centres are eleven in number. There are eight post offices. In 2010-2011 the total number of mobile connections in the district were about 150,000 (District Administration, 2009).

Natural Resources

Not only the natural resources in the form of forests but Kupwara possess a huge mineral deposit like marble, lignite, iron ore. Deposits of lignite have been discovered at Nichama in tehsil Handwara (Directorate of Census Operations ,2011). Huge deposits of marble are found at Drugmullah, Awoorah, Zurhama and Trehgam. The iron ore deposits are found in Handwara, Lolab, Shardah, Haril (District Administration, 2009).

Industry

There are three industrial estates in the area. Industrial estate Branwari is located in an area of fifteen Kanals. Industrial estate Chotipora, Industrial area Radbugh spread in an area of 107 and 80 Kanals respectively (District Administration, 2009).

Commercial and Educational Institutions

There are 32 commercial banks and 23 rural banks. The number of cooperative banks is about thirteen. There are 996 government primary schools and 110 private schools. The middle schools are 743 in number among which 94 are private schools. There are 44 secondary and senior secondary schools. The district also has four-degree colleges (District Administration, 2009).

PUBLIC HEALTH INFRASTRUCTURE IN DISTRICT KUPWARA

District Kupwara has one district hospital which covers a population of about 8,75,564. There are seven sub-district hospitals which are also called Community Health Centres (CHCs). They cover a population of 30191. There is one Tuberculosis Centre in the district which covers a population of about 875564. Two leprosy centres cover a population of 437782. There are 24 allopathic and ayurvedic dispensaries for a population of about 36481. There are 154 family welfare clinics which cover a population of about 5686. There are 46 medical aid centres for a population of 19034. There is one district mobile ophthalmic unit that covers as much population as 875564. The total number of health institutions is about 267. 135. Doctors cater to a population of 6485. The number of paramedical staff is about 464 which cover a population of about 1887. The total bed strength is about 306 for a population of 2861 (District Administration Kupwara, 2009).

The DLHS-3 data shows that the availability of the health system is poor than that of Kashmir valley as a whole. There are about 43.8 sub-centres as compared to 46.3 in Kashmir

and 47.6 as compared to the whole of Jammu and Kashmir. Primary health centres (PHCs) are about 20.8 as compared to Kashmir with the number of PHCs equal to 16.8 and in the state with the number equal to 12.4 per cent (IIPS,2010). See figure 13

Housing Characteristics

In Kupwara about 66.7 per cent of the population lives below poverty line. Ninety-two per cent of the population is electrified. Sixty-four per cent of people have access to drinking water. There are about 93.7 per cent of people who have access to toilet facility. About 12.4 per cent of people have LPG connection. There are about 39.6 percent pacca houses (IIPS,2010).

Health Services

In Kupwara there are about 43.8 villages with sub-centres, about 20.8 with primary health centres. Sixty-seven per cent of villages which have access to government health facility (Any government facility). Eight per cent of villages which have doctors and 66.7 percent of villages which have ASHAs (Accredited Social Health Activation) in place. Ninety-six per cent of villages which have aganwadi workers (IIPS,2010).

Institutional Deliveries

According to NFHS-IV, there were 91 per cent of institutional deliveries in Kupwara as compared to as recorded in DLHS-III in which it was 62.6 per cent which is a remarkable difference. Prior to this survey, in Kupwara there was the lowest number of institutional deliveries equal to 23.7 per cent as compared to Srinagar where it is 88.6 per cent according to the same survey (IIPS, 2010). According to NFHS-V, from the last five years of the survey the institutional deliveries have increased from 91.0 per cent to 97 percent which may have contributed towards the decrease in maternal mortality and morbidity (IIPS,2020).

Unmet Need for Contraception

Kupwara district is one of the low performing districts as compared to other districts of Jammu and Kashmir. The contraception prevalence rate in the district is 36.7 as compared to JK where it is 54.7. 35. 5 percent of women have knowledge about emergency contraception which is considerably low. About 34. 6 per cent of women use modern method of contraception. Female sterilizations are about 18. 3 per cent. There is no male sterilization in the district according to NFHS -IV. 16.5 per cent use traditional method of spacing. Total unmet need for contraception according to NFHS-IV is 13.1 as compared to 12. 3 in the state. There is 6.7 per cent of unmet need for spacing as compared to 5.8 per cent in J&K. There is 6.4 unmet need for limiting as compared to 6.6 in the state. The unmet need for contraception for limiting is highest in Kupwara which is equal to 24.7 per cent. The unmet need for contraception in the district Kupwara was 33.2 per cent which was highest among all the districts in Jammu and Kashmir according to DLHS-III. According to the NFHS-V, the unmet need for the contraception has shown a considerable decline from 13.1 to 5.9 (IIPS, 2020). Unmet need for spacing has also improved from 6.7to 3.1 according to NFHS-V(IIPS,2020).

Population Covered by Health Facilities

There are 334 medical institutions, 01 district hospital, 07 sub-district hospital, 55 PHCs, 06 Allopathic Dispensaries, 27 Ayurvedic dispensaries, 235 sub-centres and 296 doctors in the district (Directorate of Economics and Statistics, 2020). In Kupwara one sub-centre covers a population of 3,211. The primary health centre is for a population of 19474. Population of 76852 is covered by one Community Health Centre (CHC). 43.8 per cent of villages which have one sub-centre in a village. About 42.9 per cent of sub-centres have ANMs/ FHW. There are 28 sub-centres in the district, among which 11 are well equipped and

17 sub-centres have essential drugs available in them. Primary Health Centres have 10 Medical Officers, 5 Lady Medical officers, 1 Ayush Doctor and 17 Pharmacists according to DLHS-3 (IIPS,2010).

Outcomes of Pregnancy

NFHS-3 reveals that 90.6 per cent of live births have taken place in district Kupwara. There have been 2.0 per cent of stillbirths, 1.6 per cent of induced abortions and 5.8 per cent of spontaneous abortions in 637 pregnancies which were sampled for the purpose of study (IIPS,2010). According to NFHS-V the percentage of institutional deliveries has improved from 85.6 as recorded in NFHS-IV to 92.4 as recorded in NFHS-V (IIPS, 2020).

Pregnancy-related Complications

In Kupwara the complications which have arisen after the pregnancy is about 84.4 per cent which is the highest among all the districts of J&K. The post-delivery complications are also highest in Kupwara which is equal to 75.5 per cent (IIPS,2017).

Sex-Selective Abortions

According to census of 2001, the sex ratio in Jammu and Kashmir was 892. In the age group of 0-6 years, the sex ratio was found to be 859 as compared to 941 during 2001. Compared to this, the National Sex Ratio was 940 while child sex ratio was 944. After the 10 years of the census, the sex ratio has seen a huge decline of about 883 fewer girls than boys. Given that the sex ratio of the district showed a huge decline, the district came under a scanner. Many USG clinics were seized and doctors who would carry out the sex-selective abortions were penalised. There is a mushrooming of USG clinics in Kupwara town. The doctors have converted even the small kiosks into their clinics and carry out ultrasonographic scans. Many campaigns had to be done by the government in order to make people aware about the importance of girl children.

PROFILE OF THE FIELD OF STUDY (VILLAGE DRUGMULLAH)

Drugmulla is named after the Hindu Goddess called Durga. There is a spring in the village called Durga Nag located in a mohalla called Chailpathi. That is how the village has been named. It is about five kilometres from the district headquarter Kupwara. The village is located on Kupwara-Srinagar Highway (NH-IA). Drugmullah is also designated as a teshsil with eight census villages like Bomhama, Anderhama, Shartmuqam, Bramri, Radbugh and Drugmullah. The total number of households in Drugmullah Tehsil are 3736 among which number of SCs are 8 and number of STs are 817(Directorate of Economics and Statistics, 2020).

According to the census of 2011, the total number of households in the village Drugmullah are 1458. The total population of the village according to census 2011 is 12930 of which the number of males is 7665 and the number of females is 5265. The village has a mixed population which includes Gujjars living in the upper reaches of the village called Chailpathi. According to the census of 2011, the village has 5.60 of Scheduled Tribe population and 0.06 per cent of Scheduled Caste (Directorate of Census Operations, 2011).

The number of children in the age group of 0-6 years is 2394 which is 18 % of the total population of Drugmullah. The female sex ratio in Drugmullah according to census 2011 is low at 687 against the state sex ratio of 889 females per thousand males. The Child Sex Ratio (CSR) according to census 2011 is 769 as against the state child sex ratio of 862. The literacy rate in Drugmullah is 71.51 per cent of which male literacy is 82.73 per cent and the female literacy of just 54.73 according to census 2011. Drugmulla has better literacy rate as compared to the district Kupwara (Census, 2011).

According to the census 2011, there are 4025 workers[36] in the village out of which 3729 are males and 296 are females. 70.58 per cent are the main workers and 29.42 are marginal workers. The per capita income of the village is about 8000 Rs. There is a good production of apple, paddy, maize, walnuts and vegetables. There is a low production of paddy in the village as there is a dearth of irrigation in the village. Since chailpati is located on the upper reaches of the villages, people sow maize instead of paddy because of the lack of water supply as paddy needs abundant water supply. Natural sources are also very scarce in Drugmullah. There is only one spring in the village that too does not have a continuous water supply. For drinking water, people have to travel long distance to fetch the water.

Drugmulla has been given the status of a model village[37] during the reign of the People's Democratic Party (PDP). It comprises three panchayats halqas A, B and C. There are almost sixteen mohallas in the village which are named after the castes and occupations which people would hold in the past. For example,

1. Shah Mohalla
2. Bandapora
3. Pirmohalla
4. Marble Mohalla
5. Gulshan Kasmi
6. Fakirpora

[36] Workers are those involved in business, job, service, cultivators, labourers according to census 2011.
[37] Identification of villages under prime minister's reconstruction plan was started in the year 2005-06. Under the scheme 125 villages were identified to be developed as model villages in Jammu and Kashmir having intensive development in terms of safe drinking water, community centre, computer centre, children's park, playground etc. Drugmullah was also identified as a model village Greater Kashmir, 2015)
Mudasir Ali www.greaterkashmir.com/news/more/news/jk-model-village-scheme-to -miss-deadline/

7. Gund
8. Matipora
9. Tantray Mohalla
10. Chopan Mohalla
11. Dhobi Mohalla
12. Noor Mohalla
13. Nabshah Mohalla
14. Kumar Mohallah
15. Magray Mohalla
16. Chailpati (dominated by Gujjars)

Institutions of the village

Drugmullah is relatively better in terms of the institutions it stations in the village. These institutions are a source of convenience as people do not have to travel long distances to avail the services. There is an office of the Zonal Education Officer (ZEO) which caters to educational services in the area. There are offices of Horticulture and Animal Husbandry Department as well. Jammu and Kashmir Bank (JKB) is operational in the village with its Automated Teller Machine (ATM) installed in the market place. Grameen Bank is also in functional in the village. There is a residential headquarter of Rural Development Department. There is a fire service department in the vicinity of the village. Geology and Mining department is also in the village. There is an office of Regional Transport Office (RTO) as well.

In terms of educational institutions, there is a Girls High School and a Boys Higher Secondary School in the village. A college of Education (B. Ed) is also present in the village. There is also a police station in the village. The military has occupied some of the areas in the village and a huge military camp is stationed in the village. There is a Burns Hospital associated with the military camp.

Caste in Drugmullah

There are different caste groups in Drugmulla like Shahs, Pirzadas, Bhats, Mirs, Tantrays, Kumars and Lones etc. There is a spatial distribution of caste in the village dividing village into various mohallas based on caste and sometimes based on occupation their ancestors practised. Although, the households are not distributed in the mohallas purely based on caste. However, the majority of the households having the same caste reside in one mohalla.

The peers and shahs are usually considered as upper caste. The land belonged to few castes in the beginning. Then at the time of the land reform in 1952, the land went from landlord to tenant. So, there was considerable distribution in the land. In Drugmullah, the availability of cultivable land is not adequate.

People generally prefer marrying their children in the same caste or the caste which is equivalent to their caste. For example, Shah and Peers will marry each other who are socially considered compatible with each other. War and Bhat are considered socially of equal status do marry with each other. Kumars will marry Kumar and they will not opt for other castes.

Inter caste marriage is not routine however, it does take place occasionally. There have been few instances where upper caste Peers and Shahs have married off their girls in a different caste. Castes other than Peers and Shahs also practice endogamy and one can observe that they occasionally marry off their children in other castes. Most of the castes have been named according to the occupation they are carrying or their ancestors would carry. For

example, sheikhs in Kashmir are associated with making brooms which they still do in Drugmulla. Kumars would make earthen utensils in the past in Drugmulla, now they have left it and are associated with other occupations like livestock and driving vehicles. Sofi's in Drugmulla are associated with growing vegetables and selling them in the village itself. Magrays are mainly shopkeepers. Wars also sell vegetables and maintain kitchen gardens here in Drugmulla. Bhats are mainly agricultural workers. Peers and Shahs were/are the ones who would have religious education and would impart that to others which is why they were considered as upper caste. They would mainly lead prayers in the mosques. Now very few of them are carrying with their ancestral job. Now they have opted for different government, private jobs and do businesses also.

There is an area or a small habitation in Drugmulla which is backward from the rest of the village. This area is called Chailpati which is inhabited by Gujjars (Scheduled Tribes). The area is relatively poor than the rest of the village. The education level is also very low. Only eight people are in the government sector. Among them two are teachers, one is in police service, two are in army and two in the Forest Department. surprisingly, electricity was introduced in Chailpati eight years ago. The people of this habitation until recently would use kerosene lamp and chimney for the purpose of lighting.

People of the area are discontent with their political representatives voicing their concern saying that Member of Legislative Assemblies (MLAs) visit the areas during election time, ask for votes and then they vanish. They do not pay any heed towards the development of the area.

There is no health facility in this habitation. They have to walk on foot a few miles before they could access the service of a PHC. Few maternal deaths have been reported in the area. One of the ladies passed always along with her baby. Another lady delivered her baby in a

vehicle while she was being taken to the PHC. The medicines for the general ailments are being sold by the small shopkeepers at a very higher price and without any prescription.

UMEED: An initiative of Jammu and Kashmir State Rural Livelihood Mission (JKSRLM)

UMEED is an initiative of the Jammu and Kashmir State Rural Livelihood Mission (JKSRLM) implemented by the Department of Rural Development and Panchayati Raj, District Kupwara for the welfare of women. UMEED is a society of the government of Jammu and Kashmir and it is run as a part of the National Rural Livelihood Mission (NRLM). The key features of NRLM are universal social mobilisation, promotion of the institutions of the poor, capacity building, skill-building, and financial assistance in the form of revolving fund and capital subsidy, universal financial inclusion, provision of interest subsidy, livelihoods, infrastructure creation and marketing support.

UMEED is currently running in district Kupwara in four blocks like Hyhahma, Drugmulla, Kupwara and Nutnussa. In block Kupwara, about 561 SHGs have been formed under UMEED. Out of 561 SHGs formed 522 of them have been accredited grade ‘A’ hence are functioning properly. The office of UMEED in Drugmullah is stationed in a marriage hall. The marriage hall was being built by the Department of Rural Development some years back and then in 2010 during people’s uprising the building was vacant. Fearing that the building may be taken by the army or some other agency, it was taken over by UMEED.

The entire district is divided into clusters and Drugmullah falls in cluster D. There are about 109 SHGs of women in cluster D. The trainers with UMEED go to the various clusters and impart training to women about forming a group, lending among group members, use of revolving fund (which comes from the government), saving and repayment. The project is mainly for the rural areas and identification of the poor women (BPL).

This schemes preferably focuses on women who are poor and want to support their families. This initiative is based on microcredit and inculcating saving and lending habits in women so that a sense of responsibility is created in them and towards their families and to initiate their future business ventures. In the village itself, there are a lot of women who have been formed into self-help groups. These women meet regularly and have formed committees on health and education also.

While talking to the trainer with UMEED, he said that “there are unions of drivers, doctors and other employees, but when it comes to poor people there is no such union”. A survey is done in the area based on the record of the office about the population which live below the poverty line and above the poverty line. All the people are called to a place and self-help groups are formed. Awareness about the scheme is also done from time to time.

There are success stories where women have become small entrepreneurs with the help of microcredit. There is a lady who has the skill of designing garments using silver threads (Tilla work). She transferred this skill to her husband as well and with the assistance of microcredit started a small unit on her own. Now this couple works together and earns a good livelihood. Similarly, women have started buying cows and then capitalising on them for their livelihood. There is a lady who started a small business on her own by selling vegetables and now the same lady has a small provisional store which she runs on her own.

In the beginning, when UMEED was launched in the village there was a lot of scepticism about the scheme because it was focussing on women alone. Men were reluctant to give permissions to women to attend the meetings which UMEED would conduct periodically. But gradually seeing good work of UMEED the villagers have now developed a sense of trust.Now women come on their own for admission in a self-help group. But still, some of the people look at UMEED with suspicion.

There is a Primary Health Centre (PHC) in the village which functions well. It is located in the outskirts of the village towards the national highway. The staff of the PHC is as under. Most of the staff members have been appointed on a contract basis under National Rural Health Mission (NRHM) in 2005-2006.

1. Dental Doctor
2. Doctor (Indian System of Medicine ISM)
3. MBBS doctors (2)
4. Lady Doctor (one)
5. (Indian System of Medicine) ISM Pharmacist (2)
6. Normal Pharmacist (1)
7. Lab Technician (1)
8. Dental Technician (1)
9. General Nurse (1)
10. Health Educator (1)
11. Female Multi- Purpose Health Worker (2)
12. Nursing Orderly (2)
13. Driver (1)

Drugmullah PHC has two doctors posted in the PHC but they mainly remain in CHC Kupwara. The FMPHW caters to pregnant women and women having other ailments like urine infection, pain management, cough and cold. There is one BUMS doctor as well. He also sees patients and recommends medicines and tests to the patients. There is no facility of

USG, X-Ray or blood testing facility in the PHC. So, patients have to seek private health service for that which is expensive and not always affordable.

On the 9th of March 2020, Drugmullah PHC got its first laboratory with some of the test facilities which was inaugurated by Deputy Commissioner, Kupwara. The types of equipment which were installed were automated haematology analyser, dental chair, diesel Genset and ECG machine under Ayushman Bharat Scheme[38].

ABROGATION OF ARTICLE 370 AND ITS EFFECT ON HEALTHCARE

Jammu and Kashmir is a disputed region. Both India and Pakistan claim the territory of Jammu and Kashmir as their own. The issue of Jammu and Kashmir is a fallout of the partition of India. When British left India, India was bibliography divided into two countries India and Pakistan. It was decided that majority of the muslim state will go to Pakistan and Hindu majority stated would be retained by India. Since, Kashmir was a muslim majority state it would have become technically part of Pakistan but it had a hindu ruler who signed an instrument of accession with India and Jammu and Kashmir became part of India. People of Jammu and Kashmir were not happy with the union of J&K with India. So, in that regard Pt. Jawahar Lal Nehru, the then Prime minister of India promised the people of Kashmir plebiscite, right to self determination that is yet to take place. However, a special status was given to Jammu and Kashmir through Article 370 enshrined in the Indian constitution.

[38] A flagship scheme of Government of India, was envisaged by the National Health Policy (NHP) 2017, to achieve Universal Health Coverage (UHC). The scheme intends to meet Sustainable Development Goals (SDGs). It is an attempt to change the approach of healthcare from sectoral and targeted approach of health service delivery to a comprehensive health care service. This scheme also intends create Health and Wellness Centres (HWCs) to deliver the comprehensive healthcare by converting sub centres and primary health centres into health and wellness centres.
Pradhan Mantri Jan Arogya Yojana (PM-JAY): An insurance policy to cover 10 crore poor people identified through Socio-economic Census of 2011
Ayushman Bharat Pradhan Mantri Jan Arogya Yojana 2018, https://pmjay.gov.in/about/pmjay, Govt. of India Accessed on 07.12.2020

A movement against Indian rule in Kashmir begun in 1989. The movement was an armed struggle against India and it was political in nature as well (Schofield,2010). During the decade of 90' the valley of Kashmir witnessed violence, loss to life and property, cases of rape and abduction, curfews and shut down and it continued for a long time. In 2008 Amarnath Land Row happened and people protested against it in millions. Thus, the movement which was called as a militant one changed into mass movement. From 2008 to 2016, massive protests were seen in Jammu and Kashmir against the Indian rule. In August, 2019, the special status of Jammu and Kashmir was abrogated without any state assembly for ratification in place. The state of India wanted full integration of Jammu and Kashmir with the union of India. Before that 28000 additional troops were called. Nothing was announced beforehand. So, there were lot of rumours of war with neighbouring Pakistan. Speculating some vicious design, there was unusual scare among people of Kashmir valley. All the leaders were put under house arrest whether mainstream or separatists. There were nocturnal raids and people remotely affiliated to any of the organizations were put under detention.

Fearing shortage in the supplies in the times to come, people started crowding the markets and went for buying supplies in bulk. Long queues filling fuel to vehicles were seen. And when 5th of August was nearer, there was shortage of petrol and diesel and people had to suffer immensely because of that. On 4th of August, 2019 me and my husband were travelling to Sopore from Srinagar which is a distance of 60 Kms. Our vehicle too ran out of fuel. We went to almost all the filling stations on the way, but all the stations were closed down. At one place we could find a filling station where there was a long queue of vehicles waiting to get fuel. We had to wait for hours to reach the spot. The same was happening all over the valley.

On 4th of August evening all the channels of communication were snapped. Cable TV and satellite TV were blocked. Electricity was snapped too. That night there was a raid in our

immediate neighborhood. And same raids were happening all over the valley. Newspapers were also not circulated that day. Satellite TVs with limited channels were allowed and in the morning of 5th of August, Amit Shah (Home Minister) in the parliament declared that article 370 has been abrogated and statehood of Jammu and Kashmir is relinquished and was made a union territory. Ladakh being part of Jammu and Kashmir was also declared as separate union territory.

Post Article 370

Fearing people may come out of their houses and protest, curfew was imposed across Jammu and Kashmir. Communication channels were shut. Internet was blocked. Landline services, broadband, were blocked also. Jammu and Kashmir was totally cut from rest of the world both in terms of mobility and communication. This embargo on communication continued for about 7 seven months. It is in March,2020, that 2G internet service was started and is still in place.

Since there was internet blockade there was no sharing of information. It is only when 2G internet which is excruciatingly slow was started, one could access outside response to the abrogation of Article 370. In terms of limiting access to healthcare Lancet published an editorial on 17th of august, 2019 titled Fear and '*Uncertainty Around Kashmir's Future' in which the statement was made like this*

"Last week in a controversial move, India revoked the autonomous status of Jammu and Kashmir, allowing India greater authority over the state's affairs. The announcement fanned tension with Pakistan, which also claims the region and has fought India over it for more than seven decades. At least 28 000 Indian security forces have been deployed; in the capital city Srinagar, a lockdown has been implemented that suspended communication and internet links, and a strict curfew has been imposed. The militant presence raises serious concerns for the health, safety, and freedoms of the Kashmiri people" (Lancet, 2019).

British Medical Journal (BMJ) also published an editorial titled '*Kashmir Communications blackout is putting patients at risk, doctors warn'* by Elisabeth Mahase. The editorial reported that there is a denial in the right to seek health care of the patients because of the security lockdown, restrictions on internet, and travel. Shortage of supplies, people not able to procure baby foods and lifesaving drugs like insulin, denial of routine care, delay or cancellation of treatment of people on chemotherapy and dialysis. A group of 18 doctors wrote to BMJ to lift the restricts and ease the lives of people of Kashmir.

Once the special status of Jammu and Kashmir was abrogated, it had direct effect on health service deliverance. The staff of the PHC who lived away from the PHC were not allowed to attend their duties because of curfew and restrictions in place. However, the medical supplies were not affected because before abrogation there were rumors that something might happen. Before abrogation of 370, additional military troops were called and there was a panic like situation where petrol stations ran dry, food stocks were exhausted. So, in that scenario people started dumping and stocking essentials. So, in that scenario essential service departments had also stored huge supplies. The local staff would make it to PHC. The patients from far flung areas could not seek health service from PHC.

CHAPTER III

RESEARCH METHODOLOGY

Conceptualisation of the Study

Pregnancy loss is a multidimensional concept with social, medical, legal and moral implications (Hirve, 2004). A lot of emphasis is given to the statistics of pregnancy loss; however, the experience of women facing such loss, which can, although broadly vary from woman to woman, is not given much attention. Adolfesson (2003) argues that experiences of women facing pregnancy loss have not been researched comprehensively, and such research must be deepened and extended. Similarly, the aetiology of such loss has been extensively studied, while very few studies have attempted to explore the influence of socio-economic factors on the outcome of pregnancy (Kim et al.,2018). Besides having a medical story, pregnancy loss entails variable personalised and individual experiences ranging from physical and emotional trauma to possible socio-economic predispositions that could lead to induced and spontaneous abortions.

Like many other parts of the Indian subcontinent, Kashmir has a conservative social set-up with patriarchal dispensations and poor socio-economic indicators. The poor socio-economic indicators coupled with prolonged armed conflict in this region provide a unique context to study the qualitative and quantitative aspects of pregnancy loss. It also presents an interesting area to explore the influence of socio-economic stresses on the outcome of pregnancies and investigate the interaction of women facing pregnancy loss with available healthcare settings.

Rationale and Field of Study

Very few studies have focused on investigating the qualitative aspects of abortion through lived experiences of women facing pregnancy loss in conservative social

configurations (Anandhi,2007; Barua,2007 Morankar,2007; Radkar,2007; Barnes,2003 Jagnayak,2005; Ravindran,2002). Many previous studies have reported the incidences of pregnancy loss across different states in India (CEHAT, 2004; Sebastian et al., 2013; Singh S et al., 2018; Yokoe. R et al., 2019) while a few qualitative studies have thrown light on the experience of Indian women facing pregnancy loss (Barnes, 2003; Jagnayak,2005; Anandhi,2007; Barua,2007; Morankar,2007; Prakashamma,2007; Susheela and Nagaraj,2007; Visaria,2004). Although national surveys like National Family Health Services (NFHS) and District Level Household Survey (DLHS) report the reproductive health statistics of Jammu and Kashmir region quadrennially, however, till date, no study has attempted to gain insights into the lived experiences of women facing pregnancy loss in Jammu and Kashmir. Further, differential experiences of women facing spontaneous abortion and those inducing abortions in terms of social support, decision-making, utilisation of healthcare and general reproductive healthcare would provide valuable insights into the roles of such factors influencing spontaneous or induced abortion in Jammu and Kashmir.

Kupwara is one of the backward districts of Jammu and Kashmir and has been reported to have poor socio-economic indicators like a low standard of living, low female literacy and employment along with declining sex ratio, high pregnancy-related/post-delivery complications, low contraception prevalence rate (IIPS, 2010; IIPS 2016). With this background, it becomes imperative to investigate the lived experiences of women facing pregnancy loss and study their interaction with the available healthcare facilities in a place like Kupwara. Therefore, the present study intends to gain insights into the lived experiences of women facing pregnancy loss in district Kupwara of Jammu and Kashmir and also attempts to evaluate the impact of non-medical factors (like socio-economic factors) on the experiences of such women. The present study further attempts to explore the interaction of study subjects with the available healthcare settings.

Research Questions

The present study attempts to address the following questions regarding the women of Kupwara district:

1. What is the experience of women having a history of induced abortion in terms of their location in social structure, education, decision making and agency?
2. What is the experience of women having a history of spontaneous abortion in terms of grief and sadness? How do these women cope with it?
3. What socio-economic and medical factors influence pregnancy loss in women (Spontaneous and Induced Abortion)?
4. Do women's experiences vary with the differing socio-economic status of women facing pregnancy loss?
5. How do women utilise abortion care services? Are these services affordable, available and accessible?
6. How do women utilise and access general reproductive health services in addition to abortion care services?

Overall Objective

The overall objective is to study experiences of pregnancy loss due to induced and spontaneous abortion, health service access and its utilisation among women of district Kupwara, Jammu and Kashmir.

Broad Objectives:

1. To study the social and medical experience of women who have undergone an induced abortion.

2. To study the social and medical experiences of women who have faced spontaneous abortion.

3. To understand the social and medical factors that influence the experiences and consequences of women with a history of induced and spontaneous abortion.
4. To study the availability, accessibility and utilisation of abortion care services for women with a history of induced and spontaneous abortion.
5. To study the general reproductive health service access and utilisation by women facing pregnancy loss.

These broad objectives necessitate the study of the following specific aspects:

1. Marriage and Pregnancy
2. Obstetric History
3. Employment
4. Social Support
5. Education
6. Decision Making
7. Grief and guilt due to Pregnancy loss
8. Coping with the Loss

Experiences of accessibility, affordability and availability of abortion services after pregnancy loss

a. Physical access to abortion services
b. Economic access/Affordability of abortion services (Affordability)
c. Availability of abortion services
d. The utilisation of abortion services

Field of Study

Kupwara, a district of Jammu and Kashmir, was chosen as the universe for the present study. Kupwara is one of the frontier districts of Jammu and Kashmir and is located 87 km

from the summer capital, Srinagar. The district has low human development and socio-economic indices (Government of Jammu & Kashmir, 2008). The community has a mixed population of Gujjars and Bakerwals who live in the upper reaches of the district. Ministry of Panchayati Raj declared Kupwara as one of the backward districts in the country and it receives funds from Backward Regions Grant Fund Programme (BRGFP) (MoPR, 2009). The per capita income of the district is equal to ₹16,360 as compared to ₹24,398 in rest of the Jammu and Kashmir. Almost 31.82 per cent of the population lives below the poverty line compared to 21.63 per cent in the state of Jammu and Kashmir (Government of Jammu and Kashmir, 2008). According to DLHS-3, 65.5 per cent of people have a low standard of living (DLHS-III, 2008) in the district.

In 2001, the sex ratio in Kupwara was reported to be 906, which drifted down to 835 females per thousand males in 2011, which was attributed to sex-selective abortions (RGI,2011). According to the census of 2011, the literacy rate of Kupwara was reported to be 64.51 per cent with a male literacy of 75.68 per cent and female literacy of 50. 95 per cent (RGI, 2011).

About 84.4 per cent of pregnancy-related complications were reported, which were highest among all the districts of Jammu and Kashmir (IIPS, 2010). Post-delivery complications were also highest in Kupwara, which was recorded at 75.5 per cent. According to NFHS-4, in district Kupwara, only 23.7% of institutional deliveries took place as compared to Srinagar, where 88.6% of deliveries took place in the hospital settings (IIPS,2016). According to DLHS-3 (2007-8), in district Kupwara, there were 90.6 per cent of live births, 2.0 per cent of stillbirths, 1.6 per cent of induced abortions, and 5.8 per cent of spontaneous abortions in 637 pregnancies, which were sampled in this given survey (IIPS,2010). According to NFHS-IV, the district recorded a Contraceptive Prevalence Rate (CPR) of only 51 per cent. The total

unmet need for contraception in the district was recorded at 13.1, which stood comparatively higher than other districts of Jammu and Kashmir (IIPS, 2016).

Village Drugmullah

The present study was undertaken in the village Drugmullah of Kupwara district, one of the district's largest villages considering the total area and population. The village is situated at a distance of 4 km from the main town of Kupwara. Its population was recorded at 12,930 of which 7,665 were males and 5265 females according to the census of 2011. The number of children aged 0-6 years was 2,394, which amounted to roughly 18.52 per cent of the total population (RGI, 2011). The female sex ratio in the village was 687 against the state average of 889. The child sex ratio was 769 against the state average of 862. In Drugmullah, male literacy was about 82.73 per cent, and female literacy was as low as 54. 73 per cent. Drugmullah census village administers about 1458 households (RGI, 2011). The village has a mixed population which includes Gujjars who live in the upper reach of the village called Chailpathi. The village has a functional Primary Health Centre (PHC) where pregnancy cases were reported to a fair extent. Women visit PHC for regular ailments, reproductive health, and abortion care services. Women also access PHC for the immunisation of their children. In addition to the deliverance of health services, the PHC also offers a space for women to see and meet each other and share their day-to-day life events.

Analytical Framework, Phenomenology and Analysis

The qualitative data generated in the present study, which encompassed the impact of various socio-economic factors on pregnancy, was interpreted using Heidegger's interpretative phenomenology (Adolfesson et al., 2003; Astbury- Ward et al., 2011). The

phenomenology was also employed to comprehend the dialectical relation between the society and respondents.

The data acquired in the present study were analysed by an inductive method which involved unconditional analyses and contextualising a particular respondent in a definite social setting as described in a previous study (Loi et al., 2018).

Phenomenology is a study of lived experience or the life world (Van Manen, 1997). It is a world of experience inseparable from reality (Valle et al., 1989). The method of phenomenology helps in comprehending and understanding the lived experience and its meaning (Polkinghorne, 1983). Meaning is found as the world constructs humans, and at the same time, it is humans who build the world from their background and experience (Laverty, 2003). Heidegger emphasises that once we try to understand the reality of a person and their experience, we cannot do that without reference to the person's background (Laverty, 2003). Heidegger emphasised that an individual's background and historicity are essential to interpreting a given situation (Laverty,2003). The interpretative process concentrates on historical meanings of experience that profoundly affect both the individual and social levels (Laverty, 2003). "Although phenomenology is essentially a philosophy, however, it is now frequently referred to as both a philosophy and a research suitable for qualitative enquiry" (Astbury-Ward et al.,2012, p. 3138). “An assumption central to phenomenology is that a basic “essence” exists that is shared by those who experience the same phenomena” (Adolffeson et al., 2004, p.546).

Methodology of the Study

The study employed qualitative and quantitative research methods (Finer et al., 2005). The current study was based on qualitatively dominant (qualitatively driven) mixed-method research which includes a sequential design in which the General Reproductive Health

Survey (GHRS)[39] (Quantitative Component) is preceded by in-depth interviews (Qualitative Component) QUAL------ quan as described by Mores (1991). An *analytical point of integration* between the qualitative and quantitative study methods has been made. The analytical stage of in-depth interviews has been followed by the second analytical stage of GHRS.

Qualitative Study

In-depth Interviews: A village Drugmullah in district Kupwara was selected for the study. At first, the qualitative part of the research was undertaken in which in-depth interviews were conducted with the research participants/respondents. A semi-structured interview guide was developed for GRHS after gaining insights into the community through in-depth interviews.

Sampling and in-depth interviews: Purposive and network sampling technique was used to identify women with a history of pregnancy loss in the form of spontaneous and/or induced abortion as described in a previous study (Astbury et al., 2012; Rehnstrom et al., 2018). Data on pregnancy loss was collected from the Primary Health Center (PHC) of the village Drugmulla in Kupwara district of Jammu and Kashmir from 2015 to 2018. Accredited Social Health Activists, commonly called 'ASHA[40]', who follow pregnancies in their assigned area till delivery and regularly report the progress to PHC, assisted in acquainting the researcher with community and identifying women with a history of pregnancy loss. Since finding participants who have experienced pregnancy loss was difficult as pregnancy loss entails a very personalised and individual experience and is difficult to probe, that is why

[39] GRHS is General Reproductive Health Survey which forms the quantitative part of the study. It will be written as GRHS now onwards.

[40] "In order to provide effective healthcare to the rural population, the National Rural Health Mission (NRHM) by government of India proposed introduction of female health workers village level. These workers are called Accredited Social Health Activists (ASHA) and their role is to act at an interface between the community and the government healthcare services. More specifically, she is responsible for promoting universal immunisation, referral and escort services for reproductive and child healthcare and other health care delivery programs" (Mishra, 2010, p.1)

snowball sampling was used to recruit the participants. Although, the preliminary sample for the purpose was generated with the help of ASHAs (Naderifar, Goli & Ghaljaie(2017); (Sadler et al.,2010); Schreiber & Macdonald (2010);(Swallow et al.,2012). ASHAs are considered volunteers, although they receive performance-based incentives from time to time. ASHAs are considered very critical from the point of view of maternal health service utilisation (Agarwal et al., 2019). Five ASHAs, each assigned a specific area of the village, helped the researcher in the identification of cases of induced and spontaneous pregnancy loss. Several meetings were set up with the ASHAs in which they were informed about the importance of present research to build a relationship of trust, following which information about abortions, induced abortions, in particular, were obtained. Further, it was assured that confidentiality and anonymity were of paramount importance. Before the start of the interview, a rapport was built with each respondent after which they were briefed about the study, followed by obtaining verbal consent from the respondent to be interviewed.

The semi-structured interviews of respondents with a history of either spontaneous and/or induced abortion/s were audio-recorded (Transcribed interviews appended at Appendix-A), and Interview Guide appended at Appendix-B). The interviews lasted from about 15 minutes to 1 hour and were mostly conducted in participants' homes or the PHC. The interviews were transcribed by the researcher and validated by academicians and clinicians for its quality, following which the audio-recordings were deleted. To preserve participant anonymity, they were not identified in any part of the research outputs and pseudonyms were used wherever necessary.

The sample comprised 30 women aged between 13-45 years who had been married for two months to thirty years and reported an event of spontaneous and/or induced abortion at least once. The basic information of the respondents recorded included number of children, education, employment status of respondent and her spouse, family status (joint or nuclear),

number of abortions and neonatal deaths. To comprehend the social context of pregnancy loss, information was acquired from respondents regarding the social support they received, decision making, contraception, socio-economic reasons for pregnancy loss, feelings of guilt and relief, moral dilemma, memory, and willingness to share their experience of pregnancy loss and health service utilisation. To evaluate the interaction of respondents with the health care system, parameters like pre-and post-abortion utilisation and access to healthcare by respondents were assessed as described in a previous study (Zamanian et al., 2016).

Analysis of Qualitative Data

Heidegger's phenomenology i.e. the method of induction, was used to analyse the data (Adolffeson et al., 2012); (Astbury et al., 2012); (Rehnstrom et al., 2018). All the interviews were transcribed verbatim. Since the objectives/themes of the study were already delineated in accordance with the interview schedule, however; other themes came up during the process of in-depth interviews. Additional themes were generated during reading and re-reading the transcripts (method of induction). During the in-depth interviews, the participants were encouraged to discuss issues they thought were important to their lives. Those themes were not included in the interview schedule but were added to the final analysis as described in previous studies (Astbury-Ward et al., 2012). Some of the phrases and sentences women used were unique and would capture the essence of an event. Those were recorded and written in the original form (mother tongue). There was an attempt to translate these phrases into English as closely as possible.

Quantitative Study

General Reproductive Health Survey (GRHS)

To capture the overall reproductive health status of women in the village, a survey was undertaken. The sample for the survey was generated after scrutinising the revenue document obtained from the office of the Tehsildar. The document contained information about the

households, caste, number of children, employment, age, land holding etc. The document was fully investigated for all these variables. Since a sample of 100 households had to be generated, women were purposively sampled. An *inclusion* and *exclusion criteria* were employed to get the required model (Vallely, 2014). While considering the participants for the study, it was made sure that the ratio of different social categories in Drugmullah village roughly corresponded to the percentage of different social categories in the sampled population.

(***Format used for General Reproductive Health Survey (GRHS) is appended at Appendix-C***).

Inclusion Criteria: All those women who belonged to households having a land holding of 0-3 kanals, employment status of spouses and women falling in the reproductive age group of 18-45 years of age were included in the survey. So, Inclusion criteria were

1. Land (0-3 kanals)
2. Unemployment
3. Women in the reproductive age (18-45 years)

Exclusion Criteria: All those households were excluded in which there were not any women falling in the reproductive age group of 18-45 years of age.

In this way, 100 women belonging to 100 different households were chosen of the reproductive age of 18-45 years among 1188 households of the village. The employment status of their spouses was observed, who mainly belonged to the labour class. All these households had a land holding of 0-3 kanals. Since the revenue document was prepared in the year 2010-2011, selecting the sample of women nine years were added to their recorded age because the document was accessed in the year 2018.

Data Collection

The sample of 100 respondents generated by applying inclusion and exclusion criteria were interviewed. Since the aim of undertaking the quantitative part was to understand the general reproductive health of the women in addition to the personalised experiences of abortion and miscarriage, in this part of the study, general questions regarding marriage, conception, pregnancy, contraception, access to healthcare (ante-natal and post-natal), questions regarding abortion and miscarriage were asked. For the GRHS, a standard interview schedule developed by WHO was used with certain modifications (WHO,1996). Parts of the interview schedule on contraception, access to abortion care, reproductive health history, questions about reproductive intentions were mainly incorporated in the interview schedule used in the current study. It was ensured that none of the respondents included in the qualitative part of the study was considered for the quantitative part of the study. Afterwards, the interview schedules were scrutinised, the responses were analysed. Data were tabulated and presented as graphs prepared using Graph Pad Prism.

Ethical Issues

The current study was about a highly sensitive pregnancy and pregnancy loss issue. Informed and verbal consent were taken from the respondents to answer the questions about pregnancy loss. Utmost care was taken about the issue of confidentiality, and names of the respondents were kept confidential.

Sources Used

Demographic and Health Facility Survey, National Family Health Survey (NFHS I, II, III & IV) JSTOR, PubMed, Reproductive Health Matters, Science Direct, Elsevier, Cambridge University Press, Oxford University Press, CEHAT, WHO database, Journal articles and books, Guttmacher Institute publications.

CHAPTER IV

RESEARCH FINDINGS

Research Findings from Qualitative Study

Characteristics of Respondents

There were 30 participants/respondents in the qualitative component of the present study. The number of children born to respondents ranged from 0 to 8**.** Fifteen out of thirty respondents were illiterate, and the majority of respondents worked as housewives. An anganwadi helper and an ASHA were also a part of this study. Spouses of the majority of respondents in this study worked as labourers. All respondents bore one child to multiple children except four, who were nulliparous at the time of the interview. Nineteen respondents had experienced spontaneous abortion, twelve had experienced induced abortion, and six had experienced both induced and spontaneous abortion. The socio-demographic characteristics of respondents of this study are given in Table 7.

Social Support

The majority of respondents who underwent either spontaneous or induced abortion had limited post-abortive social support. It was observed that the majority of respondents did not take any break from the routine household work post-abortion. Many respondents claimed to have received little or no support from husbands during and after the episodes of abortion. Very few respondents who induced abortion reported having received support from their in-laws; however, a considerable number of respondents with spontaneous abortion reported appreciable support from their in-laws.

In some cases, it was observed that respondents shared a formal relationship with their in-laws to the extent that the respondents did not even share the news about the event of an abortion.

One of the participants recorded…

"I will silently bear the hardships which abortion comes along with. It is only that my in-laws should not come to know about it. Nobody should know about it." (Zahira, Personal Communication, 22, February 2018).

In some instances, it was observed that respondents continued with their household chores despite carrying retained products of conception (RPOCs) from a recent event of induced or spontaneous abortion.

"We pack ourselves with old and ragged clothes (to conceal post-abortion bleeding) and carry on with the routine household work" (Zahira, Personal Communication, 22 February 2018).

In other cases, it was found that the respondent and their spouse had mutually decided to induce abortion without informing other family members. However, a few respondents who underwent spontaneous abortion reported that the husband's knowledge about abortion did not enhance the social support offered to them by other family members. It was observed that husbands, on behalf of respondents, in most of the cases of induced or spontaneous abortion, were not able to negotiate with their familial set-ups on the amount of social and emotional support needed by respondents during events of abortion.

One of the participants said that….

"My husband could not offer much help because our familial structure does not give him much space to negotiate on my behalf with other family members" (Basheera, Personal Communication,03.09.2015, Drugmullah, Kupwara)

Some respondents acknowledged that they could not seek the social support they deserved in the event of an abortion.

"I would drag myself every time to do the routine household work which otherwise I was not in a condition to do. I could not talk about this to my in-laws"(Nazima, Personal Communication,25.01.2018, Drugmullah, Kupwara)

Respondents also reported a lack of knowledge or consideration of their husbands about the support a woman deserves in events of miscarriage and induced abortion.

"Despite the pain, I had to carry on with my routine work because my husband did not offer help. So I would drag myself and work" Zahira, Personal communication,22.02.2018, Drugmullah, Kupwara).

It was found that a few respondents hesitated to share episodes of abortion even with their parents.

> *"I did not even tell my parents about the event of miscarriage. I would come out of bed and sound fresh from receiving their phone call. They would, however, feel that I was not well. But I would assure them that I was fine" (Nazima, Personal Communication,25.01.2018, Drugmullah, Kupwara)*

Some respondents claimed that pregnancy loss to them was entirely a personalized experience with limited social support.

"I had to bear it all alone. Even my husband was unaware of what I was going through, not to mention others. (Zahira, Personal communication,22.02.2018, Drugmullah, Kupwara)

Role in Decision Making

Among all the cases of induced abortion, it was seen that most decisions to abort were taken solely by respondents. A couple of such decisions were mutual; in one case, the decision to abort was solely made by the husband. Nevertheless, the majority of the respondents remained indecisive for a long before actually inducing abortion. The respondents further claimed that such decisions involved discerning thought and labouring under dilemma for a long.

One of the respondents remarked…

> *"I waited for four months. I told my husband that I did not want to carry this pregnancy. I kept thinking about it for a long, but then the thought about my children, household and other responsibilities compelled me to induce abortion".* (*Nighat, Personal communication,27.02.2018, Drugmullah, Kupwara*)

One of the women said that she would go for an abortion in future without informing her husband if she felt she could not shoulder too many responsibilities.

"I had to manage an entire household which means much work. If I again happen to conceive, I will induce abortion without letting my husband know about it". (Sabahat, Personal Communication,05.09.2015, Drugmullah, Kupwara)

It was observed that husbands supported the decision to induce abortion in some cases, while in other cases, the decision was solely encouraged by husbands.

"When I aborted the pregnancy, I was relieved. I felt happy. And my husband was also with me. He supported my decision".

(Jahanara, Personal Communication,22.08.2018, Drugmullah, Kupwara)

It was also observed that in some instances, husbands refused to be part of the decision-making.

"My husband warned the pharmacist, from whom I had bought the abortifacient, that the pharmacist shall be solely responsible for any complication that could arise post-abortion". (Sabahat, Personal Communication,05.09.2015,Drugmullah,Kupwara)

In a rare instance of self-induced abortion, it was noticed that husband was resentful and blamed the respondent for killing her child.

"Why do you have to kill your children when you do not have to earn for them?"(Sabahat, Personal Communication,05.09.2015, Drugmullah, Kupwara)

Secrecy

In most cases of abortion, induced and spontaneous, respondents maintained a certain level of secrecy about the episodes. The news about the event was not disclosed to the family members and only to husbands when such decisions to abort were mutual. Some respondents disclosed the information about induced abortion confidentially to someone in a position to help respondents in abortion induction or in seeking post-abortive medical care. It was found that most of the respondents sought medical care after inducing abortion in village PHC citing reasons for spontaneous abortion.

One of the respondents said that…

"When my first abortion happened, we (me and husband) kept it a secret, and when things were out of control, we disclosed it to other family members (Kulsooma, Personal Communication,21.09.2015, Drugmullah, Kupwara)

Another woman recorded that….

> *Living among in-laws and disclosing information about personal affairs to them is very difficult. We hide such things because we are not comfortable sharing them with anyone. Because of concealing these events, we land in many problems. I have seen many hardships in terms of abortions, but I have never disclosed things to my in-laws". (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara).*

Some of the participants said…

"We pretend as nothing has happened. We work, eat, and do things like other family members".

Few of the women said that…

> *"We consume tablets to induce abortion. If it happens smoothly, there is no need to seek medical help. If there is some problem, then only we go to PHC and do not disclose the nature of abortion to them. We say it was a miscarriage".*

One of the participants said that…

> *"Since it is a sin, and nobody will approve of it. We try not to disclose it to anyone. My father-in-law came to know about it once. He scolded both my husband and me and warned us that the children we killed would get up in the hereafter and question us about the sin we killed them for. You are making all of us sinners. If you don't need them, why do you try to produce them". (Zohra, Personal Communication,25.02.2018, Drugmullah, Kupwara)*

Unmet Need for Contraception and Unsafe Abortion

Contraceptive measures were practised alone by respondents in most of the cases, while in a few cases, it was seen to be practised by husbands. Most of the respondents used Copper-T as a method of contraception. Overall, it was noticed that induced abortion was

used as a method of birth control in almost all the respondents. The majority of unwanted pregnancies happened due to the lower use of contraception. Most of the respondents claimed that their husbands had never agreed to use a condom during sexual intercourse, while irregular usage of condoms was observed in other cases. One of the respondents said that…

I tell my husband to use contraception, but he never pays heed. I have always felt helpless" (Rehana, Personal Communication, 22.02.2018, Drugmullah, Kupwara).

On failing to convince their husbands to practice contraception, many respondents were observed to resort to other methods of contraception like the use of Copper-T, which village PHC facilitated. However, almost all such respondents decided to withdraw it after a certain time, citing reasons ranging from hindrance in performing heavy work to continued vaginal bleeding.

One of the respondents said that…

"I am not comfortable using Copper-T because we have to do heavy work. I bled for three months once I used it. Then I got it removed". (Rizwana, Personal Communication, 05.09.2015, Drugmullah, Kupwara)

Another participant said….

"When my cousin came to know that I had used copper-T, she panicked and took me to a PHC and had that removed. She said that I was too young to use copper-T". (Jabeena, Personal Communication, 26.02.2018, Drugmullah, Kupwara)

It was observed that all the respondents had consumed the abortifacient drug, misoprostol, to induce abortion. The medicine was illegally bought through some unnamed acquaintances.

"I went to a medical shop myself to buy the medicine. The person who sells the medicine is known to me. He initially refused. I had to plead before him, and then he agreed to give me the medicine". (Zareena, Personal Communication, 07.02.2018, Drugmullah, Kupwara)

Few respondents attempted to procure the medicine from PHC or seek help in inducing abortion, but all such respondents were denied any such assistance by the PHC.

> *"I went to the village PHC and asked them to help me induce abortion as I had young children to take care of. I requested some drug, but they did not comply with any of my requests, and then I procured it from a private drug store". (Bilkeesa, Personal Communication, 27.02.2018, Drugmullah, Kupwara).*

In a few cases, it was noticed that respondents induced abortion with informal assistance from health workers or staff from the health department.

"I talked to a health worker who also happens to be our relative. I conveyed to her that I do not want to carry on with the pregnancy. She bought the medicine from PHC which I used to induce abortion". (Zareena, Personal Communication,07.02.2018, Drugmullah, Kupwara).

It was found that some respondents also approached unregistered abortion providers and underwent unsafe abortions.

"A health worker induced abortion at her house and charged us for that".

In a few cases, it was observed that failure of contraception had led to unwanted pregnancies. One of the participants said that…

"Although I had used Copper-T as a means of contraception three times, I was not comfortable using it. However, once I removed it, I conceived. It was an unwanted pregnancy which I had to abort". (Zareena, Personal Communication,07.02.2018, Drugmullah, Kupwara)

Some of the respondents said...

"My husband used condoms as a method of contraception for some time, but that failed, and my recent pregnancy was an outcome of contraception failure".

(Zahira, Personal Communication, 22.02.2018, Drugmullah, Kupwara)

It was observed that unwanted pregnancy was a distressing experience for respondents, and they were eager and desperate to end such pregnancies. Due to limited support offered by husbands and inconvenience in using conventional contraceptive methods, some respondents had repeatedly resorted to abortion induction after conception.

> *"How often should I find myself in a problem, and how often will I suffer the pain of inducing an abortion by myself? How much should I churn myself again and again? I cannot take Mala-D because I bleed for months together. I do not want to go for three monthly injectables because that does not help. Copper-T cannot be a permanent solution because I often go to the forest to fetch the firewood. That makes me uncomfortable." (Hajra, Personal Communication,09.09.2015, Drugmullah, Kupwara)*

Socio-economic Reasons for Pregnancy Loss

Socio-economic factors influenced the pattern of pregnancy loss considerably in respondents. The economic status of most respondents was low, which was observed to have influenced the decisions to induce abortion in some respondents. In other cases, it was seen that family engagements, like family marriages or young children at home, were given priority over the pregnancy carried by respondents.

One of the respondents cited poverty as one of the reasons for inducing abortion.

> *"Since my husband is a labourer. Moreover, our monthly income is meagre because he does not earn much. We have a small piece of land, and its produce is low. So, continuing the pregnancy would have meant another child, which we could not have afforded". (Sabahat, Personal Communication, 05.09.2015, Drugmullah, Kupwara).*

A respondent said that…

"My sister-in-law (husband's sister) was getting married. I had a lot of responsibilities on my shoulders as I was the eldest daughter-in-law in the family. So I decided not to go ahead with my pregnancy". (Sabahat, Personal Communication, 05.09.2015, Drugmullah, Kupwara)

Another respondent said that…

> *"My son was just a few months old when I again conceived. I was concerned. My son was breastfeeding, and I had no support around for the baby. Moreover, we were not so well-off, and we had to buy everything on our own" (Bilkeesa, Personal communication, 27.02.2018, Drugmullah, Kupwara).*

One of the respondents said that...

"This was the time that my brother-in-law (husband's brother) was about to be married. So it was his time to produce children, not mine. So, I decided to self-induce the abortion". (Shahnaz, Personal Communication, 22.09.2015, Drugmullah, Kupwara)

Another respondent said…

> *"I did not have my own house. I was living in a rented place. I already had three children, and I did not want to produce the fourth when we were yet to own a house. So, I decided to abort the foetus" (Shahnaz, Personal Communication, 22.09.2015, Drugmullah, Kupwara).*

Most respondents who underwent spontaneous abortion cited heavy household work like collecting firewood, lifting heavy objects, fetching drinking water etc., as reasons for spontaneous abortion.

One of the respondents said…

My husband was working in the agricultural field, and he was lifting heavy logs of wood. I just helped him lift one of the logs, which triggered the miscarriage. (Bilkeesa, Personal communication, 27.02.2018, Drugmullah, Kupwara)

Another respondent said…

> *"It was raining that day. Once we finished collecting firewood, I stacked it to lift it on my head. There was a log of wood in front of me. I thought since it was raining, I would roll it and keep it away from the rain. The moment I tried to roll it, the foetus fell then and there. I was in distress. God knows better". (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara)*

Other respondents reported that because of the water scarcity in the village, women had to travel long distances to fetch water which becomes extremely difficult in winters.

> *"It was snowing, and we have scarcity of water. We have to walk a long distance to fetch water. Once I was returning home with a bucket full of water, I suddenly slipped and fell. I felt water coming out of my vagina, but once I checked, it was blood. I took rest for some time, but I miscarried on the fifth day of this episode". (Shahnaz, Personal Communication,22.09.2015, Drugmullah, Kupwara)*

Guilt and Relief Feeling

Respondents in the present study who had self-induced the abortion had either a sense of guilt or a feeling of relief or both. In most cases of self-induced abortion, the feeling of

guilt was associated with 'committing an unforgivable sin'. However, the feeling of grief was profoundly present in almost all the respondents who underwent spontaneous abortions.

One of the respondents said that…

"Having induced abortion by myself, I know God will never forgive me. I am a sinner, and this amounts to a murder, which is an unpardonable sin". (Rehana, Personal communication,22.02.2018, Drugmullah, Kupwara)

Another respondent said that…

I thought the foetus had started to abort, and I felt a sense of relief and was happy to get rid of it. (Raziya, Personal communication,23.12.2015, Drugmullah, Kupwara).

Few of the respondents said that…

"It was not at all a good experience. I had fainted because I had induced abortion myself. Moreover, when I returned to my senses, I was in distress. I felt guilty. I had committed a murder. I am a murderer. God will never forgive me. I am a sinner" (Ayesha, Personal Communication,26.02.2018, Drugmullah, Kupwara)

Another woman said that…

> *"After taking medicine for abortion, I kept bleeding for days. Foetal tissue was not still retained in me. And then I went to PHC. They performed D&C. They got the foetus out and showed it to me. Once I was discharged. I went home and had rice to eat. I could see this fetus so clearly inside the plate of rice. It was not an illusion. I saw it. I fell. I fainted. I did not know what happened afterwards. When I came back to my senses, I was totally in distress. I felt guilty. I had committed murder. I am a murderer. God will never forgive me. I am a sinner. After that, I conceived again and I simply carried on with the pregnancy. I did not consider abortion. Not even for a*

> *moment. I gave birth to a son. It was the last child I gave birth to, and after that, I entrusted myself to God, and I did not conceive again" (Rehana, Personal communication, 22.02.2018, Drugmullah, Kupwara)*

(Hajra, Personal Communication,09.09.2015, Drugmullah, Kupwara)

A sense of relief was also observed in respondents who underwent self-induced abortions.

One of the participants said…

"I have already given birth to many children, so I did not have any sense of guilt or remorse while self-inducing the abortion".

Another participant said…

"It was my own decision. So, I did not feel bad about it. I felt relieved. When I was bleeding, I did not have any feeling of remorse. It was our (me and husband) choice to go for abortion."

(Hajra, Personal Communication,09.09.2015, Drugmullah, Kupwara).

A respondent recorded…

> *"When I was bleeding, I did not have any feeling of guilt. It was my choice to go for an abortion. I was relieved. I felt happy. And my husband was also with me. He supported this decision of mine" (Jahanara, Personal Communication,22.08.2018, Drugmullah, Kupwara).*

Another participant said…

"That God had already blessed me with many children. So I did not feel bad aborting my pregnancy". (A participant in the discussion, Drugmullah, Kupwara)

Spontaneous abortion of unplanned pregnancies was also found to bring a feeling of relief to the respondents. One of the respondents reported that she was disappointed once she conceived, and the spontaneous abortion brought an end to her anxiety.

“I was not aware of my conception, but when I tested positive, I was distressed. I could not hide my disappointment. Some days later, I miscarried, and I was so happy that it happened on its own". (Nighat, Personal communication, 27.02.2018, Drugmullah, Kupwara)

Moral Dilemma

In some cases of induced abortion, a moral dilemma before abortion induction was observed.

One of the participants said that…

> *"I know it is not right. I took the time to go for it. I thought I had too many responsibilities to carry out, and I already have three children. After paying thought to all this, I decided that I should go for abortion". Zuhera, Personal Communication, 16.03.2018, Drugmullah, Kupwara)*

Few respondents had feelings of sorrow after inducing abortion.

One of the respondents said that…

"I know how bad it is to abort a foetus. It is a big sin. I still feel bad about that. But what could I do? I was helpless. It was not an easy decision". (Zareena, Personal Communication, 07.02.2018, Drugmullah, Kupwara)

Another woman said that…

> *"On the one hand, I know I had sinned; on the other, my health was deteriorating. I had no resilience to carry the pregnancy to term. So, I had to decide between the two.*

I decided in favour of my health". (Hajra, Personal Communication, 09.09.2015, Drugmullah, Kupwara)

A woman recorded that….

"Both religions, as well as the law, do not permit to abort a foetus. So, it should be discouraged. But one is caught in a situation where you cannot do anything about it" (Hajra, Personal Communication, 09.09.2015, Drugmullah, Kupwara)

Memory and Willingness

Most respondents remembered vividly the episodes of induced and/or spontaneous abortion and the physical and emotional pain associated with it.

One of the respondents said that…

"I have lost many children to miscarriages. I have only one boy now. I have entrusted myself to God. But yes, I cannot forget the children whom I have lost. Those scars will always be there" (Zubeida, Personal Communication, 06.02.2018, Drugmullah, Kupwara)

Another participant said that…

"Long back, I remember we were constructing a house. We were laying a plinth of stones, and I lifted a heavy stone. I started bleeding profusely. It did not stop, and I was taken to hospital. For two days, I bled like anything, and with that, my baby was gone. But that time I was almost dead. I became weak. Oh, God! It was so painful. I still remember that pain and agony. That still haunts me".

Most of the respondents were willing to share their episodes of abortion. A sense of catharsis was observed in respondents while talking about episodes of abortion.

One of the women said that…

"If you (as an interviewer) can stay here, I will just tell you everything, and I won't stop".

Another woman said that…

> *"Abortion does not happen on its own. There are reasons for it. Women indeed hide things from all and endure them alone. And it is mentally so disturbing. There is a lot of stress. And when one shares things, one feels light. We would share things with men, but they didn't listen. They don't pay ear to what we share with them. Women go through a lot. And when men have to do the same as a woman does, it would be impossible for them to manage" (Jahanara, Personal Communication, 22.08.2018, Drugmullah, Kupwara)*

Utilization of Abortion Service

The respondents in the present study fairly accessed the government healthcare facilities like village PHC. Most respondents accessed PHC for post-conception ultrasonography, which re-directed them to certain private facilities. Irrespective of the nature of abortion, most respondents accessed PHC after abortions for dilatation and curettage (D&C) to remove retained products of conception (RPOC's), intrauterine infections, hemorrhage and abdominal pain. Most respondents who accessed village PHC were discharged on the same day, with few exceptions where women were discharged the day after. Most respondents who underwent D&C after abortion in village PHC complained of infection. Most respondents had to repeat the D&C procedure as the RPOCs were not cleared following the first procedure. Some of the respondents living in the village's upper reaches were unable to access PHC as quickly as others in the village could in the event of an emergency.

> *"PHC for us is a bit far. If we have to go there at night, we must arrange a vehicle. The terrain is not very friendly. If we cannot arrange a vehicle, the patient will simply die". (Bilkeesa, Personal communication, 27.02.2018, Drugmullah, Kupwara)*

Respondents who underwent self-induced abortion did not utilize healthcare services at village PHC for D&C because of legal apprehensions, as a result of which such respondents sought private and informal healthcare with poor hygiene and limited medical facilities.

One of the respondents said that…

> *"I had to go for uterine cleansing, which the health worker did at her home. Once I showed USG to her, she confirmed some tissue was still inside and then removed it. I could not access PHC because they would not do anything about it". (Zohra, Personal Communication, 25.02.2018, Drugmullah, Kupwara)*

On the contrary, some respondents claimed to have preferred private health facilities over government hospitals, citing reasons for inadequate facilities available at the PHC.

One of such respondents said that…

> *"We don't have an x-ray or USG facility in the PHC. We have to go to the town to do USG. And then we show it here. They treat us accordingly. In private, you must reach the hospital and then pay for a vehicle, medicines, etc. Overall, it is a very costly affair." (Zubeida, Personal Communication, 06.02.2018, Drugmullah, Kupwara)*

Another respondent who accessed private healthcare after recurrent miscarriages acknowledged that access to private healthcare is costly.

"I did all the investigations in a private hospital, yet the reason for the recurrent miscarriage was not established. We must have spent lakhs of rupees on that but all in vain." (Shabeena, Personal Communication, 08.09.2015, Drugmullah, Kupwara)

It was found that respondents who underwent self-induced abortion accessed village PHC to seek post-abortion healthcare after citing spontaneous abortion as a reason. In most cases of self-induced abortion, respondents claimed to suffer from persistent bleeding, abdominal pain and other symptoms and had to undergo D&C at least twice to clear the RPOCs.

> *"Once I induced the abortion. I went to a local PHC, where I told doctors I had a spontaneous abortion. Doctors suggested USG. After that, I did USG from a private facility. It showed the uterine cavity as clean. But I was again bleeding. I happened to go to Jammu with my sister-in-law. I fell ill there and got swelling all over my body. I had contracted an infection. My sister-in-law took me to the hospital. They recommended USG. I again did USG, and it showed foetal tissue had not been cleared yet. They again did D&C under general anaesthesia, and I was admitted to the hospital and treated for eight days. In Kupwara town, I did many USGs. Each would cost me 500-600 rupees. But in Jammu, when they did USG, although they charged me 1200 rupees, it showed the actual picture. It took me about 25000 for all this. (Zuhera, Personal Communication, 22.02.2018, Drugmullah, Kupwara)*

Extramarital Affair

The study observed that some husbands had extramarital affairs, resulting in multiple problems in women's lives. There was a sense of deceit in women, but they could not do anything about it. Women in these situations thought about the stakes they had in their lives. Some women had neither forgotten the infidelity of their husbands nor had they forgiven them. Such women were bound to stay with their husbands for their children's future or

because they had a love marriage in which parental and sibling support diminishes. Some women had tried to regain their spouses' trust and confronted the women with whom their spouses had an extramarital affair. Almost all the women thought that men had the freedom to do anything and could get away with this. This influenced their decision to induce abortion. It was observed that such women didn't want to carry on with the pregnancy once they suspected the husband's fidelity. Such respondents were reluctant to leave their spouses; however, to vent out their anger, they had resorted to abortion induction.

"Men can do whatever pleases them, and women cannot even imagine doing that because of our social set-up, " remarked one of the respondents". (Rehana, Personal Communication, 22.02.2018, Drugmullah, Kupwara)

One of the respondents recorded that…

> *"She knows about my poverty and my husband, who was not faithful to me. I learned about my husband's extramarital affair when I was pregnant with twins. I was so upset that I would visit a nurse to share my story. She would tell me to be patient and endure it. I would pour my heart out to her. She sympathized with me and agreed to abort my foetus. (Raziya, Personal Communication,23.12.2015, Drugmullah, Kupwara)*

Contraception Failure

Few women reported contraception failure as a reason for inducing abortion, and these women cited either ripping of condoms or failure of Copper-T as a reason for unintended pregnancy. These women had tried to practice contraception after the episodes of abortion. Still, some of them again experienced unintended pregnancy either because of the poor-quality condoms bought from PHC or installation of Copper-T by the local midwives, which had failed to contracept.

One of the respondents said that….

> *"I never considered using any kind of contraception. And nobody would allow me to do that. My husband also didn't support the idea of birth control. I had to force him. I told him that I did not want any children. He then talked to his mother about it. And then I took some injectable and inserted Copper-T also. But unfortunately, I had an infection in my uterus because of that. I got ill for one month. I did not go to PHC to insert Copper-T. I went to a local lady who has some know-how about it. Once my periods were over, I went to her, and she tried to insert it, but she could not place it properly. And for two months, I did not get my periods. I thought maybe it was because of Copper-T that I did not get any period. But I had no idea that I had again conceived. My husband and I went to Kupwara for USG, showing that I am two months pregnant and entering into the third month." (Zohra, Personal Communication, 25.02.2018, Drugmullah, Kupwara)*

Mye draye aereke chatte. Bei chas wana emi kour akis gareebas khash

"It sent chills down my spine. I thought to myself that she (midwife) created such a problem for a poor lady like me" (Zohra, Personal Communication, 25.02.2018, Drugmullah, Kupwara).

Another respondent said…

> *"My husband knew about the contraception (condoms), but he always refused to use it. When I suffered abortion last time, he started using condoms, but upon using them, they would rip. Initially, the condoms in the hospital were not of good quality, but now their quality has improved. The last pregnancy and the consequent abortion I had was because of the contraception failure." (Rehana, Personal communication, 22.02.2018, Drugmullah, Kupwara)*

Son Preference

Many respondents preferred a male child and a strong desire to bear multiple male children. In a few cases, respondents or husbands having daughters were found to be desperate for a male child. The desire to bear multiple sons was stronger in couples bearing multiple daughters. Respondents sought spiritual help for bearing a son in some cases. In one of the cases, a respondent had waited very long to bear a son, and, in that process, she had given birth to six daughters.

One of the respondents remarked that….

> *"I had two daughters. I was very desperate to bear a son. When I conceived, I became so worried. I thought of aborting it because of the fear of bearing another daughter. But some people stopped me from doing that as they hoped it could be a son. After some time, it miscarried. I couldn't reconcile with the situation where I had lost my baby, that could have been a boy. But then it was gone. After some time, I conceived again. The thought of bearing another daughter would again haunt me. But this time, I did not want to abort it. I gave birth. Fortunately, it was a son" (Zahida, Personal communication, 15.05.2018, Drugmullah, Kupwara)*

Another respondent recorded…

> *"We were expecting a son. But we again had a daughter. We wanted at least two sons. I know it is all the will of God. But let me tell you, girls always turn out to be more faithful to their parents. We were five sisters, and I have a first-hand experience of seeing daughters being faithful to their parents."*

Few women who had miscarried had always imagined their lost children as sons, not daughters.

"I have only one boy now. I always wanted many, and I have now entrusted myself to God. But yes, I cannot forget the children whom I have lost."

A strong son preference was observed if an immediate relative of the respondent bore only multiple daughters.

"My sister-in-law (husband's sister) has multiple daughters, that is why I wanted to have a son. In our clan, we have many daughters, so I have always wanted to have a son." (Shahnaz, Personal Communication, 22.09.2015, Drugmullah, Kupwara)

In a few cases, husbands were satisfied with one male child, but women had desired to have more sons.

"I have only one son. I wanted to have another. I keep on telling my husband that my son should have a brother, but he does not agree. He says, we are fine with one boy and two girls." (Jabeena, Personal Communication, 26.02.2018, Drugmullah, Kupwara)

Few couples were so desperate to bear a son that they had sought blessings from saints and visited religious shrines.

> *"We had six daughters, and we wanted to have a son desperately. My husband and I sought blessings from a saint. He promised that I would have a son now. The saint asked for cash and expensive home appliances and also demanded a share of the monthly income which my husband would earn. The saint had also asked for animal sacrifice. I also served the saint myself for one year. We would run a mess as a lot of people would visit him. But to my extreme disappointment, I again gave birth to a girl. When the saint came to know about it, he disappeared. He is absconding now, and we are unable to trace him. I would not have had this many children if I had had a son earlier. I would have three or four children. In the present times, it is not easy to raise seven children. It is not a joke. I desperately want to limit my family size now. Should I produce as many children so that I can't count them? But I did not give up. I again went to a saint in Srinagar (87 km away from her village) who promised me a son. I also visited a renowned shrine in Srinagar, where I prayed to have a son. And finally, I gave birth to a son". (Hajra, Personal Communication, 09.09.2015, Drugmullah, Kupwara)*

Another respondent said that…

> *"We had three girls. We were desperate for a boy. I again conceived, and a saint told me I would give birth to a baby boy. The saint told me that I would give birth to two sons. I will not be able to take (which miscarried). After that, I would again conceive a boy who would make it to the world. I would always pray and plead for a son. I sent my mother-in-law to Ajmer (a renowned Muslim shrine in Ajmer, Rajasthan) to tie a thread for a son. And finally, I gave birth to a son". (Shahnaz, Personal Communication, 22.09.2015, Drugmullah, Kupwara)*

Only one respondent had desired to bear a daughter after two kids, a boy and a girl. However, after conception, she suffered a spontaneous abortion.

> *"My husband is very supportive. After I miscarried, he cared for everything, including the children. It was a tough situation. The moment I saw the ultrasound, I was blank. It was very painful. I wanted a daughter. I believe a girl needs a sister in the kind of society we live in." (Nazima, Personal Communication, 25.01.2018, Drugmullah, Kupwara)*

Men and Reproduction

The participation of men in reproductive health matters was seen to be considerably low. However, it was observed that men made decisions about the number of children a woman would bear. Men were indifferent toward women and their matters concerning reproductive health. There was no mutual understanding between respondents and husbands regarding contraception, and most husbands were reluctant to use contraceptive methods like condoms or sterilization. The study observed a deep concern about unwanted pregnancy in respondents, forcing them to employ contraceptive methods like the insertion of Copper-T, ligation, Pills, etc. Despite the discomfort, bleeding, and infection caused after the use of Copper-T, as reported by the respondents, men were reluctant to use any modern method of contraception.

Regarding the use of condoms, some of the respondents said…

"My husband was aware of contraception. He knew about condoms, but would never use them. It is when I had an abortion, he started using them. But they would not last long. They would rip." (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara)

Another respondent reported that…

"My husband wanted four children, and then abortions followed one after the other. After that, my husband started using condoms. He started using it after my last child was born. He would never agree to use condoms." (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara)

Regarding women's issues, one of the respondents said……

Unfortunately, men do not pay any attention to these things (reproductive matters), and it is even more complicated when such things occur at the in-law's place, where one has to be pretentious. (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara)

Regarding the indifference of spouse towards woman, a respondent remarked…

> *"Husbands take us for granted. They should see us working, which is what they are concerned about. When you need them the most, they are not around. At the in-laws' place, they want work from you and nothing else. You don't have your mother there who would tell you to rest and let it heal after an abortion." (Zahira, Personal communication, 22.02.2018, Drugmullah, Kupwara).*

One of the respondents informed…

> *"My husband is still supportive. He supported my ligation because he could see my health deteriorating. Husbands support, but you have to help yourself, which nobody can do. They do their little bit, and the rest they leave to us. They don't take us seriously. (Zubeida, Personal Communication, 06.02.2018, Drugmullah, Kupwara)*

RESEARCH FINDINGS FROM THE QUANTITATIVE STUDY

General Reproductive Health Survey (GRHS)

A total of 100 women belonging to socio-economically weaker families were considered for the general reproductive health survey (GRHS) through homogenous

purposive sampling where women who fell in the reproductive age group of 13-45 years and had an unemployed spouse whose family possessed no more than three kanals[41] of land, were considered for the study. The sampled population comprised 61% of participants from the general category, 20% from the other backward class (OBC) and 19% from the Scheduled Tribe (ST).

Socio-demographic Characteristics of Study Population

All the 100 women considered in the survey were married and had mostly experienced pregnancy at least once. The study population comprised women from different social groups, viz. 61 from the General category (Tantray, Magray, Lone, Baba, Mir, Khan, Peer, Sofi, Malik, Khojah, Bhat), 19 from other backward classes (Najar, Ganai, Teli and Kumar) and 20 from schedule tribe (Dedad, Melu, Kohli, Chara, Chechi and Awan) (Table 9) which were roughly proportional to the population ratio of different social groups living in the village.

Only one per cent of the study population fell in the age group of 13-18 years, 21% were between 19-29 years of age, 75% belonged to the 30-40 age group, while only three per cent of them fell into the age group of 41-45 years. Most of the participants (93%) were home-makers except for some women who worked part-time as tailors, artisans, village healthcare workers, anganwadi workers or school caretakers. The occupation of spouses of the study participants was either unskilled agricultural/construction labourer (43%), skilled carpenter, mason/plumber (49%) or Grade-IV government servant (5%). Two of the participant's spouses had expired, while one was not engaged in any work. Seventy-four per cent of the study participants had an annual income of up to one lakh rupees, 23% had more than one lakh rupees, while the rest had a meagre income. The families of 35% of study

[41] One kanal is equal to 5445 square feet of land

participants were landless, 40% owned 1-2 kanals of land, while 22% owned more than two kanals of land.

Forty-eight per cent of the study participants had no formal schooling, 14% possessed only primary education, 30% had studied up to middle school, 4% had passed tenth standard, 1% possessed a bachelor's degree, another 1% was a post-graduate while as 1% had attended a religious school (Madrassa). Seventy-three per cent of the study participants lived in nuclear households (with spouse and children), and only 21% were a part of joint families, typically comprised of father-in-law, mother-in-law, brothers-in-law, their children and sisters-in-law etc. Eighty-six per cent of the study participants had an arranged marriage, 7% were married to the mate of their choice, while the selection of partner for the rest of 7% was made by the people outside their family (relatives or neighbours).

At the time of the survey, 61% of study participants were found to be married for 6-15 years, 16% for 4-8 years, 20% for 16-25 years and a mere 3% had been married for 1-3 years. The majority of the participants (90%) expressed marital satisfaction, while 6% were not happy with their marriage. Ninety-three per cent of the participants shared a cordial relationship with their spouse, and only 1% expressed dissatisfaction. The majority of participants were dependent on their spouse for their financial needs, 5% of the participants were financially reliant on immediate relatives, while only 1% were economically independent (The details of socio-demographic characteristics are available in Table 10).

Reproductive Health

General Reproductive Status

Sixty-four per cent of the study participants were observed to have regular menstrual cycles, while 25% suffered from irregular menstrual cycles. Twenty-seven per cent of the participants had conceived for the first time in 0-3 months after consummation of marriage,

8% in 4-6 months, 32% in 7-12 months, 18% in 1-2 years, 7% in 2-4 years and rest of 6% had to wait for four or more years to conceive for the first time after consummation of marriage. The first pregnancy was planned in 60% of the participants, and the rest of the 40% of the study participants had an unplanned first pregnancy. Thirteen per cent of the study participants had planned subsequent pregnancies, while 84% had unplanned subsequent pregnancies.

Ante-natal Care and Healthcare Utilization

Seventy-eight per cent of the study participants accessed government facilities, four per cent accessed private healthcare facilities, while 14% accessed both public and private during their latest pregnancy. However, 88% had registered for ante-natal care at the local primary healthcare centre (PHC). Out of the 88 participants, 49 visited PHC more than five times, 26 made 4-5 visits, and 13 saw the PHC 1-3 times to seek ante-natal care. Eighty-seven out of the 100 participants availed of an ante-natal vaccination facility. Up to 66 out of the 100 participants registered at the PHC received iron-folic acid supplements. Thirty-three per cent of the study participants did not receive any ultrasound scans, 50% received 1-2 ultrasound scans, 16% received 3-4 scans, and only 1% received five ultrasound scans. Fifty-seven per cent of study participants accessed private facilities, while only 4% accessed government facilities to receive the scans. About 90% of the women had experienced happiness about their first conception, 1% had experienced fear, 1% had felt surprised, and another 1% of the participants had not experienced any distinct feeling at the time of conception.

Postnatal care and healthcare utilization

Twenty-three per cent of the study participants have had up to two deliveries, 58% had delivered 3-4 times, while 17% of the participants were found to have delivered five or more times in their lifetime. Out of the total deliveries by 100 participants, 70% were delivered normally through the vaginal route, 13% had to be delivered through cesarean

section(CS), while 16% had delivered through C-section and normal vaginal route. Out of all the participants who had delivered through C-section, only 2% had developed complications like post-partum haemorrhage and/or uterine inflammation. Of the 333 deliveries by 100 study participants, 91% were institutional, and only 9% were performed at home. Out of the 91% institutional deliveries, 38.1% were performed at local PHC, 15.9% at tertiary healthcare facilities, 10.8 % at community health centres (CHC), 10.5% at PHCs outside the village, 3.3% at private clinics, 3% at local health worker's residence, 1.5% at the sub-district hospital, Sopore and 4.5% at other places. At the time of the survey, 30% of the study participants had 1-2 offsprings, 54% had 3-4 children, and 14% had five or more children. When asked about the ideal family size, 74% of study participants considered 2-3 children ideal, 14% felt three or more and only 2% considered a single child the perfect family size. A total of 311 children were born to hundred women participants, out of which 155 were boys and 156 were girls, and the sex ratio was approximately 994 males per 1000 females. Further, 47% of the study participants acknowledged their preference for a male child. Twenty-seven per cent of the study participants had an average spacing of up to 2 years between children, while 70% of the participants maintained an average spacing of three or more years between their children. Seventy-six per cent of the participants did not experience any neonatal death, stillbirth or infant mortality. Nine per cent experienced neonatal death, 4% faced infant mortality, and 3% of the participants experienced stillbirth. Only 1% experienced stillbirth and infant mortality, while another 1% faced infant and neonatal mortality.

Social and Financial Support during and after Pregnancy

Forty-nine per cent of the study population spent between ₹3000-6000 on their last pregnancy, 19% spent between ₹1000-3000, 21% spent between ₹10000-30000 while as 9% of the participants spent between ₹6000-10,000 on the last pregnancy event. Fifty-eight per cent of the participants received monetary support from the Janani Suraksha Yojna (JSY)

under National Rural Health Mission (NRHM), while 36% did not receive any financial assistance from JSY. Only 14% of the participants accessed the Aganwadi centre during their pregnancy for medicines. Eighty-three per cent of the participants acknowledged that they enjoyed support from their spouses during pregnancy, while as rest of the 17% found support in other members like in-laws, parents, cousins, siblings or ASHAs. The details about the reproductive health status are enlisted in Table 2.

Use of Contraception and Methods Employed

Ninety-nine per cent of the study participants knew various contraceptive methods like pills, copper-T, condoms, male and female sterilization, injectables (modern methods) and withdrawal method (traditional method), while 94% knew about emergency contraception. Seventy-one per cent had been practising contraception, while 29% were not practising any contraception. Out of the 71% who practised contraception, it was found that 30% had gone for female sterilization, 23% had used the withdrawal method, 6% had used condoms, another 6% used copper-T, 3% had used pills, 2% had used injectables, and the rest of 1% had used abstinence as a method of contraception. When asked about the convenient form of contraception, 26% out of the 100 participants acknowledged that it was female sterilization, while another 26% believed that the withdrawal method was more convenient, 7% said copper-T, 6% said condoms, 5% said pills, 2% injectables and rest of 1% believed abstinence to be a more convenient method for contraception. When asked about the reason for not using contraception, 19% of participants said because they feared side effects, five per cent did not cite any reason, one per cent had been practising abstinence, six per cent cited religious reasons, another six per cent said they had been planning pregnancy while as two per cent said that they forgot to use or the thought of pregnancy had not crossed their mind. Nine per cent of the participants fetched contraceptives from the chemist, while only three per cent had accessed PHC to get contraceptives. Spouses of nine per cent of the participants

had fetched the contraceptives, two per cent of either spouse had fetched it, while only one per cent of the participant had fetched it herself. Thirty-six per cent acknowledged that they received contraceptives from the PHC, eight per cent did not know about it, while 17% had not visited the PHC to receive the contraceptives. Six per cent of the participants had been counselled in PHC regarding the use of contraception, while two per cent said such counselling was done rarely. 85% of the participants had resolved to practice contraception in future by either using pills (4%), condoms (5%), Copper-T (7%), female sterilization (34%), withdrawal method (24%), injectables (2%), abstinence (3%), natural spacing (1%) or other forms (5%). Contraception had been practised by three per cent of the participants before the latest pregnancy; however, all the three had failed to contracept because of improper use of condoms or condoms were not of good quality as they would rip. See Table 12

Decision-making Regarding Reproductive Affairs

It was found that the decisions about the reproductive health of 73% of study participants were taken alone by their spouses in contrast to the 10% of participants who had taken decisions about their reproductive health themselves. While 8% of participants took such decisions in consensus with their spouses, such decisions in the case of another 8% were influenced by others. Spouses of 24% of participants, 15% of participants themselves, 52% jointly with their spouses, in-laws in case of 3% of the participant, and doctors in case of 1% of participants were involved in making decisions concerning the number of children to bear, while in 4% of participants such decisions were influenced by others. The decision to use contraception was alone taken by the spouse in case of 31% of participants, 25% of participants took such decisions jointly with their spouse, and only 16% of participants took such decisions by themselves, while the decision to practice contraception was influenced by others in 4% of cases. Seventy-four per cent of participants had found support in their husbands concerning their decision to use contraception, while 4% did not find such support.

The spouses of only 19% of participants had used contraception, out of which 11% had practised the withdrawal method, and the rest of seven per cent had used condoms. Eighty-one per cent of participants had mutually agreed upon their future reproductive intentions with their spouses, while 7% of participants shared disagreements with their spouses regarding their future reproductive preferences. The details about decision-making regarding reproductive affairs are enlisted in Table 13.

Healthcare Utilization in Induced Abortions

Fifteen out of the 100 study participants had experienced induced abortion, of which 12 participants had experienced it once, and the remaining three had experienced it twice. Sixty per cent of the participants who had induced abortion had been practising the withdrawal method or *coitus interruptus* as a method of contraception (Figure 2). All the 15 participants had used drugs to induce abortion by themselves at home, and only one out of 15 participants who had induced abortion acknowledged to have taken abortifacient drugs under medical supervision. Nine out of the 15 participants had got the drug through their husbands, while five of such participants had fetched it themselves. Thirteen out of 15 participants had accessed a chemist to bring the drug, while one had accessed PHC to fetch the medicine. Seven participants had induced abortion within 40 days of conception, six within 75 days, and one within 120 days of conception. Eight participants cited 'young children' as a reason for inducing abortion, while the rest of the seven cited either family-income issues, already bearing multiple children or limited support as other reasons for inducing abortion. Six out of the 15 participants had to undergo the procedure of dilatation and curettage (D&C) after abortion. Six participants accessed government healthcare facilities for post-abortion care, two participants, accessed private healthcare facilities while and another two consulted local healthcare workers. Seven out of the 15 received ultra-sonographic scans(USG), while another eight didn't opt for any USG. Eight of the participants who accessed healthcare

facilities for post-abortion care said that the approach of the medical staff towards them was very casual or inconsiderate. Six of the 15 had disclosed the induction of abortion once they accessed a healthcare facility, while two had not disclosed it at all. Nine of the 15 participants had spent up to ₹2000 for post-abortion care; three had to pay up to ₹4000, while another three paid more than ₹4000 for post-abortion care. Eleven of the 15 participants did not have any post-abortive complications, while as rest of the four developed infections. Post-abortion bleeding was reported by 10 participants for up to two weeks, while it continued up to eight weeks in two participants. Eight participants observed no rest from daily household work, three took rest from work for up to a week, and another three took a break from the routine work for up to four weeks. While four of the 15 participants had a feeling of guilt, three had felt sad, seven participants had mixed feelings, and one of them felt relieved. The details about healthcare utilization in spontaneous pregnancy are enlisted in Table 14.

Healthcare Utilization in Spontaneous Abortions

Twenty-five out of the 100 study participants had experienced spontaneous abortion. Sixteen out of the 25 had experienced it once, while as rest of the eight had experienced it twice. Nineteen out of 25 attributed it to physical stress in the form of either heavy work, long travels to fetch firewood, lack of rest, slipping or tripping while working, or manual ploughing at the farm. The rest of the six participants did not cite any reason for miscarriage. However, the doctors had attributed developmental issues in case of 15 participants to miscarriage, heavy work in the case of three participants and unexplained reasons for one participant who had faced miscarriage. Eighteen out of the 25 participants had suffered a miscarriage in the first trimester of pregnancy, while six had suffered it in the second trimester. Eighteen participants needed D&C during the post-abortion care, of whom 11 developed complications. Seven of these 11 participants suffered uterine infections, three with haemorrhage and two with infection and haemorrhage. Eleven participants suffered

post-abortion bleeding for up to two weeks; nine suffered from it for up to four weeks, one for up to 24 weeks, and two suffered post-abortion bleeding for a few days. During pre- or post-abortion care, 14 out of the 25 participants had accessed private USG facilities, only three had accessed government USG facilities, and two had accessed both. Seventeen participants had spent up to ₹4000 for post-abortion care; two had spent up to ₹1000 while four had spent more than ₹5000. Twenty-four out of the 25 participants had experienced a feeling of sadness after miscarriage. Ten out of the 25 had been supported by their spouses after miscarriage; three had received support from their parents, two from in-laws and the rest of the ten had been supported by others. Nineteen out of the 25 participants had rested up to four weeks from their daily work, while only two had taken a break from work for more than four weeks. The details about healthcare utilization in spontaneous pregnancy are enlisted in Table 15.

Family Planning across different Social Groups

Almost 52 per cent of the study participants from the general category, 73.6% from OBCs and 40% of the participants from STs were married above the age of 18 years, and the rest of the participants from all social groups were married at or below 18 years. Thirty-six per cent of the general category and 26.3% of the scheduled tribe had used female sterilization, while 21% of the OBCs had used condoms as a method of contraception. Seventy-three per cent of the general category, 42% of OBCs and 65% of STs had a planned first pregnancy, while the rest of the study population of either category had unplanned first pregnancy. However, 78% of the general category of study participants, 89.5% of the OBCs and 95% of the STs had unplanned subsequent pregnancies (Figure 4).

Healthcare Accessed by different Social Categories

Seventy-seven per cent of the general category participants, 73.6% from OBCs and 85% from STs had accessed the government healthcare facilities during pregnancy. 44.2% of the general category study participants, 63% of the OBCs and 26.3% of STs had received USG two to three times during the latest pregnancy, while just 3.2% of the general category, 5.2% of the OBCs and no participant from the STs had received more than three USGs. 78.6% of the general category, 79% of OBCs and 75% of the STs study participants had delivered in the government healthcare facilities, while the rest from each category were either delivered at home or healthcare facilities. 16.2 % of the general category, 15.7% of the OBCs and 55% of the ST study participants had a stillbirth, neonatal, infant or child mortality (Figure 5).

Economic Status and Induced Abortions:

The majority of the induced abortions were found in participants with an annual family income of ₹60,000-90000 and no land-holding, while two out of 15 participants (13.3%) in each of the income groups viz., ₹91000-120,000 with no land-holding and ₹120,000-150,000 with land holding up to 2 Kanals, had gone for self-induced abortion (Figure 6).

Economic Status and Spontaneous Abortions:

Thirteen out of the 25 participants who had suffered spontaneous abortions fell in the lowest annual income group of ₹30,000-60,000 with a land-holding of 0-2 Kanals. Six of these 25 participants had an annual family income of ₹61,000-120,000 with a land holding of 0-3 kanals, while another six participants fell in the income group of ₹120,000-150,000 with a land-holding of 1-3 kanals (Figure 7).

Access to healthcare in different income groups

Out of the total 100 participants, only three participants (3%) who fell in the relatively higher income group of 120,000-150,000 had delivered at private clinics, and the rest of the majority 97/100 (97%) had delivered at public healthcare facilities and a few participants out of the 97 had delivered at public as well as private healthcare facilities. Seven per cent accessed both public and private in the income group of 12,000-150,000. Four per cent of the participants accessed both public and private in the income group of 30,000-60,000. Two per cent of participants in the income group of 61,000-90,000 accessed both public and private healthcare. Two per cent in the income group of 120,000-15,000 accessed only private healthcare, and two participants in the income group of 61,000-90,000 accessed private healthcare only. The rest of the participants accessed only the public healthcare system.

Average number of children per woman and Annual Income

The number of deliveries per women recorded in the income groups of ₹30,000-60,000, ₹61,000-90,000, ₹91,000-120,000 and ₹121,000-150,000 were 3.35, 3.0, 3.2 and 3.5, respectively.

Ante-natal Check-ups in the income groups:

Twenty participants from each ₹30,000-60,000- and ₹61-90,000-income group accessed healthcare facilities five or more times to undergo antenatal check-ups (ANCs), while in the income group of ₹91,000-150,000, eight participants accessed healthcare facilities five or more number of times to undergo antenatal check-ups. In the income group ₹120,000-150,000, fourteen participants accessed healthcare facilities five or more times to undergo antenatal check-ups.

Expenditures on the latest event of Pregnancy and Delivery

In the income group of 30,000-60,000, 35/100 (35%) participants had spent 4471 Rs on the latest event of delivery and pregnancy. In the income group of 60,000-90,000, the average money spent by 28/100 (28%) participants on the latest delivery and the pregnancy was 3428 Rs. In the income group of 91,000-12,000, the average money spent by 12/100 (12%) participants on the latest episode of pregnancy and delivery was 4066 Rs. And in the income group of 121,000-150,000, 21/100 (21%) participants spent Rs 6047 on the event of the latest pregnancy and delivery.

Miscellaneous observations

Primary Health Centre as a shared space for village Women.

It was observed that the PHC was used by the village women for not only accessing healthcare but also as a common space to interact and discuss personal or common problems which they faced in their day-to-day lives. It was also observed that during such unorganized interactions/ discussions, women would either talk about their personal issues or comment upon various practices of their social system or discuss various compulsions and difficulties which they had to negotiate while dealing with the rigid patriarchal social set-up. It was also observed that some village women had approached Female Multipurpose Health Worker (FMPHW), located at the local PHC, to informally counsel their spouses about contraception, while other women had sought suggestions from healthcare workers of the PHC about the use of suitable contraceptive measures.

Accessing PHC

Once women have missed their monthly cycle, they go to the PHC for a pregnancy test or buy a pregnancy kit from the local chemist. If they test positive, they are registered with the PHC under National Rural Health Mission (NRHM), and a card is issued. They are

given iron and folic acid tablets and are also given an injection of tetanus toxoid. ASHA is informed about the new registration, and ASHA tracks these women in that given area for follow-up and ante-natal check-ups. ASHA follows them till their nine months are complete. ASHA accompanies them to the PHC for delivery, and once delivery is conducted (mainly normally at the PHC level) and the woman is discharged in one or two days. ASHA accompany them to home also once they are discharged. A vehicle is also given to drop them home in a few cases. A female Multipurpose Health Worker (FMPHW) conducts the deliveries. Only normal deliveries are performed in the PHC. Those women who face complications are referred to CHC Kupwara as First Referral Unit (FRU), which is 8 km away from Drugmullah. The cases which CHC cannot handle are then referred to Lal Ded Hospital in Srinagar, which is 87 Km from Kupwara. The anecdotal evidence says that there have been many cases where women have not been able to reach the tertiary care hospital and have passed away on the way to the hospital.

In the case of women who experience pregnancy loss, ASHAs report them to the PHC. They prescribe USG to see if the fetus is alive. The patients return to PHC, where the tests are examined, and the treatment is started. Some of the patients have to go for D&C if required.

Disposal of Condoms

In a discussion, it came to the fore that there is an issue of disposal-off condoms, which was cited as one of the reasons the women are not using them. Since the village is an open community where not all houses are fenced and there is a lack of privacy, women find it challenging to come out in the open and dispose of condoms. Women also complained that men expected women to dispose-off the used condoms. Also, there was an issue in the village where one of the families disposed off in the open, and children had played with it. When the village elders noticed it, they were furious and scolded the family; it was an embarrassment

for them in the village. Similarly, a family had disposed-off condoms in the toilet, and it got blocked, so men had to be called to open the septic tank, and condoms were found to have blocked it. Again, it was a lot of embarrassment for that family. In the village, there is not any mechanism for trash collection. Trash is usually thrown on the roadside. As a result, people don't find a proper way of disposing-off the used condoms. So, having all these issues with the disposal of condoms, women don't prefer to use them.

CHAPTER V

DISCUSSION

The current study involved both qualitative and quantitative components of research methodology. The qualitative component of the study included respondents who were financially dependent on their spouses and mostly belonged to families with low socioeconomic status. In the quantitative component, the respondents belonged to a low socioeconomic group aged between 13-45 years, belonging to families with an unsustainable source of income and/or who owned not more than three kanals.[42] of land. In generating a sample of 100 purposive homogenous sampling method was employed.

Using qualitative methodology, it was found that respondents with a history of either spontaneous or induced abortion enjoyed a limited social support[43]. This is in agreement with the previous studies where reduced social support was either associated with the incidence of abortion or increased abortion incidence by two times after controlling for potential cofounders (Sanchez-Siancas et al., 2018; Rhenstrom Loi et al., 2018). An association between the incidence of induced abortion and low social support has also been demonstrated, wherein social support from husband, family, and friends has been reported to provide emotional and physical support needed during pregnancy (Zegeye et al., 2018). Limited social support was also observed in the General Reproductive Health Survey (GRHS). The survey revealed that 50% of the participants who had experienced spontaneous abortion enjoyed social support from their spouses or their families, while the rest had support from their parents or other relatives. The GRHS, therefore, revealed that the

[42] One kanal of land is equal to 0.125 acre.
[43] Social support is "the perception and authenticity that one is cared for, has assistance available from other people, and that one is a part of a supportive social network" (House, 1981.p,27)

pregnancy and not pregnancy loss had garnered good social and financial support from the spouses.

The qualitative part of the study revealed that most respondents lived in a joint family structure and shared a formal and conventional relationship with their in-laws. This social set-up thus forced women to conceal the episodes of pregnancy loss which consequently fetched them limited support. Contrary to the findings in the qualitative part of the study, the GHRS revealed that most participants lived in nuclear families where social support was naturally limited. Support was limited in a joint family structure because of the conventional and conservative relationship family members shared. In nuclear families, it was naturally limited because of the small family size.

In the qualitative part of the study, disclosure of pregnancy among respondents was avoided until it became apparent, while pregnancy loss was found to be more of a lonely and personal experience because of non-disclosure of the event. The observation agrees with a previous study where non-disclosure meant that women felt lonely and isolated in their feelings of grief and loss (Bellhouse et al., 2018). In agreement with the findings of the qualitative part of the study, in GHRS, it was found that less than half of the participants who had induced abortion had made disclosures at a healthcare facility. In contrast, the rest had cited spontaneous abortion as a reason or had not accessed any healthcare facility for post-abortion care. A study conducted on women who had undergone induced abortion in the United Kingdom revealed that women found the induced abortion as a highly stigmatizing event because of which disclosure to others was severely affected (Astbury-Ward et al., 2012). This finding is in line with a study in which it was observed that women keep episodes of pregnancy loss to themselves and share them with very few confidants (Duggal & Ramachandran,2004). Another study recorded that women hide an event of pregnancy loss because they fear social disapproval and negative comments from others (Greenway,2009). A

similar finding was observed in one of the studies revealing that women keep silent about their pregnancy and miscarriage (Yilmaz & Beji, 2013). In partial agreement with the qualitative part of the study, GRHS revealed that while the events of spontaneous abortion were revealed to other family members after the episode, the events of induced abortion were kept secret and hardly revealed to anyone. A much broader study on women in five countries who had terminated un-intended pregnancies revealed that the abortion-related stigma had played an immense role in the non-disclosure of individual abortion behaviour (Shellenberg et al., 2011).

Since abortion is a socially disapproved event, there is a culture of silence and secrecy around the issue of pregnancy loss. Women who face pregnancy loss are not able to share or mourn their loss openly and publicly, and this "disenfranchisement of grief" (Doka et al., 1999, p.4) leaves them alienated and snatches them the right to mourn or grieve (Malacrida,1999). The grief is also exacerbated by the pre-conceived notions of pregnancies advancing smoothly and steadily (Stinson et al., 1992). Therefore, women generally blame themselves for the loss, thinking that their bodies have failed them and that they could have acted differently to prevent the pregnancy loss (Dunn et al., 1991).

The qualitative part of the study revealed that pregnancy loss is a very individual experience that happens to one's self with barely anybody empathizing with the condition and disapproval, stigma and taboo attached to it. In GRHS also, it was found that the events of induced abortion were kept secret, and only spouses knew about the status of such women. This finding aligns with a study in which it has been demonstrated that pregnancy loss is very personal and is considered taboo (Ekstrand,2009).

Abortion being a contentious issue in terms of social disapproval, religious prohibition, and moral wrong, it was observed in the present study that abortion induction is a difficult

decision to reach for women, mainly when the decision is not mutual. Some respondents acknowledged that they induced abortion at an advanced stage of pregnancy because of a state of indecision, which had caused a delay in availing of abortion services and had resulted in complications. The observation is in line with a study in which it was found that delayed abortions can cause severe complications in women having undergone induced abortions (Singh et al., 2018). The current study revealed that irrespective of the husband's role in decision-making to induce abortion, they were informed about the pregnancy loss. The observation agrees with a previous study where it was ascertained that husbands were aware of the status of pregnancy loss in cases of induced abortions (Zamanian et al., 2016). Similarly, in the GRHS, it was found that the spouses had fetched abortifacient medicines in more than half of the participants who had induced abortion, indicating that the decisions taken to induce abortion were predominantly mutual.

The qualitative part of the study revealed a feeling of disapproval from healthcare providers in the case of induced abortion, due to which such women either did not access healthcare or reported induced abortion as spontaneous abortion. The observation agrees with the current GRHS, where participants who accessed health facilities had reported induced abortion as spontaneous abortion. In contrast, others had either visited a healthcare worker's home or managed the post-abortion care themselves without accessing the healthcare facility to evade the disapproval and criticism. In the present study, it was also observed that respondents who induced abortion without any complications did not access health services, while those who developed complications post-abortion-induction accessed PHC for seeking medical care after claiming to have undergone a spontaneous abortion. Similar experiences were observed in a study where all induced abortions were officially reported as spontaneous abortions because of the restrictive abortion policy and social disapproval of induced abortions (Whittaker, 2013). Similar observations were also reported by previous studies in

which women inducing abortions claimed to have undergone spontaneous abortion to access healthcare facilities, as a result of which the majority of induced-abortion cases were reckoned as spontaneous abortions (Shahbazi et al., 2011; Knudusen et al., 2003).

In the qualitative part of the study, it was observed that women would remember pregnancy loss events even after many years had elapsed. Some of the participants reported that their experience of past events of pregnancy loss always haunts them. A cathartic feeling was observed in respondents while sharing their experiences of abortion (spontaneous or induced or both), which was probably because these women had concealed such events for a long time and had not talked to anyone about them except for a few confidants. All the respondents wanted to discuss it in detail with the researcher. Some of the women said they felt good after talking about it, and a few were eager to share more details regarding pregnancy loss. Similar eagerness to share experiences was found by Warner et al. (2012) in a study in which it was observed that all women participants appreciated the opportunity provided to them to share their experiences of pregnancy loss, which several women claimed to be cathartic (Warner et al., 2012).

The qualitative study revealed that respondents who suffered induced and/or spontaneous abortion belonged to families with poor socioeconomic conditions. The GRHS also divulged that about 67% of participants who induced abortion and 44% of participants who suffered spontaneous abortion were part of the families who did not own any land and had an unsustainable source of income. Various studies have indicated a definite association between adverse pregnancy outcomes and socioeconomic status (Zheng et al., 2017). While low socioeconomic status can increase the risk of vulnerability associated with pregnancy, women with low socioeconomic status also have a chance of receiving low prenatal health care (Kim et al.,2018; Lee et al.,2016; Leppalahti et al., 2013; Paredes et al., 2005).

Since the study was conducted in a rural area, it was observed that the village healthcare facility lacked proper infrastructure, often referred patients to secondary or tertiary healthcare facilities, treated patients without empathy, and often performed procedures of D&C on patients' post-abortion, following which most of the patients suffered an intrauterine infection. A similar trend of post-abortion intrauterine infections or complications was observed in the participants of GRHS who had either induced or suffered abortion. This is supplemented by a recent study in which it was confirmed that women living in rural areas are twice as likely to be at risk of adverse pregnancy outcomes than women in urban areas (Kebede et al.,2018). A previous study has revealed that a substantial percentage of abortion-related admissions in hospitals with limited abortion-related facilities have potentially life-threatening complications (Calvert et al., 2018).

The majority of the respondents in the present study were either illiterate or possessed poor educational qualifications, which goes with the trend observed in GRHS, in which it was found that 62% of participants were either illiterate or received only primary education. Interestingly, 53.5% of the participants who had induced abortion and 72% of the participants who had suffered spontaneous abortion were either illiterate or hardly passed the middle school, which is partially in agreement with a previous study where it was found that induced abortion tends to increase with lower education (Ajentunji,1997; Herold et al.,1994). The observation also agrees with a previous study where it was noticed that women with low educational status have a high risk of adverse pregnancy outcomes compared to women with higher educational status (Kebede et al., 2018). In another study, it has been argued that low education of women is associated with the under-utilization of maternal health services that can result in adverse pregnancy outcomes (Kebede et al., 2018). It has also been seen that women having low educational attainment are at a higher risk of having induced abortion, stillbirth, and a pre-term delivery (Hegelund, 2019). In a study on 1.8 million women in

India, illiteracy or low educational status were associated with unsafe abortions (Yokoe et al., 2019). Nevertheless, it is interesting to note that education may influence the women accessing obstetric care. However, the present study observed that physical access to a health facility is equally essential for women accessing primary care irrespective of their educational attainment. Since most of the women in the study group were illiterate or had low educational attainment but had availed of ANC care multiple times, as observed in qualitative study and GRHS.

Many respondents in the qualitative study claimed that spontaneous abortion was triggered by heavy work like fetching water from a nearby source or firewood from the forest or lifting heavy objects. In the GRHS, a similar trend was observed where 76% out of the total spontaneous abortions described physical stress-related factors as a reason for spontaneous abortion. This observation aligns with what was observed in the qualitative part of the study. According to the UK Royal College of Physicians and NHS guidelines[44] the risk, however low with lifting weight, cannot be ignored. It states that there is a 0.2 per cent of a chance of spontaneous abortion per 100 women lifting heavyweight during pregnancy. Another study reflects that the risk of spontaneous abortion increases with lifting heavy weights (Juhl et al., 2013; Evennson et al.,2014). It is also important to note that 72% of spontaneous abortions occur in the first trimester of pregnancy. It agrees with some previous reports about the difficulty in handling physical work in the first trimester and evidence showing a threefold enhanced risk of pre-term labour or spontaneous abortion in women who bend at waist height for more than 1 hour per day (Mac Donald et al.,2013).

It was also seen that the respondents terminated some planned pregnancies because of socially compelling reasons like the marriage of a sister- or brother-in-law or any other event

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at home. This observation agrees with a study that reports that women prefer other responsibilities over carrying a pregnancy (Jones, Frohwirth & Moore, 2008). Despite having strong feelings attached to pregnancy, women had yielded to the pressures of circumstances and terminated such pregnancies. The considerable number of unwanted pregnancies found in current studies, thirty out of one hundred and thirty women, and subsequent termination of all, is strongly indicative of the fact that women of the village enjoyed limited reproductive rights. It is in agreement with a previous study where it was found that women alone cannot have the autonomy to regulate or control their fertility (Eggleston, 1999). In a condition of sexual obligation, women and their body products are appropriated by men, which robs them of choice to reproduce or their decision on the number of offspring to bear. As a result, women cannot exercise their reproductive rights fully (Guillaumin, 2014; Cisne et al., 2018). In Jammu and Kashmir, only 66 per cent of women took the decision of abortion themselves, 21 per cent were performed medically, and 13 were decided by others like their husband, mother-in-law, or other family members or friends (Maharana, 2017). It has also been found that less autonomy of women, lack of health services, and lack of patient-centred approach are responsible for women's indecision concerning abortion (Frederico et al.,2018).

Extra-marital affairs pursued by the husbands of respondents in the current study were also seen in some cases as an alibi to abort a pregnancy, which is in agreement with a study that ascertains that relationship problems can influence the decision to abort a pregnancy (Finer et al., 2005). However, no such finding was revealed in the GRHS. Such findings revealed during an in-depth interview in the qualitative study could have been because of the extra probing to elicit complex responses.

Respondents in the present study experienced an intense moral dilemma, with conflicting feelings regarding carrying a pregnancy or aborting it, which they found extremely difficult to resolve. The indecisiveness caused by the moral dilemma led to second-trimester abortion

inductions, followed by severe complications in a few cases. The GRHS revealed that about 87% of total induced abortions were performed in the first half of the first or second half of the first trimester. In comparison, only 6.6% were performed in the early second trimester, which could be because of the moral dilemma faced by some participants. The observation agrees with the qualitative part of the current study and a study in which it is observed that moral and personal issues regarding abortion decision-making make it a very complex phenomenon (Hoggart, 2019). Collectively, the result from both the study components suggests that despite facing moral dilemmas, women with unwanted pregnancies went on to terminate them either at early or later stages associated with or without complications.

It was found that most of the respondents, who faced either spontaneous or induced abortion or both, tended to reasonably cope with their pregnancy loss because they already bore children from earlier births. Further, respondents ascribed events of spontaneous abortion to their destiny, fate, or the will of God. That aligns with a pre-modern approach where pregnancy loss is attributed to religion, nature, and destiny (Frost et al.,2007), which gives them a meaning to their loss (Adolfessen et al., 2003).

In the GRHS, it was found that participants had either mixed feeling (46.6%), sadness (20%), an element of guilt (26.6%) or relief (6.6%) following abortion induction which correspond to the findings of the qualitative part of the study in which women had a feeling of sinning. A feeling of guilt and emptiness has been reported following pregnancy loss in a previous study conducted by (Adolfesson et al., 2003), which agrees with the similar experiences of respondents in the qualitative and quantitative parts of the current study.

In the qualitative study, contraception was found to be very low, resulting in unintended and unwanted pregnancies. The reason for limited use of contraception was attributed to lack of perceived risk of pregnancy, unacceptability and unaffordability of contraception,

discomfort caused by contraceptive methods like the use of Copper-T, and reluctance shown by husbands to practice contraception. In GRHS, about 66 per cent of the study population used one or the other method of contraception. The most commonly used method of contraception was the withdrawal method (traditional method), followed by female sterilization. At the same time, a considerable number of women participants preferred female sterilization. Male sterilization was not practised despite female sterilization being a more invasive and complex surgical procedure than male sterilization. Collectively, both the components of the study suggested that the onus of using contraception was put on the women involved in the present study. Moreover, the withdrawal method or coitus interruptus is a traditional method, and there have been many conflicting reports about its safety; however, it is still being widely practised (Demir et al., 2020; Nguyen et al.,2020). In the current study, it was observed that there was an unmet need for contraception; women wanted to use contraception but, because of many compulsions, were not able to use it, resulting in a low contraceptive prevalence rate (CPR). Low CPR is generally considered a reason for the unmet need for contraception (Cleland et al.,2006), as also shown by the current study.

It was found in the qualitative part of the study that unwanted pregnancies that ended in self-induced abortions could have been prevented to a large extent if proper contraception usage had been practised. One of the studies confirmed that there was a reduction in induced abortions in Denmark from the year 1974-1995 because of the reduction in the desired rate of children and the availability and acceptability of contraception (Knudsen et al.,2003). This indicated a lack of knowledge and unawareness about the significance of the use of contraception in the respondents and their husbands evaluated in the present study. Further, it was observed that availing of abortion services provided by the MTP Act, which allows legal termination of unintended pregnancy caused due to contraception failure, could have considerably reduced the loss of health and financial burden faced by the respondents due to

delayed abortion. However, a complete lack of awareness of such provisions of the MTP Act among the women was noticed.

In the GRHS, it was revealed that the knowledge about contraception was almost universal, with 99 per cent of the study population knowing about it. However, 96% of the study population did not know about Emergency Contraception. The use of Emergency Contraception to avoid unintended pregnancy was not found in either qualitative or quantitative components of the study. None of the respondents had ever consumed Emergency Contraception in both the study components. The NFHS-4 revealed limited knowledge (1.6) about emergency contraception in district Kupwara. Further, according to NFHS-4, the Contraception Prevalence Rate (CPR) in Jammu and Kashmir was 57 per cent, while that in district Kupwara has been observed to be 51 per cent (IIPS,2016). "In such social configurations, where contraceptive use is still rare but where non-procreative sexuality is becoming increasingly common, emergency contraception could reduce the number of unplanned pregnancies and consequently reduce mortality and morbidity linked to illegal abortions, a major public health problem" (Institute National d'Etudes Démographiques, 2013,p.8).

According to WHO, contraception failure significantly contributes to unwanted births, unintended pregnancies, and adverse pregnancy outcomes (WHO,2019). The incidence of contraception failure varies with socioeconomic factors and demographic characteristics like age, education, wealth, residence, marital status, and parity. "Unintended pregnancies and abortions due to failure of the contraception not only discourage the intentions of use but also affect the social and economic wellbeing of the family"(Singh et al., 2020, p.3). To minimize the contraception failure, improve the counselling services, information, and use, and effectively implement and identify the clients, it is essential to identify the variables responsible for limited access and utilization of contraception (Sedge & Hussain, 2014).

Further, out of 25 of those who had miscarriages, 32 per cent had experienced it twice. One of the participants had experienced the event of miscarriage thrice. Almost all the miscarriages experienced by women were over two months, so each had to undergo D&C, which had resulted in complications like infection and hemorrhage. It is also observed in a study that some women tend to go for second-trimester abortion because of poverty, lack of physical access, and lack of agency (Singh et al.,2018).

The limited use of contraception had possibly resulted in unplanned pregnancies. The GRHS revealed that 40 per cent of the first and 85 per cent of the subsequent pregnancies were unplanned. For example, 80 per cent of study participants who had undergone induced abortion had their subsequent pregnancies unplanned. Interestingly, the majority of the pregnancies that were spontaneously aborted were too unplanned. In the GRHS, about 73 per cent of those who had subsequent pregnancies as unplanned did not go for induced abortion. Among those who had gone for induced abortion, about 60 per cent of them had used the withdrawal method as a method of contraception which could have likely impregnated the participants because of its safety issues, as reported in other studies (Nguyen et al.,2020; Hassoun,2018; Cagnacci et al.,2014). It was also noted in the GRHS that about 26 per cent of the study participants used the withdrawal method as a means of contraception. The reason for the non-use of contraception was fear of side effects, as was stated by 23 per cent of the study participants. Also, the prevalent method of contraception after withdrawal method was female sterilization which was seen in about 30 per cent of women. However, female sterilization was performed after having given birth to the desired number of children by the participants. According to NFHS-4, the female sterilization rate in Jammu and Kashmir was found to be 43 per cent which, however, was at 50% in NFHS-3. In NFHS-3, the female sterilization rate was 50 per cent which might indicate a decline. Also, it has been observed that not only the use but the effectiveness of contraception influences abortion rates. There is

a risk involved in all the methods of contraception, even if they are used correctly and routinely (Fejka & Atkin, 1996; Huntington, 1998). However, inconsistent use of pills, incorrect way of using condoms, and withdrawal methods increased abortion rates in countries like Turkey, UK, and Italy (Bestianelli, 1996; Price, 1997; Pile 1997). "The lack of an association between contraceptive knowledge and pregnancy intention status may indicate that awareness does not always indicate an ability to obtain methods or to use them correctly and effectively" (Eggleston, 1999, p.32). Unintended pregnancies may also indicate non-use of contraceptive methods, use of methods inconsistently and incorrectly, and use of the traditional method of contraception which has little efficacy (Singh et al., 2018). Marriage and sexuality of women are accomplished to maintain the power relation in a given social structure (Institut National d'Etudes Démographiques, 2013). So, the issue of contraception cannot be understood from the standpoint of women alone when there is a power relation between men and women to maintain the social hierarchy (Cisne et al., 2018).

Unplanned first and subsequent pregnancies from the GRHS were found higher in either social caste or scheduled tribe than in the general category, which partially agrees with previous studies where unplanned pregnancies have been associated with women belonging to the scheduled tribe (Dixit et al., 2012). Limited ante-natal care in the form of ultrasonographic scans was observed in the scheduled tribe category, which also corresponded to the high stillbirth, neo-natal, child, and infant mortality. The observations agree with previous studies where infant mortality has been observed to be higher in scheduled tribes compared to other social groups (Sahu et al.,2015; Bora et al., 2019). It has also been observed that ANC visits in developing countries can reduce infant and maternal mortality and morbidity to a great extent (Khatib et al., 2009).

Interestingly, all the respondents who underwent self-induced abortion used abortifacient drugs, mostly misoprostol, and did not resort to any traditional or conventional methods of

abortion induction as has been demonstrated in other studies (Bello, 2018). The GRHS also revealed that 100 per cent of participants had induced abortion using abortifacient drugs. The drug is readily available in the market, and some chemists supply it without formal medical prescription. Most of the time, women discussed that the chemist who sells the drug happens to be their acquaintance, and it was mostly spouses who would negotiate with the chemist for the drug. It has been observed that abortifacient drug-like misoprostol has replaced many methods of unsafe abortion (Grimes et al.,2006; Salakos et al.,2008; Chen, & Creinin, 2015).

The current study observed a marked preference for male children, which was particularly practised by women, a deep bias against bearing children of the female gender, and a strong desire to bear multiple male children. These observations were in partial consonance with the NFHS-IV data of 2016, which recorded a very strong element of male-child preference in J&K (IIPS, 2016). However, most men were observed to have a preference for a male child, contrary to women as reported in NFHS-IV. Contrary to the study's qualitative part, GHRS revealed that 41 per cent of the respondents preferred sons over daughters, and about 47 per cent did not have any son preference. In Jammu and Kashmir, NFHS-4 reveals that 20% of women prefer sons over daughters, while 80-82% of women have dual preferences (IIPS,2016).

In the qualitative study, an issue of disposal of condoms was noticed since the village is an open community, where compounds of houses are rarely fenced. Men expect women to dispose of condoms, and for women, it is difficult to dispose of condoms amidst the apparent gaze of the village people. There is no trash collection mechanism in the village which could allow women or men to dispose of condoms without anybody noticing them. The issue of disposal with condoms also prevents women from using condoms.

In the current study, the location of the primary health care centre in the village was paramount for women accessing the primary health centre for Ante Natal Check-ups. The ANC visits did not vary much according to income groups because the PHC was physically accessible, and the treatment in the PHC was free for every visitor. The observation agrees with a previous study which reported that people, irrespective of their socioeconomic status, accessed primary healthcare because the services were accessible and affordable (Aftab et al.,2012).

In the qualitative study, it was observed that the majority of the participants had accessed public health services in the form of primary health centres, community health centres, non-local primary health centres or tertiary public hospitals for their deliveries. In the GRHS, it was again observed that about 85% of the participants had accessed the public health system for their deliveries. In rural areas, people use the public health care system more than the private health sector.

Since PHC is located in the village, people access PHC very frequently. It is expected that the PHC will provide all the medical help required to the patients. However, most often, very few facilities are available in the PHC in the form of medicine, equipment, diagnostic testing, etc. As a result, the patients have to spend money out of pocket. The participants in the study were living in the lowest wealth quintile, and the amount of money they had spent on the latest event of pregnancy and delivery. It is observed that sometimes the OOP throws people into poverty. The primary healthcare financing in India is majorly out of pocket, with no health insurance coverage for the people, which throws people into poverty and deepens it (Ghosh,2011).

CHAPTER VI

CONCLUSIONS

The current study attempts to gain insight into the experiences of women facing pregnancy loss and their access to reproductive healthcare services in the frontier district of Kupwara, Jammu and Kashmir, using a mixed (Qual→Quan) methodological approach. The following conclusions were derived from the current study:

Induced abortions

Despite religious prohibitions, induced abortions were found to be widely practised in the Muslim-dominant society of Kupwara, Jammu and Kashmir. The experiences of women who had induced abortions revealed that no or limited contraceptives were used by women or their spouses, while the quantitative study revealed that the majority (73.3%) of such abortions were observed in women practising either *coitus interruptus* or no contraception. The experiences further revealed that the decision to induce abortion was influenced by poverty, family engagements or young children at home; however, most of such decisions were solely taken by respondents. The quantitative study also revealed that most abortions (66.6%) were found in women belonging to lower-income groups (0.6 to 0.9 Lakhs of annual income). A limited pre- and post-abortive social and emotional support were enjoyed by respondents inducing abortions. The experiences also revealed that such respondents experienced moral dilemmas before inducing abortion and later had a strong sense of guilt, relief, or both post-abortion. Most of the respondents who had induced abortions had not visited any healthcare facility because of legal apprehensions. However, some women had accessed healthcare facilities citing reasons for spontaneous abortion.

Spontaneous abortions

The experiences of women facing spontaneous abortion also enjoyed limited social and emotional pre- and post-abortive support. The respondents often associated their pregnancy loss with the routine heavy work to running household chores like fetching firewood or water from a long distance. The respondents vividly remembered episodes of abortion and the physical and emotional pain associated with it. The feeling of grief was profoundly associated with women who had suffered spontaneous abortion. Most women who suffered spontaneous abortion accessed primary healthcare for post-abortion procedures or general follow-up.

Reproductive health and access to healthcare:

The quantitative study data revealed that 64% of participants had regular menstrual cycles at the time of marriage, and 67% had conceived within one year of the consummation of marriage. It was observed that 60% of participants had a planned first pregnancy while 84% had an unplanned second or subsequent pregnancy. Out of 94% of the participants who knew about contraception, only 71% of participants had practised it. The decisions about reproductive affairs mainly were (73%) taken alone by the participants.

For ante-natal check-ups, 78% of the participants had accessed government healthcare facilities during their last pregnancy, out of which 75% had visited the village PHC four or more times. Out of 333 deliveries by 100 participants, 91% were institutional, and 70% were normal vaginal deliveries.

General Conclusions

Despite the knowledge and easy availability of contraceptives, reluctance shown by men to use contraception or practice *coitus interruptus* was widely observed in the study area, which likely resulted in unwanted pregnancies that were consequently self-aborted. The majority of the self-induced abortions had taken place using abortifacients which were fetched by a spouse or acquaintance from local pharmacies. Contraception failures arising from low-quality condoms procured from village PHC and poorly installed Copper-T had also resulted

in unintended pregnancies. Interestingly, lack of facility to dispose-off condoms was also reported as one of the reasons for their limited use. Surprisingly, it was observed that male sterilization was not at all practised as a method of birth control, unlike female sterilization, which was still somewhat being practised. Although the respondent mostly took the decision to abort, such decisions were usually influenced by socio-economic conditions like poverty, family engagements or young children at home. However, the decisions regarding general reproductive affairs like planning a child, use of contraception, number of children, and spacing between children were mostly taken by men. The quantitative study also revealed that most abortions (66.6%) were found in women belonging to lower-income groups (0.6 to 0.9 Lakhs of annual income). Such respondents faced a moral dilemma and a strong sense of guilt and grief before and after inducing abortion, respectively. Further, the respondents maintained secrecy around the episodes of self-induced abortion which consequently fetched them limited social support and medical care. Interestingly, a cathartic feeling was observed in women during their narration of the episodes of pregnancy loss irrespective of the type of abortion they had suffered. A strong feeling of grief followed by vivid memories of the episodes of spontaneous abortion along with the associated emotional and physical pain was also observed. Such women were observed often to associate their pregnancy loss with the routine heavy work like fetching heavy firewood or water from long distances apart from doing household chores. More than half of the respondents who had suffered spontaneous abortion belonged to the lowest income group. Irrespective of the type of abortion, limited social support was enjoyed by the respondents before and after abortion. For post-abortion procedures, the healthcare facilities were reasonably accessed by women after spontaneous abortion. At the same time, most women who induced abortion had also accessed healthcare facilities after citing 'spontaneous abortion' as a reason. Most respondents accessed healthcare

facilities post-abortion for dilatation and curettage, intra-uterine infections, haemorrhage and abdominal pain.

The quantitative study data revealed that 64% of participants had regular menstrual cycles at the time of marriage, and 67% had conceived within one year of the consummation of marriage, indicating a reasonably good reproductive health status of the women. It was observed that 60% of participants had a planned first pregnancy while 84% had an unplanned second or subsequent pregnancy. The decisions about reproductive affairs were mostly (73%) taken alone by the participants, which was in agreement with women's experiences concerning decision-making. For ante-natal check-ups, 78% of the participants had accessed government healthcare facilities during their last pregnancy, out of which 75% had visited the village PHC four or more times. Further, four or more than four antenatal visits were observed in 67% of participants who had either never attended school or attended school up to 9^{th} grade. It was also observed that 73.6% of participants in the scheduled tribe population had undergone either one or no ultrasonography scans during their last pregnancy compared to 51% from the general population and 31.5% from social caste. All the social groups, likely, more or less uniformly accessed public healthcare facilities because of the centrally-placed PHC in the village. Most of the deliveries were institutional and had taken through a normal vaginal route which is in stark contrast to the trend observed in urban areas of Jammu and Kashmir, where most of the deliveries are performed through lower segment caesarean section. Higher percentages of stillbirth and infant/child mortality were observed in schedule tribe groups compared to other groups. Overall, the quantitative part of the study revealed that most participants possessed fairly good reproductive health status. Further, the access to general reproductive healthcare in the village was also found to be satisfactory, although a lack of some basic facilities in terms of infrastructure and human resources in the village PHC was noticed.

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TABLES

Table 1

Classification of the discourse on induced abortion into conservative (pro-life approach), moderate approach (pro-abortion) and liberal approach (pro-choice).

Conservative (pro- life)	**Moderates (Pro-abortion)**	**Liberal (Pro-abortion)**
Abortion is prima-facie a moral wrong.	Abortion is appropriate for woman's therapeutic benefit (e.g., ectopic pregnancies).	Women are entitled to the right of choice based on self- morality.
Unethical	Prevents back-alley abortionists.	Gives woman control over their bodies and reproduction.
Personhood commences at conception.	Abortion can be allowed if foetus is severely disabled (eugenics)	It is individual's choice to terminate any unwanted children.
Abortion amounts to murder.	Terminates incest pregnancies	Allow woman desired life style (e.g., pursue career)
Sanctity of human life is important.	Terminates rape and forced sex pregnancies.	Allows woman's social and political equality with men.
Abortion devalues human life.	Reduces parental/psychological and mental health stress.	Allows desired sex-selection of children
Abortion encourages permissive society.	Allows women greater financial freedom	Abortion eugenic for society (e.g., socio-economic medical savings).
Abortion denigrates women.		Pro-life discriminates against women.

Note: Reprinted from Carey, L. B., & Newell, C. (2007). Abortion and Health Care Chaplaincy in Australia. *Journal of Religion and Health, 46*(2), 315-332. doi: 10.1007/s10943-006-9078-x

Table 2

Statistics related to unintended pregnancy and abortion rate globally

	Unintended Pregnancy		Abortion	
Region	**Rate**	**80% uncertainty interval**	**Rate**	**80% uncertainty interval**
World	64	60 -70	39	35 - 44
Sub-Saharan Africa	91	86-96	33	29-38
Western Asia and North Africa	86	67-114	53	34-78
Central and Southern Asia	64	59-70	46	42-51
Eastern and south East Asia	58	48-73	43	34-54
Latin America and the Caribbean	69	61-79	32	25-41
Europe and North America	35	33-39	17	15-20
Australia and New Zealand	38	32-45	15	12-19
Oceania(Excluding Australia and New Zealand	78	58-113	34	16-66

Note: *All values are annual averages for 2015–2019. Rates of abortion and unintended pregnancy represent the number of those events per 1,000 women aged 15–49.*

Note: Reprinted from Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. The Lancet. Global health, 8(9), e1152–e1161. https://doi.org/10.1016/S2214-109X(20)30315-6.Reprinted from abortion report.eu Source:Guttmacher Institute, 2020

Table 3

Studies on spontaneous and induced abortion across the world

S.No	Author	Topic	Journal	Country
1.	Tiemeyer, S., Shreffler, K., & McQuillan, J. (2020)	Pregnancy happiness: implications of prior loss and pregnancy intendedness.	*Journal of reproductive and infant psychology*, 38(2), 184–198.	USA
2.	Garrod, T., & Pascal, J. (2019)	Women's Lived Experience of Embodied Disenfranchised Grief: Loss, Betrayal, and the Double Jeopardy.	*Illness, Crisis & Loss, 27(1), 6–18.*	United Kingdom
3.	Meredith, P., Wilson, T., Branjerdporn, G., Strong, J., & Desha, L. (2017)	Not just a normal mum": a qualitative investigation of a support service for women who are pregnant subsequent to perinatal loss.	*BMC Pregnancy and Childbirth17*(1).	Australia
4.	Martel, S. L. (2014)	Biopower and Reproductive Loss.	*Cultural Studies, 28*(2), 327-345.	-
5.	Robinson G. E. (2014)	Pregnancy Loss	*Clinical Obstetrics and Gynaecology* (28), p. 169-178	UK
6.	Yilmaz, S. D., & Beji, N. K. (2013)	Effects of Perinatal Loss on Current Pregnancy	*Midwifery* (29), p.1272-1277	Turkey
7.	Mehran P et al. (2013)	History of Perinatal Loss and Maternal-Foetal Attachment Behaviours	*Women and birth: journal of the Australian College of Midwives*(26), p. 185-189	Iran
8.	Sell-Smith, J., & Lax, W. D. (2013)	A Journey of Pregnancy Loss: From Positivism to Auto-Ethnography:	*The Qualitative Report*, 18(92), p. 1-17	USA
9.	Van der Sijpt E. (2010)	Marginal Matters: Pregnancy Loss as a Social Event	*Social Science and Medicine* (71), p. 1773-1779.	Africa
10.	Dahlbäck, E et al (2010)	Pregnancy Loss: Spontaneous and Induced Abortion Among Young Women in Lusaka	*Culture, Health & Sexuality*,12(3) p.247-262	Zambia
11.	McCreight B. S. (2005)	Perinatal Grief and Emotional Labour: A Study of Nurses Experience in Gynae Wards	*International Journal of Nursing* (42), p. 439-448	UK
12.	Adolfsson, A., Larsson, P. G., Wijma, B., & Berterö, C. (2004)	Guilt and Emptiness: Women's Experience of Miscarriage	*Health Care for Women International*, (25)6, p.543-560	Europe (Sweden)
13.	Root, R., & Browner, C. H. (2001)			USA

		Practices of the Pregnant Self: Compliance with and Resistance to Pre-Natal Norms	*Culture Medicine and Psychiatry* (25), p.195-223	
14.	Bagchi, D., and Friedman, T(1999)	Psychological Aspects of Spontaneous and Recurrent Abortion	*Obstetrics and Gynaecology*, 9, p. 19-22	USA
15.	DuBose, J. T. (1997)	The Phenomenology of Bereavement, Greif and Mourning	*Journal of Religion and Health*, (36)4, p.367-374	Pittsburgh
16.	Layne, L. L. (1997)	Breaking The Silence: An Agenda for the Feminist Discourse on Pregnancy Loss 23(2), p. 289-315	*Feminist Studies* (12)9, p. 289-315	USA
17.	Beutel, M., Willner, H., Deckardt, R., Von Rad, M., & Weiner, H. (1996)	Similarities and Differences in couples Grief Reactions Following a Miscarriage: Results from a Longitudinal Studies	*Journal of Psychosomatic Research* (40)3, p. 245-253	Germany
18.	Hern, W.M. (1971)	Is pregnancy Really normal?	*Family Planning Perspectives* (3), p. 5-10	USA
19.	Fair H. D. (1913)	Miscarriage	*American Journal of Nursing* (13)9, P.666-672	USA

Note: The table depicts the studies which have been conducted in different countries with respect to the experience of pregnancy loss. There are not many studies which would capture the lived experiences of women who experience pregnancy loss.

Table 4

Studies on pregnancy loss in India

S.no	Title of the Study	Conceptualisation	Methodology	Main Findings
1.	Women, Work and Abortion Practices in Chengalpattu District, Tamil Nadu by S. Anandhi (2007)	The study was conceptualised around the problems faced by Dalit women (married and unmarried) while seeking abortion service.	The study was conducted in four villages of Kanchipuram, Tamil Nadu. In addition to the dalit women service providers, village functionaries and people working in pharmaceutical companies were also interviewed.	Women go for abortion as they have limited and incomplete knowledge about contraception that results into unwanted pregnancy. Abortion decision making and practices has increased in the context of increasing employment of rural women who are being employed in industrial sector in peri- urban area.
2.	Study on Availability of Abortion Care, Gujarat by Alka Barua	The study was conducted with those women who have experienced abortion and are married. It also included the abortion service providers. The main focus of the study was to see availability of health services in two urban slums of Ahmadabad.	Married women who had an experience of induced abortion were interviewed along with abortion service providers.	The couples go for sex determination tests and after wards abort female children if it happens to be a girl. 10 out of 62 or 16 per cent of abortions were performed after confirmation of female foetus. Girls married to NRIs who became pregnant soon after marriage resorted to abortion. Also, women who are married and get pregnant soon after their marriage want to abort their foetus. The abortifacient drugs were

				available at the drug stores wherein women who wanted to go for abortion would easily access those. Pressure to abort a foetus was enormous in families which were conjugal and extended.
3.	Ethnographic Exploration of Abortion and Abortion Care Related to Community Needs in Velhe Block of Pune, Marashtra by S.N. Morankar	The study focussed on ethnographic exploration of the attitudes of community towards abortion.	The study was conducted in fourteen villages in Pune, Maharashtra. In this study men of the community along with women were interviewed. Opinion leaders and service providers were also interviewed. Vigenette[45] method was used.	Women reported that they find the methods of spacing very difficult and cumbersome and prefer sterilisation after they have given birth to required number of children. Women used invasive methods to abort their foetus like sharp objects etc. to initiate bleeding. Pregnancy which happened out of wedlock had to be necessarily aborted for the reasons of shame which it can bring to a family. Also, the study found that when female children were born or conceived both family and community condoned the need to abort foetus.
4.	Post-Abortion Care through the Public Health System, Andhra Pradesh by Prakashamma	The study included both spontaneous and induced abortion and tried to assess the medical care in terms of abortion services.	The study was conducted in three villages and public health facilities were assessed in these villages.	This study indicated that abortions were preferred for medical reasons which was a divergence in the reasons cited by women and by those who provide abortion services. The study also noted that if women would conceive right after their marriage, they were likely to abort their foetus. Also, it was found that there is no or very limited use of contraceptives among women.
5.	Abortion in Rural Community Near Urban Areas, Maharashtra by Anjali Radkar	The study was conceptualised around the issue of decision making of women when it comes to abortion and providers choice.	The study was undertaken in two peri-urban villages of Pune, Maharashtra. The married women were being interviewed in the age group of 15-49 years.	Women were likely to abort their children if they would conceive right after their marriage. Sex- selective abortion was also seen as one of the main cause of abortion. 8 out of 70 which is 11 per cent of abortions were performed after sex determination. Even after abortion women would work tirelessly as they have the perception that rest is not all important after abortion. Also, it was found among many women that occasional intercourse would not lead to pregnancy. Sex- selective abortions are very rampant and women always said that they need a male heir to perform their last rites.
6.	Process and Factors Underlying Choice of Induced Abortions: A Qualitative Investigation in Rural Tamil Nadu by T. K Sundari Ravindran, 2002	The study was conceptualised around the issue of gender dynamics and inter-generational differences in abortion seeking behaviour.	The study was undertaken in 98 hamlets of Kancheepuram district of Tamil Nadu. The study focussed on low income and marginalised couples.	The younger women viewed the frequent child birth shameful and went for abortion to space children. Also, if women would conceive right after marriage they would go for abortion. 29 0f the 66 women who were interviewed knew about the reversible methods. Some women said that they don't use contraceptives and pills because of their side effects. Also, men were found to be inconsistent in using condoms. Women also said that they feel uncomfortable with IUDs as they give lot of pain and discomfort. Women were found to accept abortion as they said it is their husbands who have to pay. There was also an interesting observation wherein women said they aborted the third child as number three was inauspicious and unlucky.

[45] It is a method of social and psychological experimenting in which participant are given a hypothetical situation and are asked to act in that thus revealing their perceptions, feelings, norms and other values.

7.	Abortions in Dekshina Kannada: Socio-Cultural and Medical Underpinnings and Consequences by K. Susheela and K. Nagaraj	Socio-economic and cultural factors associated with loss of pregnancy.	The study was conducted in the village Udipi in Karnataka. The study tried to focus on women beedi workers and agricultural workers.	Poverty was one of the reasons cited for induced abortion.
8.	Sex-Selective Abortion in Mehsana and Kurukshetra Districts of Gujarat and Haryana by Leela Visaria	The study was conceptualised around the issue of son preference and subsequent abortions thereof.	The study was conducted in six villages of Mehasana Gujarat and six villages of Kurukshetra Haryana	The women indicated that there was a lot of pressure from their families to go for sex- selective abortion. The study also indicated that decision was entirely of their husband's and of their mother-in-laws. Some difference was found among the women of higher social groups. There was an interesting observation that women of high caste had to consult their in-laws to decide whether or not they go for abortion. On the other hand, women of lower caste had to ask for the permission to their husbands alone. Majority of women also knew all the abortion providers of the area and said they will access them if the need arises.
9.	Abortion Options for Rural Women: Case Studies from the Villages of Bokaro District, Jharkhand by Lindsay Barnes,2003	The study is conceptualised around the issue of documentation of women's experience of abortion.	Twenty- five women who had experienced abortion during the previous two years were selected and interviewed. Semi-structured questionnaire was used. A small number of service providers were also interviewed.	The study highlighted the total lack of accessible, affordable and safe abortion service. Also, the decision-making capacity to control their own fertility unless and until health system does not become sensitive to women's overall wellbeing was the main findings of the study.
10.	A Study on Abortion Practices in Kerala by S.S. Jagnayak	There are many studies regarding abortion which has been done by physicians, demographers and sociologists but there is a little awareness of lay woman about abortion. Since Kerala is a demographically advanced state where total fertility rate (TFR) is lowest among all states, yet there are woman who use abortion as a method of spacing. In the wake of changing value system, erosion of family and kinship, media explosion on sex proactive themes, availability of MTP services almost on request and existing threat of HIV/AIDS is what this study has been conceptualised around.	The method used in the study is both qualitative and quantitative. There is use of interview schedules, documentary evidence and field notes have also been used. The study was undertaken in three districts of Kerala viz Thiruvananthapuram, Pathanamthitta and Thrissurm. From each of these districts 40 respondents were selected from the rural and urban areas. 10 respondents who had undergone abortion were selected from each district.	The term abortion was known to all respondents. But women had less information about the various aspects of abortion. The psychological aspect of abortion with respect to the general health conditions was not known. Legal implications of induced abortion are not known among women. The level of knowledge about medical termination of pregnancy is inadequate.

Source: Visaria et al (2004a)

Table 5

Aspects of Patient-Centered Care around abortion care

	Dimensions	**Consideration**
1.	Respect to patient's value system, preferences and expressed needs	Respect for the patient; focus on individual patient; shared decision-making
2.	Coordination and integration of care	Coordination and integration of clinical care; ancillary and support services and front-line patient care
3.	Information, communication and education	Information on clinical status; progress and prognosis; processes of care and education
4.	Physical comfort	Pain management; assistance with daily activities and living needs; hospital surroundings and environment kept in focus
5.	Emotional support, alleviation of fear and anxiety	Anxiety over clinical status; treatment; prognosis; impact of the illness on themselves and family and financial impact of illness
6.	Involvement of the significant other	Accommodation for social and emotional support; respect for and recognition of the patient advocate's role in decision-making; support for family members as caregivers; recognition of the needs of family and friends

7.	Continuity and Transition	Understandable patient information; coordinated plan after discharge; information regarding access to support
8.	Access to Care	Geographical accessibility; waiting times; ability to schedule appointments (when needed)

Note: Understanding and Promoting Patient-Centered Care from Gerteis et al, 1993.p,108)

Table 6

Use of Contraception as recorded in NFHS III, IV &V - India

Method of Contraception	NFHS-III	NFHS-IV	NFHS-V
Any method	52.6	57.3	59.8
Any modern method	44.9	46.1	52.5
Female Sterlization	26.3	24.4	21.1
Male Sterlization	2.6	0.4	0.3
IUD	2.7	2.8	5.9
Pills	4.7	6.2	9.0
Condoms	8	11.3	11.7

Source: (IIPS,2010; IIPS,2017; IIPS,2020)

Table 7

Unmet need for family planning as recorded in NFHS-I,II&III, India

	NFHS-III	NFHS-IV	NFHS-V
Unmet need for family planning	14.5	12.3	7.8
Spacing[46]	5.8		3.8

[46] According to RCH, "all women who desire more children, but only after two years, are defined as those having an unmet need for spacing. The women who are not sure about whether to have a child and when to have the next child are also included in the category of unmet need for spacing" (RCH,2015)

Limiting[47]		
	8.7	5.8

Source: (IIPS,2007; IIPS,2016: IIPS;2020)

Table 8

List of the districts of Jammu & Kashmir with Mean number of Children born to a female

Name of the district	No. of Children
Kathua	2.5
Jammu	2.6
Udhampur	2.7
Leh/ Ladakh	2.7
Srinagar	2.8
Badgam	2.8
Rajouri	2.8
Doda	3.0
Jammu and Kashmir	3.0
Poonch	3.1
Pulwama	3.1
Anantnag	3.2
Badgam	3.3
Kupwara	3.6
Baramulla	3.6
Kargil	3.9

Source: IIPS, 2010

Table 9

Use of contraception in district Kupwara, Jammu and Kashmir as per National Family Health Surveys III, IV and V

Method	2005-2006 NFHS-III	2015-16 NFHS-IV	2019-2020 NFHS-V
Any Method	36.7	50.9	64.5
Any Modern Method	31.9	34.4	56.5
Male Sterilization	0.0	0.0	0.3
Female Sterilization	-	18.2	25.7
IUD	4.1	2.1	6.8
Pill	4.3	5.8	11.6
Ecp	1.66	5.8	9.4
Condom	3.4	6.2	9.4
Injectable	-	2.2	2.2

[47] "All the eligible women/ husbands who are not using any method, who are neither pregnant, nor in menopause/ not had undergone hysterectomy at the time of survey and at the same time do not desire an additional child are defined as the women with unmet need for limiting family size" (RCH,2015)

Source: IIPS, 2010;IIPS,2017;IIPS,2020

Table 10

Unmet need for Contraception in the District Kupwara, Jammu and Kashmir as per National Family Health Surveys IV and V

	NFHS-IV	NFHS-V
Total unmet need	13.1	5.9
Unmet need for spacing	6.7	3.1

Source: IIPS, 2010; IIPS,2020

Table 11

Table showing the Caste/ Social category distribution in the village Drugmullah, Kupwara

S.No.	General Category	Number of households	OBC/Social Caste	Number of households	Scheduled Tribe	Number of Households
1.	Shah	124	Najar	63	Dedad	47
2.	Bhat	122	Sheikh	62	Chohan	30
3.	Peer	106	Shah Faqir	32	Khari	21
4.	Dar	63	Dhobi	27	Melu	7
5.	Wani	61	Kumar	26	Chechi	7
6.	Lone	55	Ganai	23	Kohli	7
7.	Rather	49	Teli	15	Chara	6
8.	Mir	42	Doom	8	Bajad	1
9.	Sofi	38	Hajam	7		
10.	Magray	32	Sheer Gujri	3		
11.	Khan	26	Ahangar	2		
12.	Malik	25				
13.	Gojri	15				
14.	War	18				
15.	Baba	17				
16.	Darzi	9				
17.	Khawaja	7				
18.	NNngar	5				
19.	Bukhari	4				
20.	Gilani	3				
21.	Reshi	2				
22.	Beigh	1				
Total		**824/1188 (69%)**		**268/1188 (22.5%)**		**126 /1188 (10%)**

The information was extracted from the revenue document accessed at office of the Tehsildar, Drugmulla

Table 12

Socio-demographic characteristics of study participants under General Reproductive Health Survey in village Drugmullah

SNo.	Characteristics	Number* (Percentage)¶
1.	**Maternal Age (Years)**	
	13-18	1 (1)
	19-29	21 (21)
	30-40	75 (75)
	41-45	3 (3)
2.	**Social Category**	
	General	61 (61)
	Schedule Caste	0 (0)
	Schedule Tribe	20 (20)
	Social caste	19 (19)
3.	**Participant's Economic Activity**	
	Housewife	93 (93)
	Tailoring	1 (1)
	Handicraft	1 (1)
	Asha	2 (2)
	ICDS worker	2 (2)
	School caretaker	1 (1)
4.	**Husband's economic activity**	
	Skilled Labor	43 (43)
	Unskilled Labor	49 (49)
	Service	5 (5)
	No Work	1 (1)
	Deceased	2 (2)
5.	**Annual Income (Rs)**	
	30,000-60,000	34 (34)
	61,000-1,00,000	40 (40)
	1,00,000-1,50,000	18 (18)
	Above 1,50,000	5 (5)
6.	**Education level**	
	Illiterate	48 (48)
	Primary School	14 (14)
	Middle School	30 (30)
	10th	4 (4)
	12^{th}	0 (0)
	Graduation	1 (1)
	Post-graduation	1 (1)
	Madrassa	1 (1)
	NA	1 (1)
7.	**Possession of Land (±Kanals)**	
	0	35 (35)
	1-2	40 (40)
	>2-3	22 (22)
	NAV	3 (3)
8.	**Family Structure**	
	Joint family	21 (21)
	Nuclear family	73 (73)
	NAV	6 (6)
	Extended family	0 (0)
9.	**Age at marriage (Years)**	
	12-18	50 (50)
	19-25	47 (47)
	26-29	3 (3)
	30-35	3 (3)

10.	**Choice of match**	
	Parent's Choice	86 (86)
	Participant's Choice	6 (6)
	Both	1 (1)
	Others	7 (7)
11.	**Years in marriage**	
	1-3	2 (2)
	4-8	16 (16)
	9-15	61 (61)
	16-25	20 (20)
	>25	1(1)
12.	**Marital Satisfaction**	
	Yes	90 (90)
	No	6 (6)
	NAV	4 (4)
13.	**Relation shared with spouse**	
	Cordial	93 (93)
	Not Cordial	1 (1)
	NAV	6 (6)
14.	**Relation shared with in-laws**	
	Cordial	84 (84)
	Not Cordial	9 (9)
	NAV	7 (7)
15.	**Financial status**	
	Dependent on Spouse	94 (94)
	Dependent on others	5 (5)
	Independent	1 (1)

*Represent number of participants, ¶Represents percentage calculated out of hundred study participants, NA: Not Applicable, NAV: Not available, ±Kanal is a unit of area of land used in parts of northern India, each kanal is equivalent to 5445 Sq ft.

Table 13

General reproductive health status (GRHS), ante- and post-natal health service utilization and socio-economic support during pregnancy

SNo.	Characteristics	Number* (Percentage)¶
1.	**Regularity of menstrual cycles**	
	Regular	64 (64)
	Irregular	25 (25)
	NA	11 (11)
2.	**Time interval between marriage and first conception**	
	0-3 months	27 (27)
	4-6 months	8 (8)
	7-12 months	32 (32)
	1-2 years	18 (18)
	2-4 years	7 (7)
	>4 years	6 (6)
4.	**Planned/Unplanned first pregnancy**	
	Planned	60 (60)
	Unplanned	40 (40)
5.	**Planned/Unplanned subsequent pregnancies**	

	Planned	13 (13)
	Un-planned	84 (84)
	NAV	3 (3)
6.	**Feelings associated with conception**	
	Happiness	94 (94)
	Surprised	1 (1)
	Fearsome	1 (1)
	Lost	1 (1)
	NAV	3 (3)
7.	**Deliveries**	
	1-2	23 (23)
	3-4	58 (58)
	≥5	17 (17)
	NA	2 (2)
8.	**Method of delivery**	
	Normal	232 (70)
	Cesarean Section	43 (13)
	Both	53 (16)
	NAV	5 (1.5)
9.	**Number of off-springs**	
	1-2	30 (30)
	3-4	54 (54)
	≥5	14 (14)
10.	**Gender of off-springs**	
	Current number of live off-springs from 100 study participants	311 (100)
	Boys	155 (49.9)
	Girls	156 (50.1)
11.	**Average Spacing between children (Years)**	
	≤2	27 (27)
	≥3	70 (70)
	NAV	3 (3)
12.	**Number of children preferred by the participants**	
	1	2 (2)
	2-3	74 (74)
	>3	14 (14)
	NAV	10 (10)
14.	**Preference for son**	
	No	47 (47)
	Yes	41 (41)
	NAV	6 (60
	NA	6 (6)
14.	**Place of delivery**	
	Institutional	281 (84.4)
	Home	52 (15.6)
15.	**Deliveries at Healthcare facilities**	
	Local Health worker's residence	10 (3)
	Local Primary Health Center	127 (38.1)
	Community Health Center	36 (10.8)
	Non-Local Primary Health Center	35 (10.5)
	Tertiary Healthcare Facility (Lal-Ded Hospital, Srinagar)	53 (15.9)
	Private Healthcare Facility	11 (3.3)
	Home Delivery	42 (12.6)
	Sub-district Hospital, Sopore	4 (1.2)
	Other Healthcare facilities	15 (4.5)
16.	**Ante-natal Care (ANC) availed at Primary Health Center**	
	Registered	88 (88)
	Not Registered	10 (10)
	NAV	2 (2)

17.	**Number of ANC visits**	
	0	10 (10)
	1-3	13 (13)
	4-5	26 (26)
	>5	49 (49)
	NA	2 (2)
18.	**Ante-natal Vaccination facility availed**	
	Yes	87 (87)
	No	12 (12)
	NA	1 (1)
19.	**Pregnancy Supplements received (Iron)**	
	Yes	63 (63)
	No	34 (34)
	NA	3 (3)
20.	**Pregnancy supplement received (Folic acid)**	
	Yes	66 (66)
	No	29 (29)
	NA	5 (5)
21.	**Access to Service**	
	Government	78 (78)
	Private	4 (4)
	Both	14 (14)
	None	2 (2)
	NA	2 (2)
22.	**Number of ultra-sonographic scans**	
	0	33 (33)
	1-2	50 (50)
	3-4	16 (16)
	5	1 (1)
23.	**Facility used for ultra-sonographic scans**	
	Govt.	4 (4)
	Private	57 (57)
	Both	7 (7)
	No USG	32 (32)
24.	**Mortality**	
	Neo-natal	9 (9)
	Infant	4 (4)
	Both Infant and neo-natal	1 (1)
	Still birth	3 (3)
	Still birth and Infant	1 (1)
	None	76 (76)
25.	**Expenditure on pregnancy and delivery**	
	1000-3000	19 (19)
	3000-6000	49 (49)
	6000-10,000	09 (9)
	10,000-30,000	21 (21)
	30000	01 (1)
	NA	1 (1)
26.	**Monetary support from National Rural Health Mission**	
	Yes	58 (58)
	No	36 (36)
	NA	6 (6)
27.	**Social support during pregnancy**	
	Spouse	83 (83)
28.	**Accessed aganwadi during pregnancy**	
	Yes	14 (14)
	No	86 (86)

*Represents number of participants or number of deliveries; ¶Represents percentage calculated out of hundred study participants or out of total number of deliveries by 100 study participants; NA: Not Applicable; NAV: Not available; Average spacing between children was calculated as (Time interval between the birth of first and last child / n-1) where 'n' represents the number of children

Table 14

Contraception and its various methods employed by the study participants under the General Reproductive Health Survey in village Drugmullah

S. No.	Characteristics	Number* (Percentage)¶
1.	**Knowledge about contraception**	
	Yes	99 (99)
	No	1 (1)
2.	**Knowledge about emergency contraception**	
	Yes	94 (94)
	No	5 (5)
	NA	1 (1)
3.	**Whether using any method of contraception**	
	Yes	71 (71)
	No	29 (29)
4.	**Knowledge about different methods of contraception**	
	Pills	70 (70)
	Emergency contraception	3 (3)
	Condoms	47 (47)
	Copper-T	58 (58)
	Female sterilization	51 (51)
	Male sterilization	35 (35)
	Injectables	35 (35)
	Withdrawal method	36 (36)
	None	5 (5)
5.	**Current method of contraception practiced**	
	Pills	3 (3)
	Condoms	6 (6)
	Copper-T	6 (6)
	Female sterilization	30 (30)
	Male sterilization	0 (0)
	Injectable	2 (2)
	Withdrawal method	23 (23)
	Abstinence	1 (1)
	None	29 (29)
6.	**Convenient method of contraception**	
	Pills	5 (5)
	Condoms	6 (6)
	Coppert-T	7 (7)
	Female sterilization	26 (26)
	Male sterilization	0 (0)
	Injectable	2 (2)
	Withdrawal method	26 (26)
	Abstinence	1 (1)
	NA	21 (21)
	No	6 (6)
7.	**Reason for not using any method of contraception**	
	Desired pregnancy	6 (6)
	The thought of pregnancy didn't cross my mind	2 (2)
	Moral reason	0 (0)

	Economic reasons	0 (0)
	Religious reasons	6 (6)
	Lack of knowledge of contraception	0 (0)
	Husband does not approve of contraception	0 (0)
	Fear of unknown	0 (0)
	Fear of side effects	19 (19)
	Practicing abstinence	1 (1)
	No reason	5 (5)
	Natural Spacing	2 (2)
	NA	49 (49)
	NAV	9 (9)
8.	**Place of getting contraceptives**	
	NA	88
	PHC	3
	Chemist	9
9.	**Person who gets them**	
	Participant	1 (1)
	Husband	9 (9)
	Both	2 (2)
	NA	88 (88)
10.	**Whether received free contraceptives from PHC**	
	Yes	36 (36)
	No	7 (7)
	Don't know about it	8 (8)
	Don't visit PHC	17 (17)
	NAV	3 (3)
	NA	29 (29)
11.	**Whether counselled in PHC regarding the use of contraception**	
	Yes	6 (6)
	No	81 (81)
	Rarely	2 (2)
	NA	5 (5)
	Don't visit PHC	6 (6)
12.	**Whether resolved to practice contraception in future?**	
	Yes	85 (85)
	No	12 (12)
	Not decided	3 (3)
	If Yes, What is the intended method?	
	Pills	4 (4)
	Condoms	5 (5)
	Copper-T	7 (7)
	Female sterilization	34 (34)
	Male sterilization	0
	Injectable	2 (2)
	Withdrawal method	24 (24)
	Abstinence	3 (3)
	Natural Spacing	1 (1)
	Others	5 (5)
13.	**Use of contraception in latest pregnancy**	
	Yes	3 (3)
	No	95 (95)
	NA	2 (2)
14.	**Reason for not using any contraception for last pregnancy**	
	Desired pregnancy	66 (66)
	Not having regular sexual relations	0 (0)
	The thought of pregnancy didn't cross my mind	8 (8)
	Opposition from husband	0 (0)
	Lack of knowledge	0 (0)
	Unable to obtain a method	0 (0)
	Methods are too expensive	0 (0)

	Fear of side effects	10 (10)
	Actual side effects	0 (0)
	Others	6 (6)
	NA	10 (10)
15.	**Was the last pregnancy because of contraceptive failure?**	
	Yes	3 (3)
	No	95 (95)
	NA	2
16.	**Reason for the failure of contraceptive method**	
	Improper use	1 (1)
	Forgot to use	1 (1)
	Can't say	1 (1)
	NA	95 (95)
17.	**Source of information about contraception**	
	Doctor	2 (2)
	Nurse	0 (0)
	Trai Birth Attendant	0 (0)
	Mother	0 (0)
	Teacher	0 (0)
	Friend	3 (3)
	Asha	5 (5)
	Acquaintances	68 (68)
	Others	13 (13)
	None	9 (9)

*Represent number of participants; ¶Represents percentage calculated out of hundred study participants; NA: Not Applicable; NAV: Not available; Pills also called as birth control pills are usually combination of two hormones, estrogen and progestin, which work by preventing release of eggs from ovaries, Copper-T is an intra-uterine device used for birth control and emergency contraception is used within five days of unprotected sex. The device is placed in uterus and lasts up to 12 years; Female sterilization is a tubal ligation procedure that prevents pregnancy; Male sterilization is a permanent method of contraception for men which works by blocking vas deferens that are tubes that connect testicles to urethra; Injectable contraception are usually hormones, estrogen and progestin, which come in injectable form and work in the similar way as birth control pills; Withdrawal method also called as coitus interruptus is a method of withdrawing the penis from vagina well before ejaculation to prevent pregnancy; Abstinence here refers sexual abstinence

Table 15

Role of participants, spouses and immediate relatives in decision-making concerning reproductive affairs of the study participants

S. No.	Characteristics	Number* (Percentage)¶
1.	**Decision about reproductive health**	
	Husband	73 (73)
	Participant	10 (10)
	Both	8 (8)
	Others	8 (8)
	NA	1 (1)
2.	**Decision about number of children**	
	Husband	24 (24)
	Participant	15 (15)
	Both	52 (52)
	In-Laws	3 (3)
	Doctor	1 (1)
	Others	4 (4)

	NA	1 (1)
3.	**Decision about use of contraception**	
	Husband	32 (32)
	Both	25 (25)
	Respondent	16 (16)
	NA	23 (23)
	Others	4 (4)
4.	**Whether husband and wife agree on future reproductive intentions**	
	Yes	84 (84)
	No	7 (7)
	Have not decided yet	4 (4)
	NA	1 (1)
	NAV	4 (4)
5.	**Whether husband supports use of contraception**	
	Yes	74
	No	4
	Na	22
6.	**Whether husband uses any method of contraception**	
	No	80 (80)
	Yes	18 (18)
	NA	2 (2)
7.	**Which method does he use?**	
	Condoms	7 (7)
	Condoms and withdrawal method	2 (2)
	Withdrawal method	9 (9)
	NA	82 (82)

*Represent number of participants, ¶Represents percentage calculated out of hundred study participants, NA: Not Applicable, NAV: Not available

Table 16

Health service utilization by participants who had induced abortion in the study population under General Reproductive Health Survey (GRHS)

S. No.	Characteristics	Number* (Percentage)¶
1.	**Induced abortion**	
	Yes	15 (15)
	No	85 (85)
	NA	0 (0)
2.	**Number of times induced abortion**	
	Once	12 (12)
	Twice	3 (3)
3.	**Method of induction**	
	≠Abortifacient Drugs	15 (15)
	Any other method	0
4.	**Place of induction**	
	Home	15 (15)
	Clinic	0 (0)
	Any other	0 (0)
5.	**Person who induced abortion**	
	Participant	14 (14)

	Doctor	1 (1)
6.	**Person who got abortifacient drugs**	
	Husband	9 (9)
	Respondent	5 (5)
	NAV	1 (1)
7.	**Place from where drug was fetched**	
	PHC	1 (1)
	Chemist	13 (13)
	NAV	1 (1)
8.	**Age of the Embryo/Fetus**	
	40 Days	7 (7)
	75 Days	6 (6)
	120 Days	1 (1)
	NAV	1 (1)
9.	**Reason for inducing abortion**	
	Young children	8 (8)
	Family income and young children	1 (1)
	Young children, no support	2 (2)
	Young children and income issues	1 (1)
	Young and too many children	1 (1)
	Too many children	1 (1)
	Income issues	1 (1)
10.	**Dilatation and Curettage**	
	Yes	6 (6)
	No	9 (9)
11.	**Facility accessed**	
	Government	6 (6)
	Private	1 (1)
	General Practician	1 (1)
	Healthcare worker's residence	2 (2)
	Didn't access	2 (2)
	NA	3 (3)
11.	**Ultrasonography**	
	No	8 (8)
	Yes	7 (7)
12.	**Post Abortion Care at healthcare facilities**	
	Inconsiderate or Casual approach	8
	Didn't access	3
	NA	4
14.	**Disclosure**	
	Yes	6 (6)
	No	2 (2)
	NA	7 (7)
15.	**Expenditure on the event (Rupees)**	
	1000-2000	5
	3000-4000	3
	>5000	3
16.	**Complication if any**	
	No	11 (11)
	Developed Infection	4 (4)
17.	**Period of bleeding**	
	Up to 2 Weeks	11 (11)
	Up to 8 weeks	1 (1)
	NA	2 (2)
18.	**Rest Period**	
	No rest	8 (8)
	Up to 1 week	3 (3)
	Upto 4 weeks	3 (3)
	NAV	1 (1)
19.	**Feeling**	

Sad	3 (3)
Guilt	4 (4)
Mixed	7 (7)
Relieved	1 (1)

*Represent number of participants; ¶Represents percentage calculated out of hundred study participants; ≠Abortifacient drugs used by the participants contained mostly misoprostol as their major salt.

Table 17

Health service utilization by participants experiencing spontaneous abortion in the study population under General Reproductive Health Survey (GRHS)

S. No.	Characteristics	Number* (Percentage)¶
1	**Miscarriage**	
	Yes	25 (25)
	No	75 (75)
2.	**Number of times**	
	Once	16 (16)
	Twice	8 (8)
	NA	1 (1)
3.	**Reason for miscarriage**	
	Fetching firewood/travelling long distance	4 (4)
	Heavy work	11 (11)
	Falling off	2 (2)
	Lack of rest	1 (1)
	Farm labour	1 (1)
	On its own	6 (6)
4.	**Reason for miscarriage according to the doctor**	
	Developmental issues	15 (15)
	Heavy work	3 (3)
	Unexplained	1 (1)
	NA	6 (6)
5.	**Age of the embryo**	
	1-3 Months	18 (18)
	>3 Months	6 (6)
	NA	1 (1)
6.	**Dilatation and Curettage**	
	Yes	18 (18)
	No	7 (7)
7.	**Post-abortion bleeding lasted for?**	
	Few Days	2 (2)
	Up to 2 Weeks	11 (11)
	Up to 4 Weeks	9 (9)
	Up to 6 months	1 (1)
	NAV	2 (2)
8.	**Complication following D&C**	
	Yes	11 (11)
	No	14 (14)
9.	**Nature of complication**	
	Infection	7 (7)
	Hemorrhage	3 (3)
	Infection and hemorrhage	2 (2)
	Not available	13 (13)
10.	**Facility accessed for USG**	
	Private	14 (14)
	Government	3 (3)

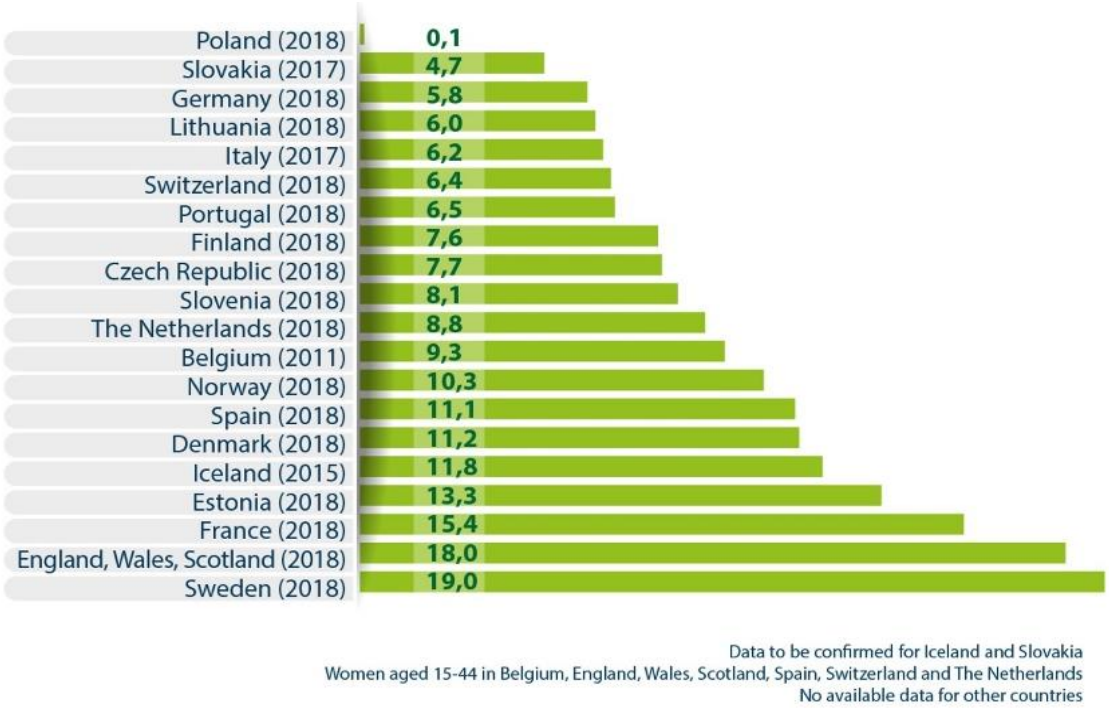
	None	6 (6)
	Both	2(2)
11.	**Amount of money spent on the episode (Rs)**	
	500-1000	2 (2)
	2000-4000	17 (17)
	5000 and above	4 (4)
	NA	2 (2)
12.	**Feeling after miscarriage**	
	Sad	24 (24)
	NA	1 (1)
13.	**Social support during miscarriage**	
	Husband	10 (10)
	Parents	3 (3)
	In-laws	2 (2)
	Others	10 (10)
14.	**Days of rest post-abortion**	
	Up to 4 Weeks	16 (16)
	>4 Weeks	3 (3)
	Non Rest	4 (4)
	NAV	2 (2)

*Represent number of participants, ¶Represents percentage calculated out of hundred study participants, NA: Not Applicable, NAV: Not available

LIST OF FIGURES

Figure 1

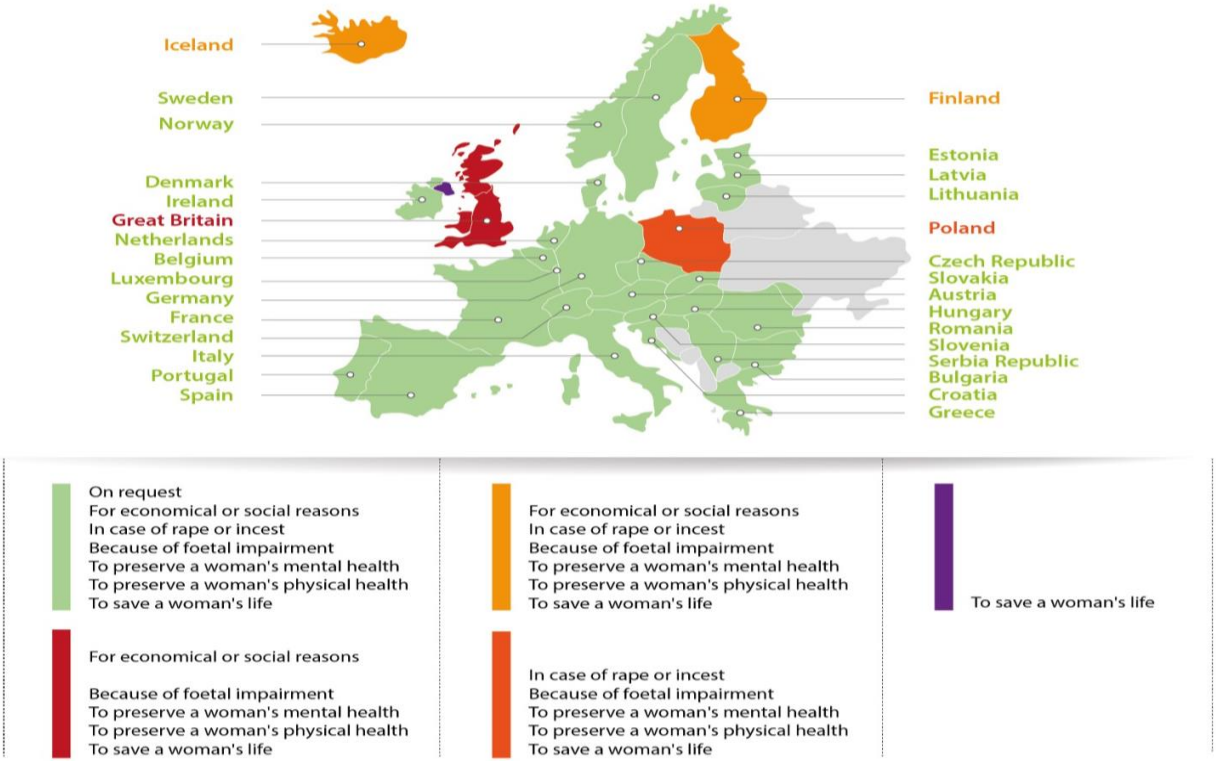
Abortion rates per thousand women aged 15-49 across Europe



Note: The figure shows the rates of abortion for the year 2011,2015,2017 & 2018 for different countries across Europe adapted from Abort Report.eu,2019.

Figure 2

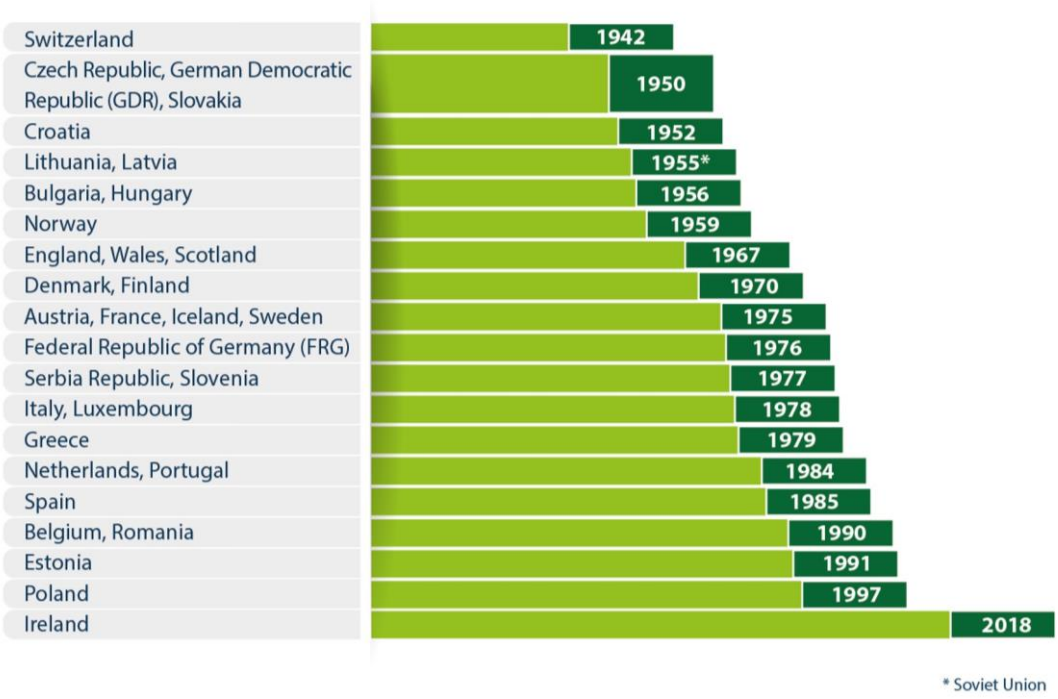
Legal grounds for induced abortion



Source: Abort Report.eu,2019

Figure 3

Abortion legalisation/legislation dates across different countries



Source: (Abort Report.eu,2019)

Figure 4

Gestational limit of medical abortion in different European countries

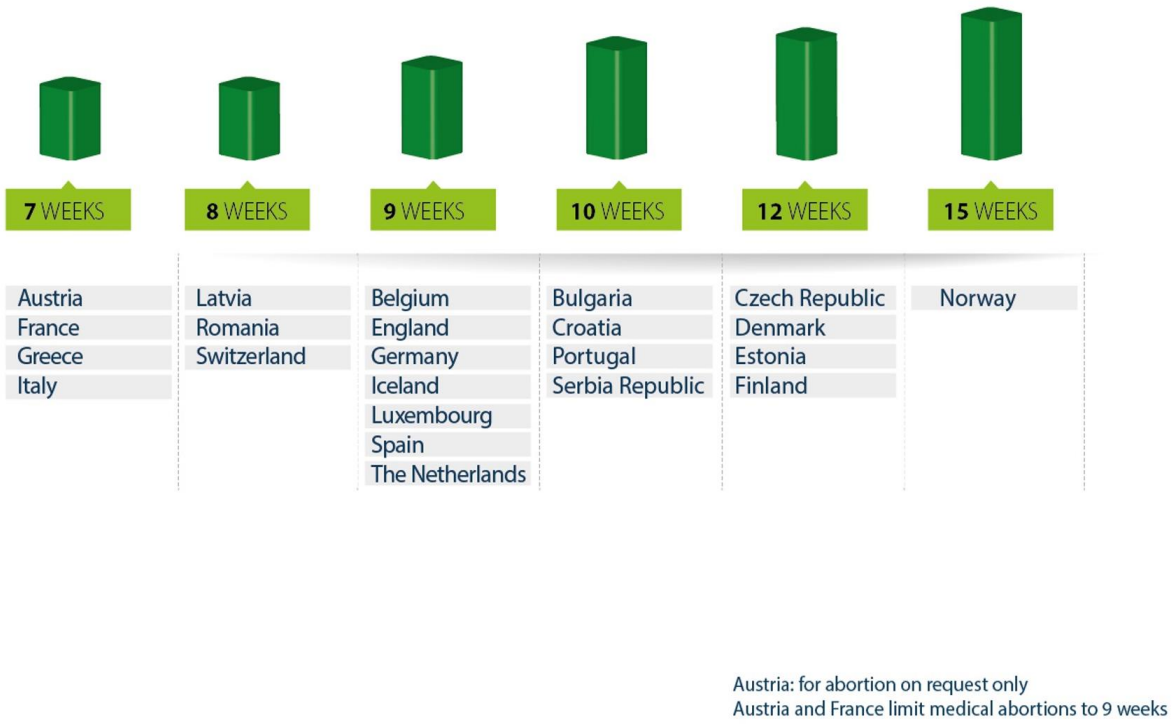
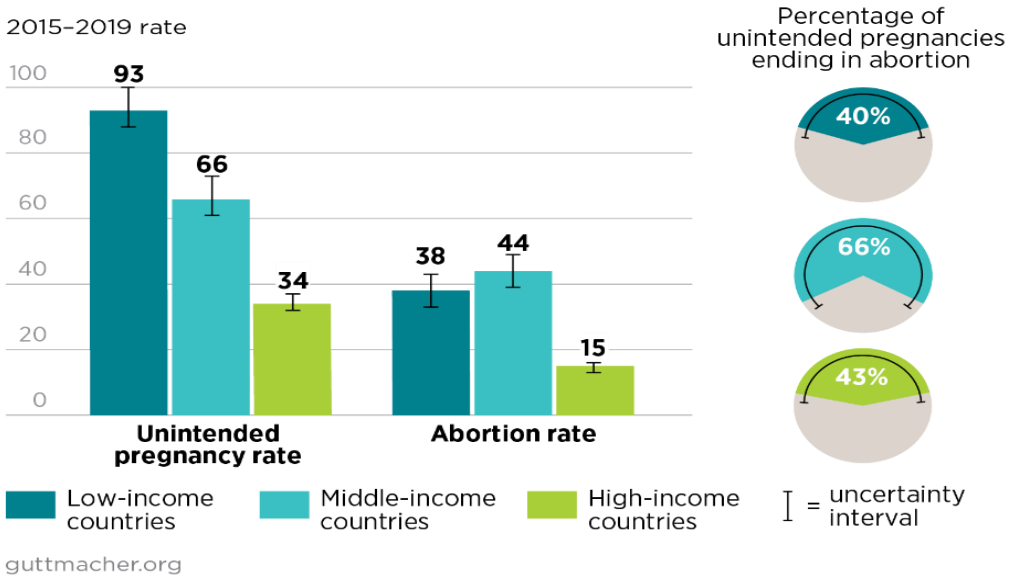


Figure 5

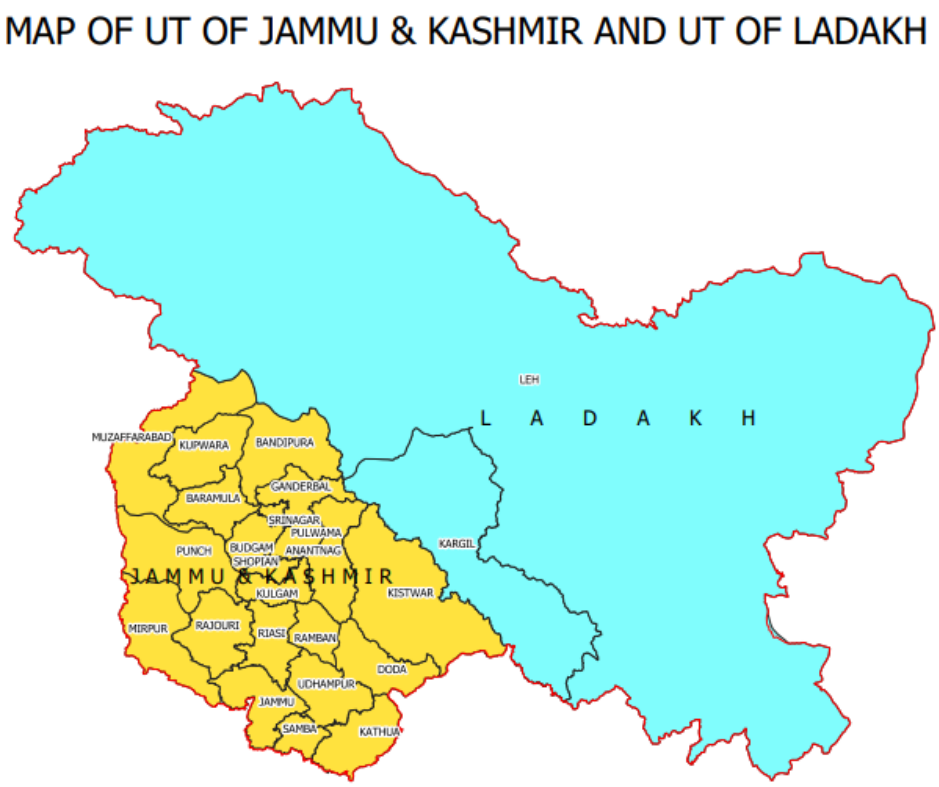
Unintended Pregnancy and abortion rate in low, middle, and high-income countries



Source: (Guttmacher,2020)

Figure 6

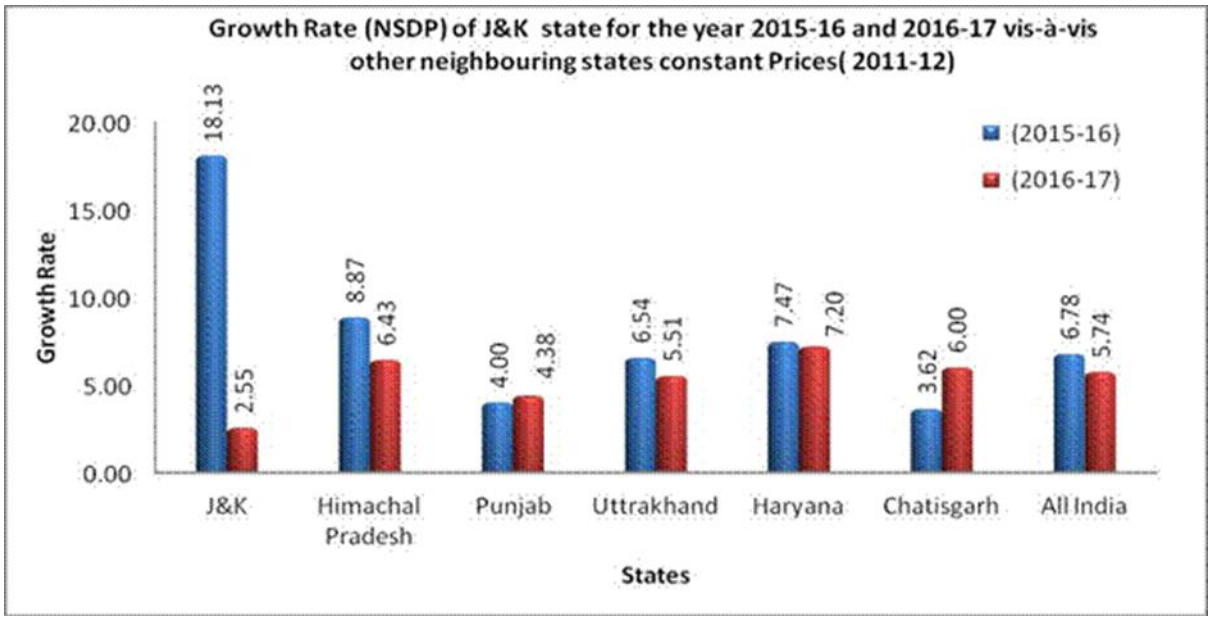
Map of Jammu and Kashmir



Source: *Ministry of Home Affairs; Posted On: 02 NOV 2019 6:11PM by PIB Delhi*

Figure 7

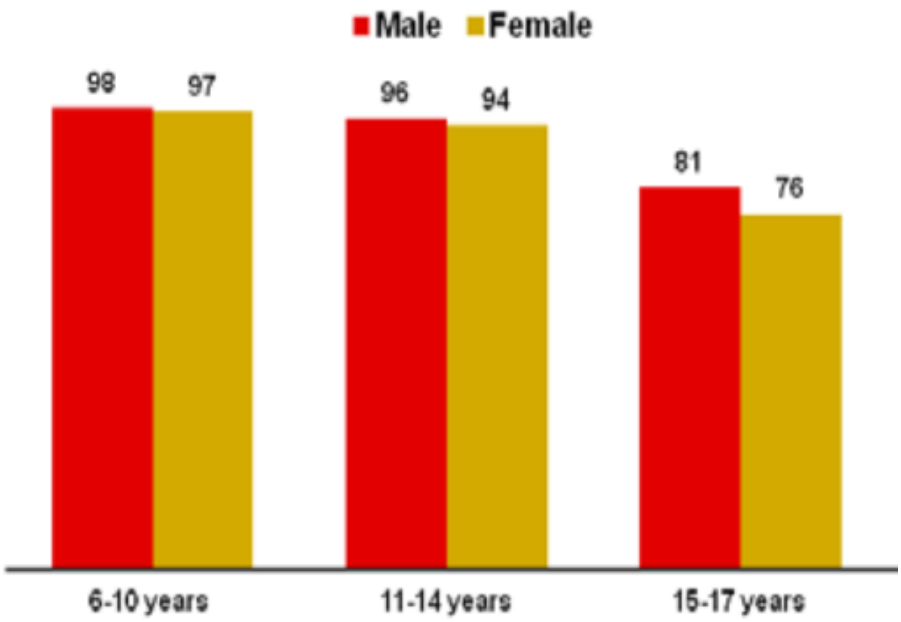
Growth rate of Jammu & Kashmir for the year 2015-16 and 2016-2017 compared to other neighbouring states of India



Source: (Envis,2011)

Figure 8

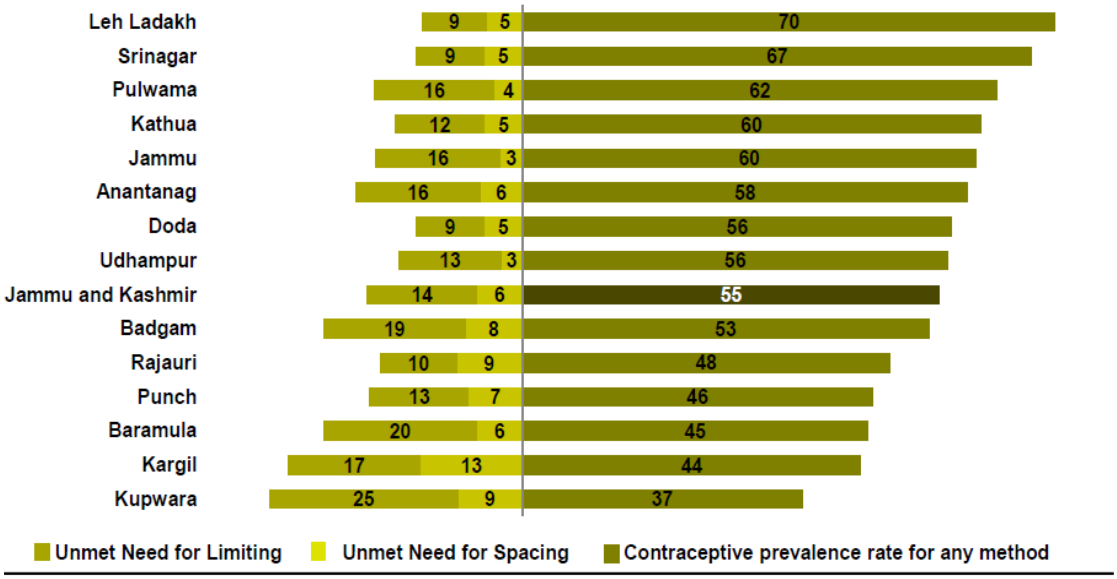
Percentage of Children attending school as per age in Jammu and Kashmir



Source: (IIPS,2020)

Figure 9

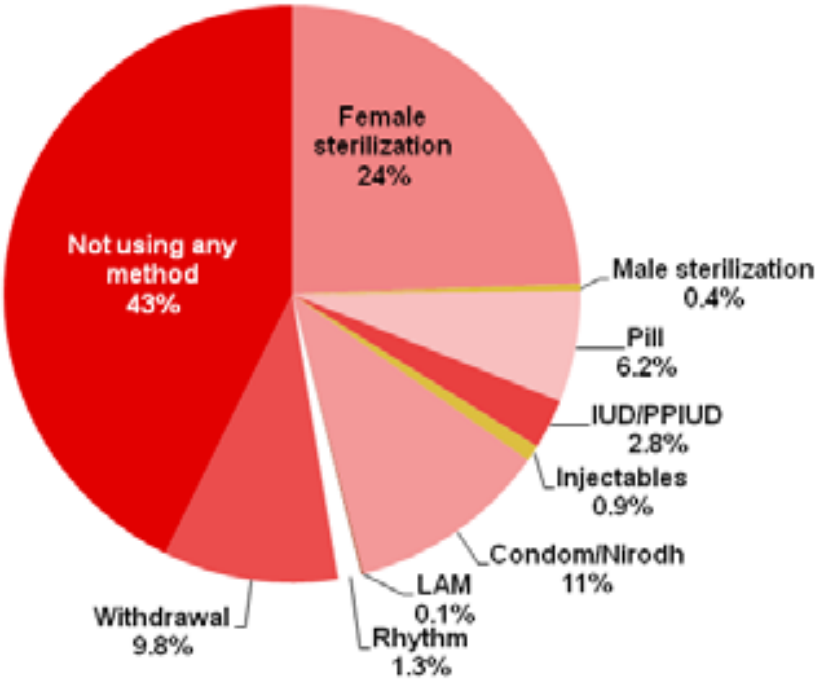
Contraceptive Prevalence Rate (CPR) and unmet need for contraception in various districts of Jammu & Kashmir



(Source: IIPS,2010)

Figure 10

Use of contraception in currently married women in Jammu & Kashmir



Note: Majority of the participants are not using any method of contraception, followed by female sterilization and rest of the women practice other forms of contraception from (IIPS,2017)

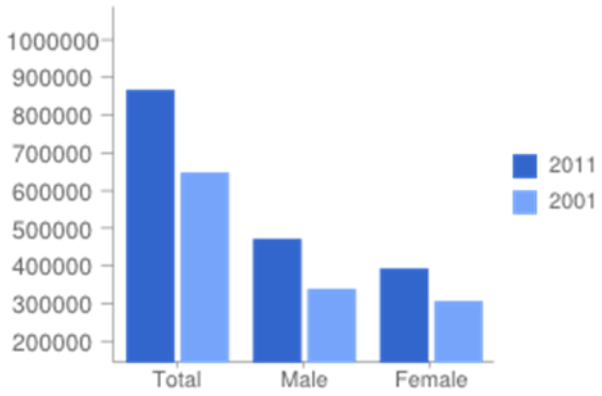
Figure 11

Map of the district Kupwara with its three Tehsils: Kupwara, Handwara and Karnah

Source: (District Administration,2009)

Figure 12

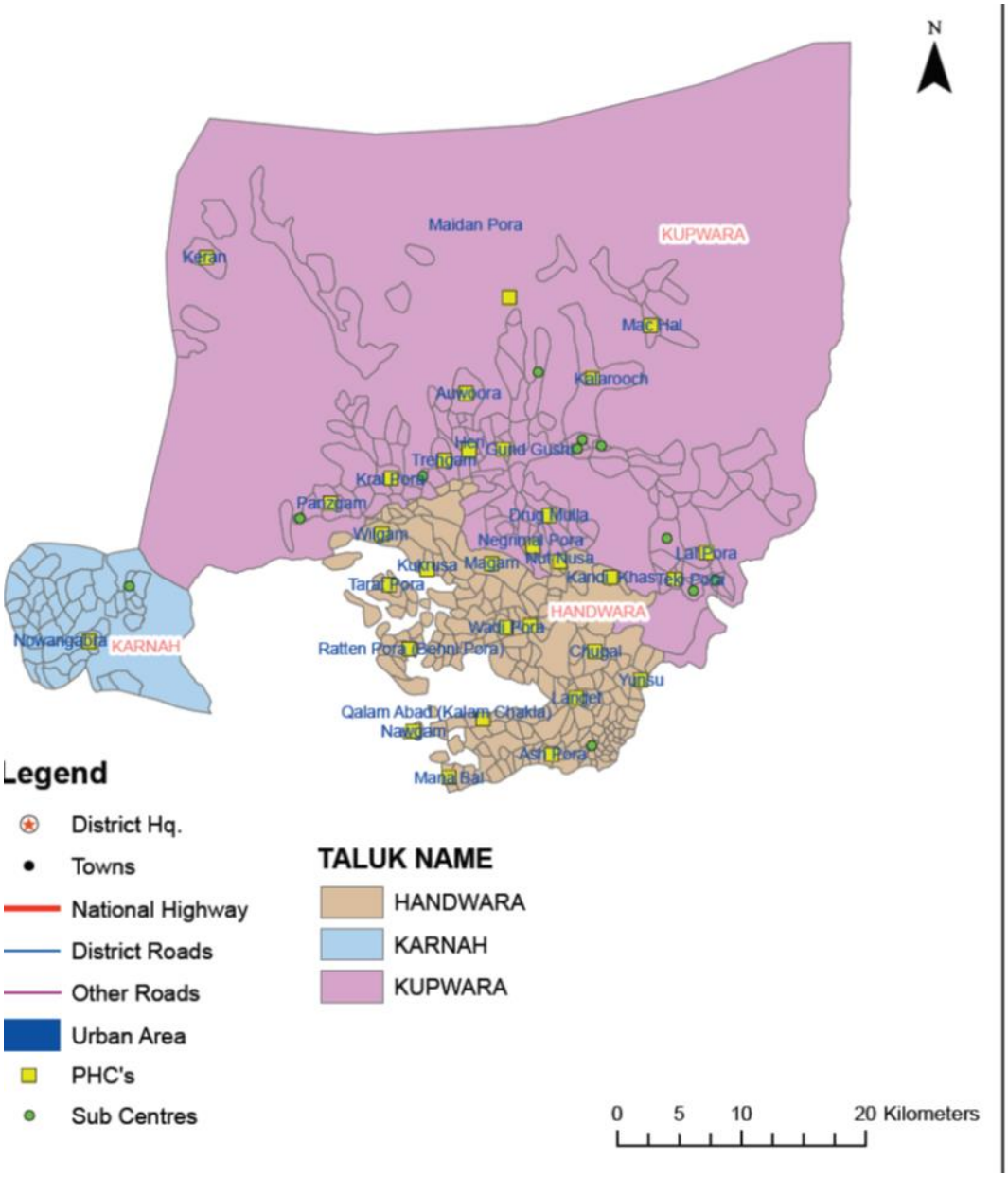
Comparison of Population of the District Kupwara between 2001 and 2011 census



Note: The figure depicts the male female ratio of District Kupwara for the year 2011 and 2001 from Census,2011

Figure 13

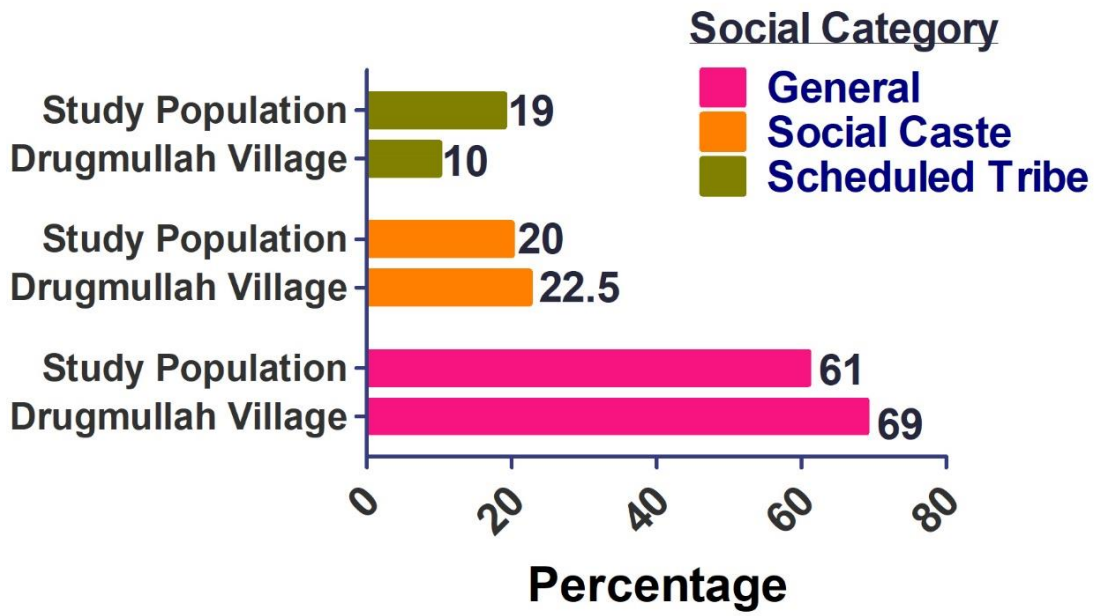
Map of the health facilities in District Kupwara



Note: The figure shows the health facilities spread in district Kupwara , source (RGI,2009).

Figure 14

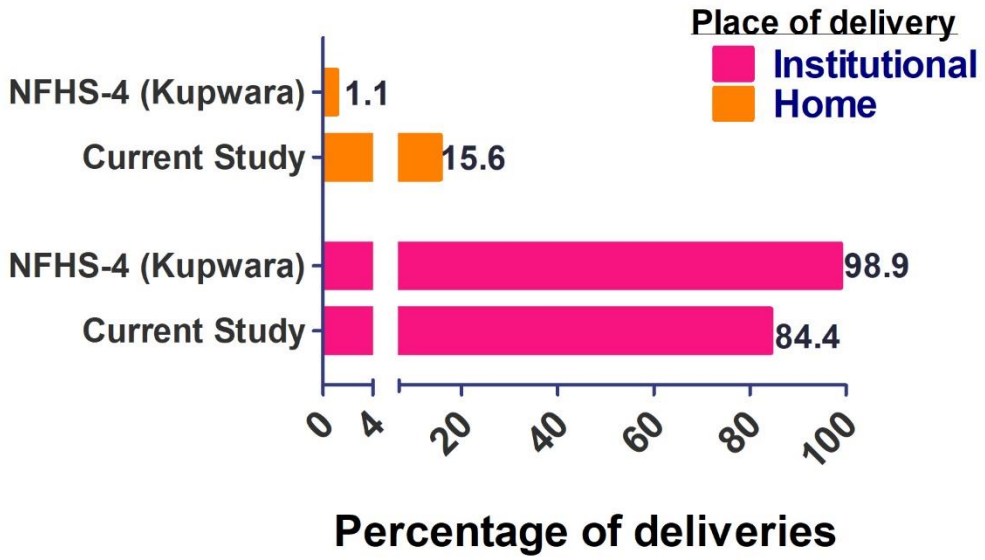
Sampling of the population of village, Drugmullah according to different social categories for General Reproductive Health Survey



Note: Comparison of the distribution of households based on the social category in village, Drugmullah vs the percentage of sampled population from each social category for the reproductive healthcare survey conducted in the present study. The values are presented as percentage (%) of the total population and Drugmullah village.

Figure 15

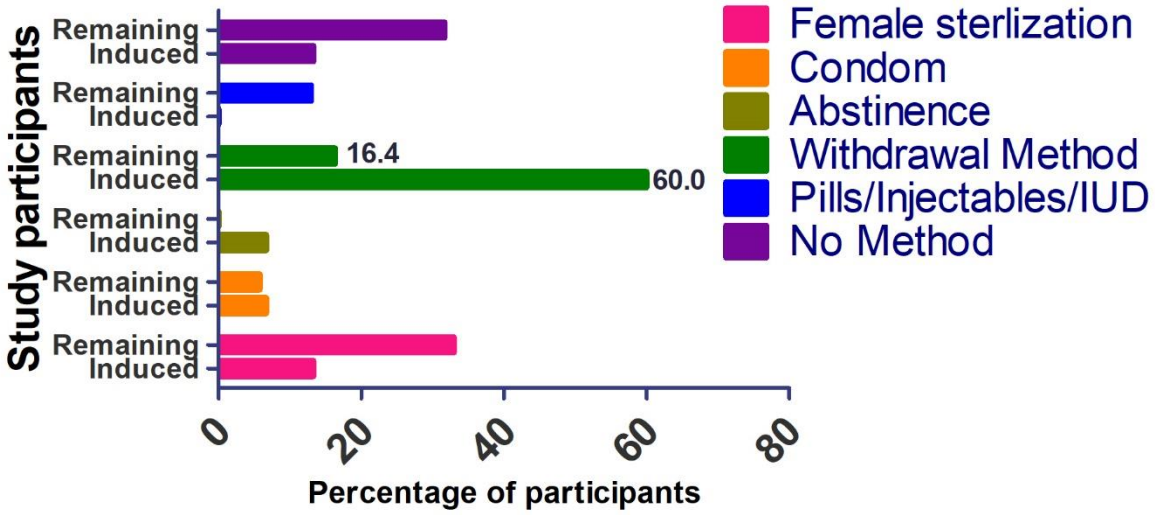
Institutional Versus Home Deliveries in women of Drugmulla of District, Kupwara as revealed by the General Reproductive Health Survey



Note: The graph presents the percentage of institutional and home deliveries in the current study vs as revealed in NFHS-4 (Kupwara). The values are presented as percentage (%) of the study population.

Figure 16

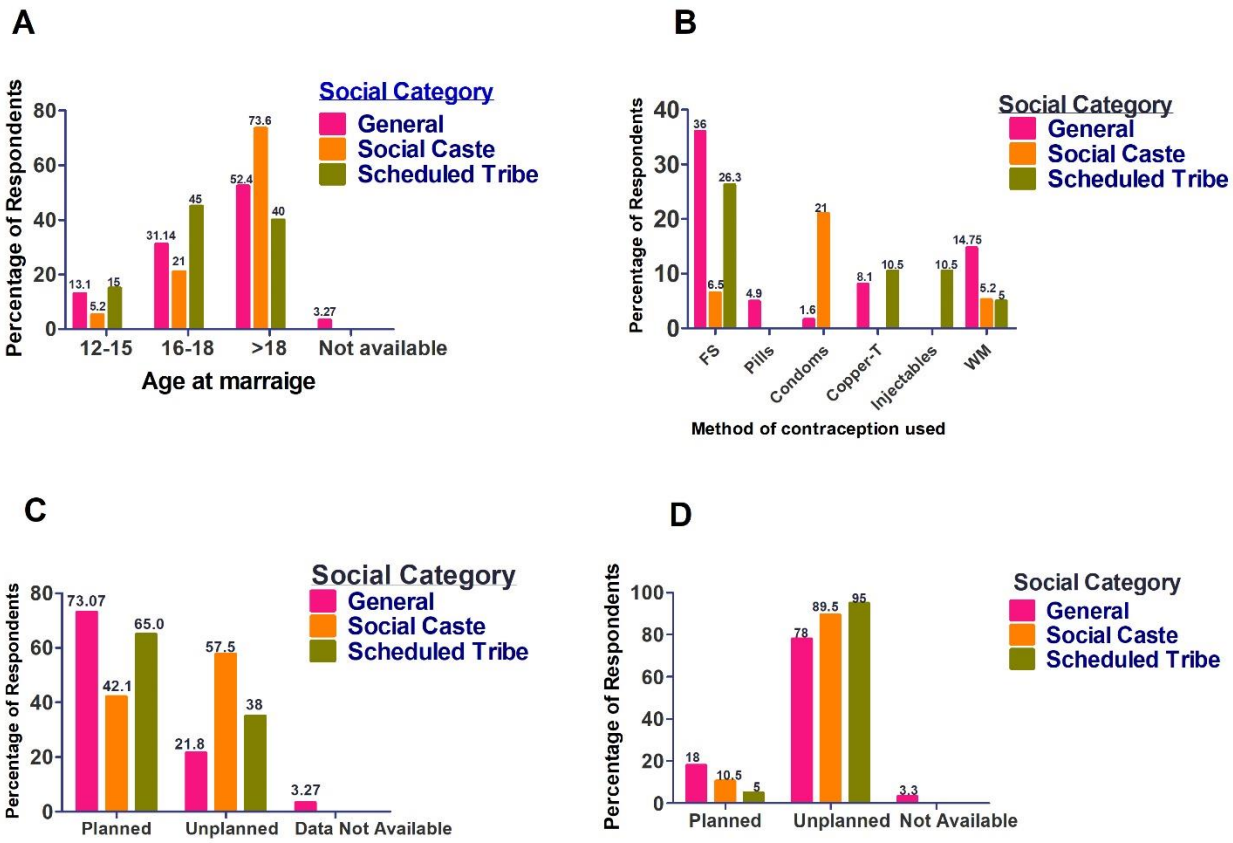
Methods of contraception used by the study participants in Drugmullah village as revealed by the General Reproductive Health Survey



Note: Methods of contraception used by percentage of participants who induced abortions plotted against percentage of rest of the study participants. 'Induced' refers to the percentage of participants who have induced abortion. 'Remaining' refers to the percentage of study population except those who have induced abortion. The values are presented as percentage (%) of the study population.

Figure 17

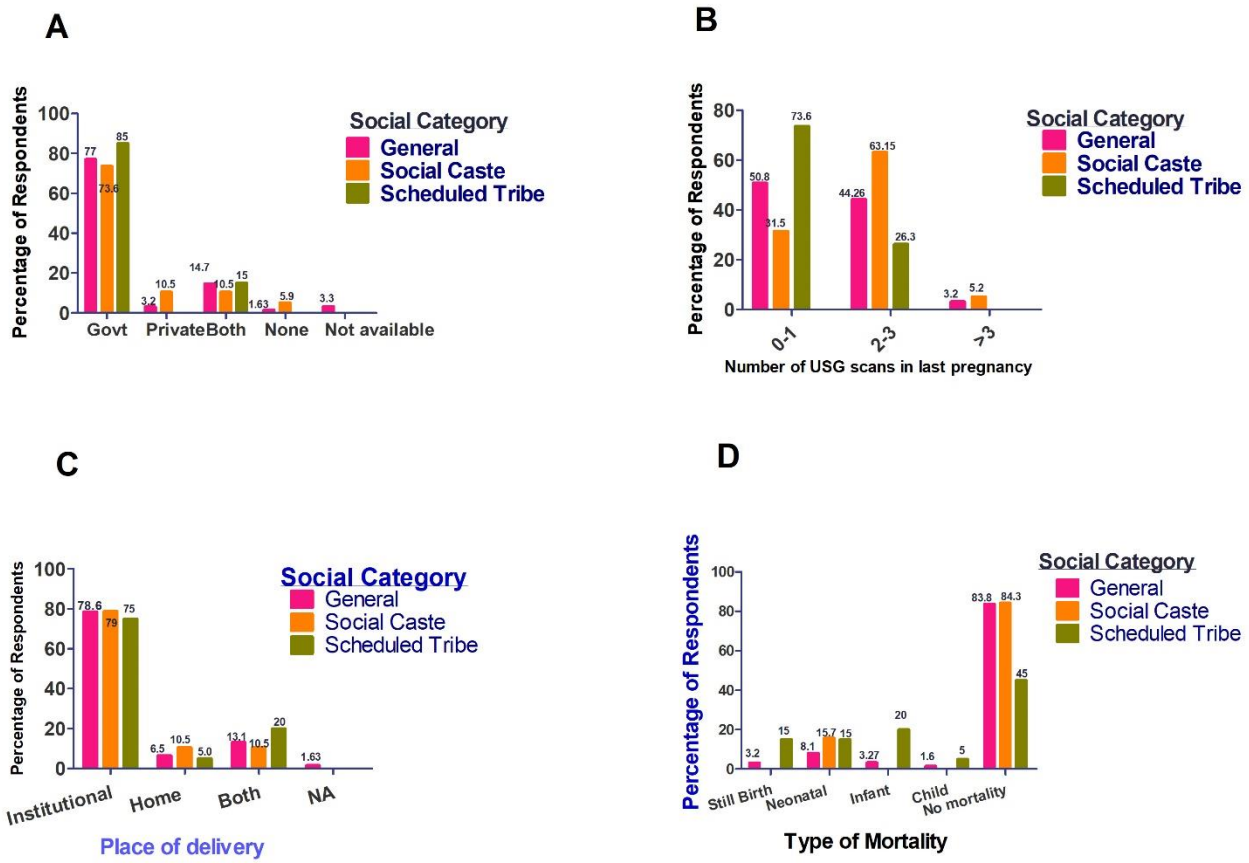
Social categories and reproductive health variables in the study population of Drugmullah village under General Reproductive Health Survey



Note: Age at marriage of the study participants belonging to different social categories (A); Method of contraception practised by the study participants of different social categories, FS-Female Sterilization, WM refers to withdrawal method (B); Percentage of study participants from different social categories who had either planned and unplanned first pregnancy (C); Percentage of study participants from different social categories who had either planned and unplanned subsequent pregnancy (D). The values are presented as percentage (%) of the study population.

Figure 18

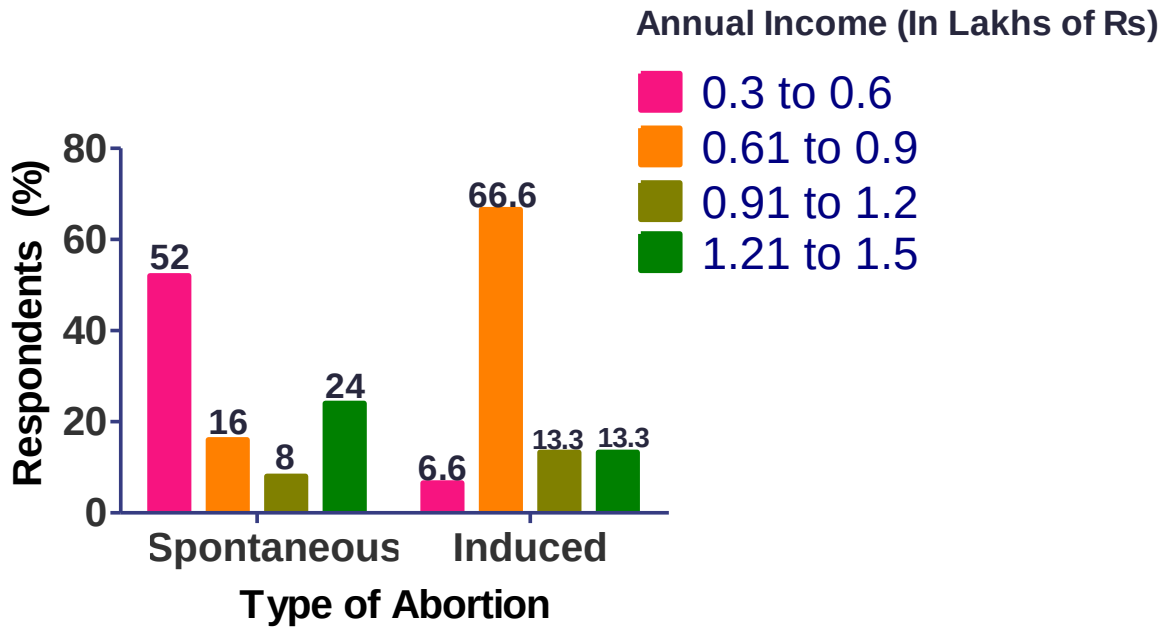
Healthcare facilities accessed during pregnancy by different social categories of the study participants during latest pregnancy in the village drugmullah under the General Reproductive Health Survey



Note: Healthcare facilities accessed during pregnancy by different social categories of the study participants during latest pregnancy (A); Number of ultrasonographic scans received by the participants of different categories during latest pregnancy (B); Place of delivery by participants of different social categories (c); Type of mortality of offspring of participants of different social categories (D). The values are presented as percentage (%) of the study population.

Figure 19

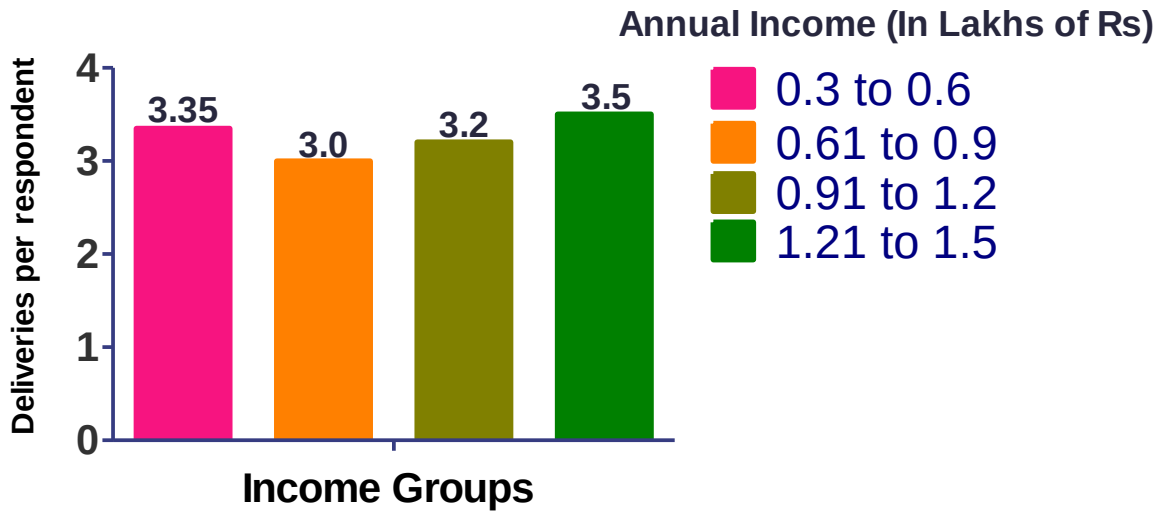
Type of Abortion in various income groups in the study population of village Drugmullah under the General Reproductive Health Survey



Note: *The values are presented as percentage (%) of the study population.*

Figure 20

Deliveries (Private & Public) by women in the study population of village Drugmullah in government and private healthcare facilities accross various income groups under the General Reproductive Health Survey.



Note: The values are presented as number of deliveries per respondent under each income group of the study population.

Appendix A

Transcriptions of case studies entailing experiences of women with a history of spontaneous and/or induced abortions

Cases of Induced Abortion

1. Interviewer: Rafia Farooq
   Interviewee: Hajra
   Date of Interview:09.09.2015
   Place: Drugmullah, Kupwara

Hajra lives in one room house along with her husband and seven children. She has six daughters and a son. Her husband is a driver of a hired vehicle. They own a kanal of land. Hajra has never been to school. She used to weave carpets. Presently, she is associated with UMEED group, an initiative of the central government to give soft loans to people in need of financial assistance or some exigencies which demand financial attention.

Hajra has been married at the age of eleven years. Since she was married at a very young age, she did not know what marriage is about. Two of her four brothers were militants. So, their house was raided again and again during those times by the Indian Army. Fearing any mishap in terms of rape and molestation by the army, her parents decided to marry her off early. Both of her brothers who were militants were martyred afterwards. On the day of her marriage, their house was raided by the army and the whole marriage function was disrupted. As a result of the early marriage, Hajra has spent maximum numbers of fertile years in a marital bond resulting in nine to ten conceptions and seven live births.

Hajra gave her first birth two and a half years after her marriage. Two of her daughters were born after a gap of two and a half years but her other children have been born only after a gap of nine months. She has been married for 28 years.

Hajra has delivered all the children in PHC of the village through a normal vaginal route. She says in a lighter vein that she does not know when she conceived her eighth child,

although they were using condoms as contraception at that time. She adds that when all the condoms were over, they were still having sexual contact and she never knew that she will conceive, but she did. She quotes…

"We were using condoms this time but once they were over, we thought that there won't be any chance of conception, but something happened that I conceived. God has bizarre plans for the poor. He tries to find some pretext to bring problems to the lives of those who are poor".

The couple was desperate for a son and in that process; they ended up giving birth to six girls and in the end, they had a son. After giving birth to a son, Hajra does not want any child. She feels embarrassed because of having so many children. She feels that she has become laughing stock among her neighbours for having so many kids.

She was now pregnant with her eighth child once I met her. Once she found she is pregnant, she did not want to abort the foetus. She also thought that it is a sin to kill a foetus in the womb. Her husband too told her that it is a sin. But she convinced him and it is her husband who got the abortifacient drug from Kupwara, a nearby town. She consumed the drug and after few days, she started to bleed. Her bleeding did not stop for one month. She had to attend to her family as well those days. It was the toughest thing for her to manage her household in illness. It had been almost one month that she had consumed the abortifacient drug. After that she did USG and she could find RPOCs still inside her uterus. Then she underwent D&C. This episode cost her about two and a half thousand rupees. She had fallen ill due to inducing abortion and the group leader of the aforementioned UMEED which she is associated with had given 1500 rupees which helped her fetch medicine for herself.

The couple does not take any precautionary measures as such. She was using copper-T for some time, but that did not work. Her husband also does not use any contraception. She was given condoms supplied by the health worker. Once they were

exhausted, they did not buy them again. She thinks that couples should seriously use them. She did not have any answer about not using contraception. But having given birth to seven children, now she wants some birth control.

"Kotah khakhas karre be panas."[*How much should I churn myself again and again? How many times shall I find myself in a problem and how many times will I suffer the pain of inducing an abortion by myself"].*

Hajra added that…

> *I can't even take Mala-D (pills). It does not suit me because I bleed for months together. I do not want to go for three monthly contraceptive injections because that does not help either. Copper-T cannot be a permanent solution because I go to the forest very often to fetch the firewood. That makes me uncomfortable. But let me tell you, having consumed the abortion-inducing drug, I feel relieved now. Once I consumed the tablet, I could see a little bleeding on day one. But on the second day, I bled profusely. I went to the washroom and could not come out of it as I was losing a lot of blood. I told my daughter to give me the water pipe from the window to wash the blood away. That moment, everything went dark and I fell down on the floor of the washroom. My family managed to get me out of the washroom and my mother who had incidentally come, laid the bed for me. After that, the bleeding stopped and I was taken to a hospital. I was hospitalized for three days and was administered the medicine, injectables and saline. I was discharged from the hospital. After four to five days, I went to forest to fetch firewood. I again bled for a week. I went to Kupwara hospital where I got a scan done and they confirmed that I had some foetal tissue inside the uterus. They told me to get D&C done as soon as possible. I came back and went to PHC and consulted FMPHW who I pleaded to see me, but she refused because of the sin*

which I had committed. I told her that I have already had the medicine to abort the foetus, so why is she hesitating to take me as her patient? She somehow agreed and administered an injection and performed D&C and I again bled for five to eight days. After this episode, I have stopped going to forest. I just do the household chore and stay home.

Since Hajra wanted to have a son desperately, the couple had sought a faith-healer. He had promised that her seventh child will be a boy. As a result, the faith healer had asked for cash and expensive home appliances including a Television (TV) set worth rupees 22000.They somehow recovered that TV afterwards, from the faith-healer. The faith-healer had also demanded a share of monthly income which her husband earned being a taxi driver and had asked for animal sacrifice. Not only had that Hajra served him for almost a year. But to her extreme disappointment, she gave birth to a girl. Afterwards, the faith-healer disappeared and changed his mobile phone number. He is absconding now and they are unable to trace him. The faith-healer took almost 70,000 Rupees from them. Now that the faith-healer stayed there for one year, so a lot of people would visit him. The family had to run a kind of mess for the people who would visit him. That incurred a lot of cost. If she had a son the faith-healer would continue his game and befool people. Since she had a girl, this faith healer ran away never to be found again.

If she had a son earlier, she would not have this number of children. She would have three or four children. She says that in the present times it is not easy to raise seven children. "*iye chune makhole. wei katte khalakh aed kale peth te aed asan khoru telli." [*It is not a cakewalk to raise seven children. Now should I produce as many children so that I can't count them.]

She again went to another faith healer in Srinagar (90 km away from her village) who promised her that she would have a son. She also visited the renowned shrine in Srinagar

where she prayed. At last, she gave birth to a son after nine months of the birth of her last daughter.

While being asked how she feels about aborting a child, she says that one feels guilty as it is a sin and not permitted in our religion (Islam). Although, she feels that this decision was good for her because her health was deteriorating. She says that it feels embarrassing to have so many children who are now grown-up the oldest being in class ten. She remarks…

I have grown-up children. When my children would come from school and always find me in bed, they will not feel good. Although, we struggle with poverty yet people think that this is the only area in which we are progressing in.

Hajra says….

"Abortion is not a good thing. It is a sin. Law should not allow it at all. It should not be encouraged. Women do it out of sheer ignorance."

About marriage she says…

> *Life after marriage is nothing. Once you get married things change drastically. Not only does childbirth change one's life but tending to the needs of in-laws and keeping them happy is something that takes a toll on your own life and your health. Hashe mah che dekas gyeen, hyouhur mah che naraz. barbaedi haz chi gassan .[Then the lady is churned between her maternal relatives and in-laws coupled with the children. That makes one's life not worth living. One is completely ruined after marriage.*

Hajra added…

> *Those who are sensitive take the whole matter very seriously and their health gets affected as a result. Those who take the whole matter lightly can at least live their life happily. There is no gain in getting married. Those without marriage have all*

the freedom in terms of exercising their choice. Once you are married one is pressurized to do many things which one would not like to do otherwise.

Hajra is living a life of poverty and destitution but she stays firm saying that she won't ask for any money or share of property from her maternal home. Although, her two brothers have already taken their share. But she and her sisters have warned their brothers that they should always take care of their sisters and welcome them in their maternal home. If they will not do so, then they will ask for their rightful share in the property.

2. Interviewer: Rafia Farooq
Interviewee: Raziya
Date of Interview:23.12.2015
Place: Drugmullah, Kupwara

Raziya has been married in the village Drugmullah. She is basically from Rohama, district Baramulla. She is illiterate and has gone to school just once or twice. She has been married for twelve years. She has four children, two boys and two girls. The eldest daughter is in first standard. Her husband drives a load carrier.

Raziya says…

I conceived after one and a half years of my marriage. My relation with my husband was not good initially but now it is fine. I conceived for the second time after one year. Again, after one year I conceived twins. After my two sons were born, I again conceived after one and a half years. My periods are regular. When I did not get my periods this time. I suspected that it must be some weakness. But I was not feeling well. I would feel weak and fatigued. Then I suspected that I may be pregnant. I took the test and it came out to be positive. I got worried. I have young children and we are poor. I didn't want to carry this pregnancy, so I went to a senior nurse who works in a hospital. I told her that I have conceived and I don't want the child. She first scolded me like anything and then agreed to abort

it. Actually, she knows about my poverty and my husband; who was not faithful to me. When I was pregnant with twins. I came to know that he had an extra-marital affair with a woman. I was so upset and then I would go to the same nurse to share my story with. She would tell me to be patient and endure it. I would pour my heart out to her. She sympathized with me and agreed to abort my foetus. She gave me the medicine. Once I consumed it, after a few days, I began to bleed. Bleeding remained for some time and stopped suddenly. I thought the foetus has started to abort. I felt a sense of relief and was happy to get rid of it. But after some days, I was again not feeling well. I again went to the nurse. She told me to do a pregnancy test again and shockingly, it came out to be positive. I again went to the nurse to get the feotus aborted. I wanted to get rid of it as soon as possible. It did not matter at that time whether it was a boy or a girl.

Raziya says that her husband had fallen in love with a girl from adjacent village. Her husband had an extramarital affair with her. Raziya added that…

That woman was married and had children also. I noticed my husband many times talking to her in the evening on mobile phone. On the mobile recording I heard their conversation also. It was so difficult for me to reconcile with it. Once I caught him talking to the lady on phone? He became violent and started beating me. I would have never doubted him. I always gave him love. But in turn, he did not prove to be a good husband. I told him that you have two daughters. This does not look good. He would not pay any attention to the household. If he would have cared a little, we would have added one more storey to our house which is otherwise very cramped.

"Patte fut yei, amis tour fikre mei gaye kharabi, magar myoon zuv kheth Yeli nei ame mei kerr qadr, myanen koren keh karre, tomi asen pheran garre patte garre". [Then he gave up. He

understood that this will not work. But unfortunately, I had to suffer a lot. However, I thought that if he does not value me, he cannot value his daughters. Their home would be lost forever. So,I stayed with him].

Raziya says…

"*Now he has changed his ways. I told him that you have ruined my life, now show some concern toward the little girls. Let's be together for the sake of our children. I don't care about myself. I am only concerned about my children and their education. When I remember that how he treated me, I cry inconsolably."*

"Kotah boud dil che amis zanne asan"[A woman is generous and is often forgiving.]

Raziya says that…

> *We don't use any method of contraception that is why we land in a problem. Although we have tried. We would sometimes use condoms also but they would rip apart. I would have used copper-T but my husband does not agree using them. Since I do heavy work and it can slip and cause a problem. Now I will go to the hospital for the insertion of multiload (an intra-uterine device). My sister is using it and she says that it is better than Copper-T.*

3. Interviewer: Rafia Farooq
Interviewee: Zareena
Date of Interview:07.02.2018
Place: Drugmullah, Kupwara

Zareena lives in Drugmullah. She is 25 years old. Her caste is Malik. Her husband is a barber and his monthly income is meagre. Zareena is illiterate. She lives in a joint family. She is married for nine years. She conceived immediately after marriage and delivered a baby after 11 months of her marriage. Zareena had home delivery. There is a midwife in the village who assisted her in the delivery. She says…

"Bi keh wanha wariven yoray mei niyu haspatal. Magr suo rud theek" [I wanted to go to the hospital but I could not gather the courage to tell my in-laws to take me there. But fortunately, everything went well. There was no problem.]

After two years, Zareena gave birth to a baby boy and after that, she had a daughter who was born two years later. She has three children. The pregnancy which she aborted was her fourth one. Zareena was unaware that she had conceived. She consecutively missed her periods but she did not know that she was pregnant.

> *I conceived again although this time I did not want children anymore. I had no support at all. I have a mother-in-law at home but I do not rely much on her. I would go to the maternal home; I have a mother there living in that home who would not be able to help me. So, I thought of inducing the abortion. I did not know that I have conceived. My cousin passed away and I was there for some time. And after we were home, I took a test and it came out to be positive. The feotus at that time would have been two months. Once I informed my husband about it, he suggested me to abort the baby. Because he thought that we are poor we cannot raise a fourth child. Also, when my first child was born, he was afraid of whether he can raise him up or not and because of that, he fell ill and from that time he has to take medicine every day. Now with four children, it was never easy.*

Zareena says that it was her husband who was not at all willing to carry on with the fourth pregnancy. So, it is he who suggested aborting the foetus.

> *Since it was my husband's suggestion to induce abortion but he hesitated to go to the medical shop to buy the medicine. So, I went myself to the local medical shop and bought medicine. First, he refused to give me and said that it is a sin and*

then I had to plead to him and I told him to do something for me then only he gave me the medicine. That medicine cost me about 800 rupees.

Zareena had not consumed the medicine immediately after she had bought it. She was not sure whether to take the medicine or not.

"Once I got the medicine, I had it after few days. I started bleeding and it continued for about three months. I then went to the local PHC where I was given some medicine by a health worker and it stopped. It is now after one and a half months that I got my periods back."

Since Zareena had fourth pregnancy as unwanted. When asked about contraception. She says…

Although I had inserted copper-T three times, the copper-T didn't work for me. When I conceived, I had no copper-T on and we were not using any method of contraception. It was an unwanted pregnancy that I had to abort. For some time, I was also taking Mala-D (Pill) but my husband told me that I should stop taking it because it reduces one's blood volume.

She had to undergo D&C which was done after one month of her abortion. Consequently, she developed an infection and had to take medicine for that. Zareena continued to bleed and she went to Kupwara CHC and got a scan done. She was still having RPOCs and had to take medicine to get it cleared. She had to spend thousands of rupees on this episode of abortion.

Zareena says that…

I don't want to have more children now. I am fine with having three children. I have come to meet Female Multipurpose Health Worker (FMPHW). I want to

take some medicine because I don't want to conceive. There is no reliance on any of the methods of contraception.

When her abortion took place, there was nobody to take care of.

When I had an abortion there was nobody at home to take care of. I had to call my sister to help me in those days. I know how bad it is to abort a child. It is a big sin. I still feel bad about that. But what could I do? I was helpless. I keep good relation with my maternal home and they visit me often. I also pay visit there sometimes. I also have a good relation with my husband and we decide on things together. I had to spend 10,000 rupees on all this. I had a lot of stress those days.

4. Interviewer: Rafia Farooq
Interviewee: Shaheena
Date of Interview:07.02.2018
Place: Drugmullah, Kupwara

Shaheena is a 25 years old. She has been married at the age of twenty, which she says was a love marriage with her cousin. She has studied up to class 12th and has left her studies because she got married early. She repents about it (early marriage) now. Her husband had five sisters all of whom are married. And that is the reason her husband insisted upon her getting married so that they can run a household properly.

She has been married for five years. She gave birth to her first child after one year of her marriage and her second child was born after three years. She had to undergo two caesarean sections upon two childbirths. She has one male and one female child.One kid is of four years of age and the second one is of fourteen months. For both deliveries, she has accessed private medical care. She has gone to Sopore private nursing home which is about

50 km away from Kupwara both times. According to Shaheena, her son is healthy and her daughter is very weak.

Her daughter is fourteen months of age but she still cannot walk. Now the doctor had advised her not to go for a third issue because of the probable complications. The doctor had warned her that she might not tolerate the third caesarean section. If she wants to conceive again, she has to give herself time which should be at least four years.

But the young Shaheena has conceived just after 14 months. Shaheena does not want another child now because she thinks that she can't manage three children. She is the only daughter-in-law in the family and has to manage the household by herself.

Now that Shaheena has conceived, she finds herself in a situation. In this frustration, she has already consumed the abortion-inducing drug (mifepristone 500m). Her husband had got the drug for her and the chemist has easily given them the drugs without any prescription. The chemist happens to be a relative of her husband. Shaheena says that such drugs are easily available in the market but the chemist supplies them at a very high cost and at a high insistence.

I met Shaheena at a nurse's clinic. Shaheena had consumed the drug one month ago to abort the foetus on her own. She had bled which made her think that she is no more carrying the foetus. After one month she could experience pain in her abdomen and missed her monthly cycle. She approached a local doctor who suggested the pregnancy test. She again tested positive but she did not go for an ultrasound to see if the foetus is viable because now, she had consumed the abortion-inducing drug.

Also, the doctor had told her that the drug which she has consumed is not a proper one even if she had to abort her child. There is a gynaecologist in the town, Shaheena wanted to

see but she attends her clinic twice a week only. Shaheena after consuming the drugs had approached the local nurse to get her foetus aborted. She has pleaded before the nurse to abort her foetus.

> *I have three young children. Now I have conceived but I don't want to carry it. It is not easy. I have to take care of three children. There is babysitting which nobody at home would take responsibility for. I have a father-in-law who is old and cannot do babysitting. I have lost my mother-in-law. I do not go to a government hospital because it is not safe. Accessing private service means 20000-30000 rupees for childbirth which I cannot afford. For my first child, my parents spent money. And the second time my husband did that. Accessing private service is costly but at the same time safe and comfortable. I prefer to go to Sopore Private Nursing Home because my relatives live there and take care of everything (which includes food, medicine, clothing etc).*

Shaheena says that the medical shops just supply the abortion-inducing drugs without any prescription and it is a good source of money minting (the drug are sold at a high price). Her sister, who was accompanying her, admitted that they (Shaheena and her husband) were using condoms as a means of spacing but she admits that it is not a reliable method of spacing. She says injection and drugs are more reliable. Shaheena says that it is their own mistake as they did not use condoms for quite some time which had resulted in an unwanted pregnancy. Now her husband has also consented to abortion. She was accompanied by her sister who was a teacher by profession. She was also insisting upon the abortion of the foetus.

Shaheena has two sisters and a brother. Her father is a teacher. Her mother is a housewife. As revealed by Shaheena her father is a great support to them. Her father would even bring them home if they are not comfortable in their in-laws home. About her brother,

she says that being the only son he got all the luxuries of life but unfortunately that spoilt him and he left his studies.

The nurse tells her to get a USG done so that she confirms the state of the foetus (because she has already consumed the drug). The nurse contends that if she has a foetus in a normal state, she can't abort the foetus. And if she has a foetus that is not in a normal state then only can she abort it. Shaheena does not want to listen to anything and is adamant that she wants her foetus to be aborted. She gets her USG done and sees that her foetus is not normal and the nurse aborts it. She admitted that many such small clinics do these kinds of abortions.

5. Interviewer: Rafia Farooq
Interviewee: Jahanara
Date of Interview:22.08.2018
Place: Drugmullah, Kupwara

Jahanara has been married for nine years. Her maternal home is in Bandipora which is 40 km from Kupwara. She has two children, a son and a daughter. Her daughter is in class two and goes to a private school. Her son is six year old who is yet to join a school. Jahanarasays that this year she will admit him to the same school where his sister goes. They live in a nuclear family. Her husband is a labourer.

Jahanara says that…

"My husband does not have a permanent job. He keeps on shifting from one work to another. He does not have any skill."

They have a few kanals of land. They had both paddy plantation and a kitchen garden. However, they don't have a permanent source of water which is required for paddy. So, they sow maize that does not require much water.

"We don't produce much because we have a shortage of water here. We have a stream in the village but that does not cover this area because we live on the side of the village which is at a considerable height."

Jahanara conceived right after her marriage. She had her first child as a daughter and she says that when her daughter was nine months old, she again conceived.

> *When my periods were late, I went to a PHC and tested for pregnancy. It came out to be positive. I became restless because my daughter was only nine months old. I pleaded to the doctor to give me medicine for abortion, but he did not agree. Then I started looking for a private doctor. I found one who lives in the same village. I went to him and told him about it. First, he too did not agree. After I requested again and again, he agreed and gave me medicine for 900 rupees. That time my foetus was forty days old. And I took that medicine the other day. And on that day, I started bleeding four hours later. My bleeding continued for about six days and it stopped but after some time, I again bled. Then I again went to the doctor. The doctor said that I have developed an infection. And then he recommended some medicine and I was fine. I bled for about one month. After one month, I got my periods back. After three years, I gave birth to a son. And now my son is six years old.*

"Mei gaye bekhabari natte khemehena bei dawah zanh." [I was not aware at that time as what to do. Otherwise, I would have never consumed the medicine for abortion.]

"When I was bleeding, I did not have any feeling of guilt. It was my choice to go for an abortion. I was relieved. I felt happy. And my husband was also with me. He supported the decision of mine."

Upon asked what method of contraception did she use which helped her to keep a gap of three years. She laughed and said that

"*We didn't use any method of contraception. However, we managed to keep the gap."*

"Bharose chune kin ath peth, risk che [You cannot rely on any of the methods of contraception. There is imminent risk involved.]

> *"Now I don't want any children. Two is enough for me. Although, my husband also wants two children only but even if he tells me to keep more. I won't agree. I don't have any such idea of having two or more sons as is the case with many women. I am fine with one son."*

Jahanara says…

"Suo zamane moukliyav yei panch sheh sheur ases thavan. Zanne che asan nuzuk…mamooli che kinh gasan ate che gasan problem". [Gone are the days when women would keep five or six children. Women are fragile. Even a small thing can land you in a problem.]

"I and my husband decide things together. We have together decided that we don't need more children. Sometimes I exercise my choice also. My husband does not get angry with me. He is gentle. Sometimes I overpower him…. (laughing)."

Jahanara says that once a girl is married her life changes.

> *"Oh oh amsenz zindagi kecha che badla garre bapath peva khabar keh korun. Hete mete mei gasse abortion. Kinh nate kinh che gasan che haqeeqat ki ase che thavan sorui choore. insan che lotan kath karne seth. Zehene dabav asan. Mard che ne thavan zehn. Zane kotah bardash che asan, mard mare panun paan. Islamas manz che zane darje. Ase che kar paknawan". [The life of a woman*

changes after marriage. She does a lot for her household. She goes out of her way. Abortion does not happen on its own. There are reasons for it. It is true that woman hide things from all. And endure on their own. And it is mentally so disturbing. There is a lot of stress. And when one shares things, one feels light. We would share things with men, but they don't listen. They don't pay ear to what we share with them. Women go through a lot. And when men have to do the same as a woman does, they will kill themselves. Since women have to exert much that is why their status in Islam is exalted.]

Jahanara remarks…

My husband fulfils all my needs. He spends money on me and I do not own anything. Here in this village girls do not ask for any kind of property from their parents or brothers because they think they may get offended. Otherwise, we all know that it is guaranteed to you but still we don't ask for it. But some parents keep the share of the property for their daughters on their own.

6. Interviewer: Rafia Farooq
Interviewee: Shakira
Date of Interview:22.08.2018
Place: Drugmullah, Kupwara

Shakira belongs to nomadic community. She has been married only five months back. She has conceived after two months of her marriage. She had done USG just after forty-five days of her conception. Now some days back she had her scan done and it had confirmed medical a case of missed abortion.

Her foetus was 7 weeks and six days old. The clinicians had cited the reason for the abortion as intra-uterine infection. The woman had now come to a local nurse for uterine

cleansing. Now the post-abortive period for the lady is highly traumatic. It was just after three days of her D&C that I met her. She was trying to know from me what wrong went. She had been pregnant for about three months and said that those three months for her too were very difficult.

The lady was accompanied by her brother-in-law and mother-in-law. Her husband is in the military and has gone for a two months course in Arunachal Pradesh. She had called him on phone and he had advised her to go to the doctor and take the medicines properly as revealed by Shakira.Her brother-in-law was taking all the care she needed. He also talked to me and said she does take care of everything including her diet and her medical care.

After one day I called her to see if she was fine. Her brother-in-law picked up the phone and said that her condition is deteriorating. He also revealed something which they did not earlier. He said that that she had consumed the drugs to abort the foetus.

On further investigating, I talked to the brother-in-law of the girl who had earlier said that that she has consumed the abortion drugs now refutes the same by saying that it was said by the doctors at the district hospital that she might have consumed the abortion drugs. After few days her pain had aggravated and they rushed her to Lal Ded Hospital in Srinagar. In LD hospital they were told to repeat all the examinations and it was found that the D&C which the local nurse had done was not properly done and some foetal tissue was still in the uterus. They did a proper D&C there and it is after three days that they were discharged. Now the patient is absolutely fine.

Upon talking to the lady afterwards, she was furious and was saying that she wanted to file a case against the nurse who had not treated her properly. Even after the nurse did D&C, she had visited her twice or thrice complaining about the abdominal pain. But she had taken it casually and had told her to continue with the drugs. She also said that once she recovers, she

will go to her home and talk to her about the whole issue and will file a case against her. But her brother-in-law said that that they don't want to fall into the legal issue.

7. Interviewer: Rafia Farooq
Interviewee: Sabahat
Date of Interview:22.08.2018
Place: Drugmullah, Kupwara

Sabahat has been married for seven years. She has three children, two daughters and a son. She has twin daughters. She delivered one daughter at home and another at LD hospital in Srinagar which is 55 km away from her home. She has been married at the age of 21 years. Her husband is a labourer. She has studied up to eight class.

Having three children, Sabahat again conceived some months back. Once she came to know about it. She was disappointed and wanted to abort the feotus.

I already have children who are too young. I have her sister- in -law who is going to get married. So, I thought that if I am pregnant, I will suffer because there are a lot of responsibilities on my shoulders as I am the eldest daughter-in-law in the family. Once I decided to abort the feotus, I went to PHC to buy the medicine but I was refused. Then, I went to a private clinic which is in the village itself. They too were reluctant to give the medicine. But after I pleaded a lot, only then they agreed to.

Sabahat says that her husband did not agree for abortion.

The day I bought the medicine. I forcibly took my husband to the clinic to make payment for abortion drug because my husband would not agree. When I took the medicine for inducing abortion, I had to fight with my husband. He had gone to the clinic and told the chemist there that he is responsible if anything happens to me. I did not remember age of the feotus at the time of abortion. When I

consumed the drug, the amount of blood and tissue which was coming out likely indicated that I would have been pregnant for one and a half months. Eventually, the abortion progressed. I bled for about one and a half months. I went to a doctor and the doctor recommended USG. On the same day, I argued with my husband over some matter and decided not to go for USG. The same day, I had to do some important household chores as well (picking rice etc). I did not take rest at all after the abortion, neither I watched my diet.

It has been three months since she consumed the medicine to abort her feotus. She says…

I still feel a lot of pain in the abdominal area and my normal monthly cycles have not resumed. I guess that there may be some tissue still inside my uterus which is why I feel pain in the belly and the abdominal area. I am afraid if things are fine with me. And I had two major surgeries as well for two childbirths. I don't know what is happening inside my system. Day by day, I am getting pale and weak. My health seems to be deteriorating. Now I went to a private doctor who prescribed blood and urine tests. I was diagnosed as anaemic.

Sabahat does not want more children because she says it is difficult to manage a lot of children. But her husband does not support her. He wants to have one more son. *"mei che marnas gaemet dah doh pethee". [I am on the brink of death.]*

Sabahat says she has to manage the entire household herself. So, she cannot take responsibility of the fourth child. If she conceives again, she will again consume the abortion inducing drug without informing her husband. Her husband is a labourer, so she cannot afford to keep more children. He does not earn much to support the whole family. But her husband is against abortion.

Her husband says that…

> *He will try to earn as much as possible for his children. Since Islam does not allow abortion but looking at our condition, it important for us to think about the betterment of our children and family. Also, sometimes men argue that we have to earn for the children and women do not have to. So, they should give birth to as many children as they can and we men can take care of as many children as possible.*

Sabahat says…

> *The life of a woman is very difficult. It feels meaningless on the one hand because it has been made so difficult by the society and on the other hand women have their own importance in this world. In maternal home, a woman is treated considerably well but again her parents prefer her brothers over her even there.*

Part II

Cases of Spontaneous Abortion

8. Interviewer: Rafia Farooq

Interviewee: Nazima,

Date of Interview:25.01.2018

Place: Drugmullah, Kupwara

Nazima has been married for ten years. She is from district Baramulla and has been married in Drugmullah. She has done her Bachelors in Psychology from Government Degree College, Baramulla and has done her Masters in Education. She has two children, a boy and a girl of eight and six years of age respectively. Both of them study in a private school. They have a decent land holding of15 kanals which is yet to be distributed.

Nazima says…

I gave birth to a girl after one year of my marriage. After that, I had a boy. After having two children we were planning for a third child. When I conceived and came to know about it, I saw a doctor. After some time, I went for USG and it showed the foetus as seven weeks. At that time, it was fine. When I went for the second USG, the feotus should have been twelve weeks that time. But it was only nine weeks. The doctor said that the feotus is not growing. It has stopped growing at nine weeks only. It was a very difficult situation. The moment I saw the ultrasound, I became blank. It was very painful. I wanted a daughter. Since I have a daughter already. A girl should have a sister in the kind of society we live in. Having a sister means to have a support. I desperately wanted this child. If I would not have wanted it so desperately, it would have thrived. That is what I think and feel.one should not be desperate.

While she had just conceived, her father-in-law had passed away.

Unfortunately, during that time my father-in-law had passed away. Although, we live separately still I am compelled to work because we live close by. So, during the early conception, I was in my in-laws' home for more than forty days. I had to do a lot of work. There were a lot of people who would pour in and I had to attend to them. "*Bei ases zabardasti keem karan, nati aes ne mei hekhthey asan. Bie chas bei zadaya pahan knhocahn, nate che ase alag rozan".* [*I would drag myself to work. Otherwise, I was in no condition to work. Although, we live in a nuclear family. Still, I have fear of my in-laws.]*

Nazima says…

When I had a miscarriage, I developed some pain in the back and abdomen, I thought it must be due to exertion. Not only that we would come back home late in the night. And it is not advisable to roam around at night when you are pregnant. "Bei hisabech zenne chane gasan motivanas peth".[A pregnant lady does not go to the house of a dead.].One day when we came back, I went to the washroom, I saw some clot. Initially, I did not pay much attention to it. I talked to FWMPH who happens to be my relative. She told me to go for USG at the earnest. I went to Kupwara town for USG and it indicated missed abortion and then I did one more scan to confirm and it showed the same. It just happened because of the amount of work I did those days. There were a lot of people who visited those days. Not only that, it was raining continuously for four days when my father-in-law passed away which again would mean taking care of a lot of things.

"Keem hadde kohte zyade keem, te watha beethi,bei thacheis.Waye keh che iye koor banemech khodayan, agar khabar keh te ase , mulaezim te asae, toti che iye

nosh asan, aram hekine karith, bemar ase qamaras manz chus ne kanh iwan, amis kori kecha nadamat che asan."[Work was immense, there was no limit to that. I was exhausted. The girl is God's unique creation. Even if she is well educated and working, she still has to carry out the role of a daughter-in-law. She is always at work, she cannot rest. When she is in her room, sick, nobody comes to see her. She is so humble by nature.]

Even though the feotus inside her was not developing. She did not bleed immediately. It took her some time because it was a case of missed abortion.

From one scan to another, I did not bleed. And then I was given injectable. I still did not bleed. After some days, I started bleeding and then I went for D&C from the local PHC. It was a very frightening experience. Once I saw those instruments, I was scared. Once they took out the feotus, they were talking to each other and saying what would be the age of the feotus. But I did not want to see it. If I would have seen it. I would have felt miserable. Once I was discharged, I was given cytolog tablets as well so that all the RPOCs would come out of the uterus. I am still bleeding. I am lying in the bed since that day. Clots are coming out. Will it clear on its own? How long do I have to take medicine? I am taking lot of medicine including antibiotics. Otherwise, I have never taken any kind of medicine so far.

Nazima says…

I was married at a very young age. I did not know the ways which one has to follow in the in-law's home. I was naïve and innocent. I would sit in a room like any other person. Daughter-in-law generally sits near the door. But I would sit as

usual away from the door or sit at a place of my choice. Once my mother-in-law had some argument with me and in that argument, she said to me that… tche chakh behwan huer kun, be mah chasay tche kinh wana. Myane khodaya bei chas sochan ame keh won mei. Suo kath che mei wenti goonjan. Patte te beethis ne bei zanh huer kun. Agar mei oume che wan te kuni sath huer kun ben, be chas ne behwan.[My mother-in-law said to me, "you sit in the room the way other family members sit; I have never objected to that. That does not behove of you as a daughter-in-law." This struck me like anything. I always think about it. Then I decided not to sit in the room, the way I used to. Now, I always sit near the door. Now sometimes my mother-in-law tells me to sit on the other side of the room. I don't comply. I simply deny.

[Nemith che pewan rozun, jukun che pewan, malein heth, tome te che guel gandan, kori mah gaye kinh galti. Tome che asan wana meanfi dezev agar kori ase kinh galti.]

We have always to be subservient. We cannot say or do anything on our own. Not only daughter-in-laws but her parents have to always show humility and subservience. They are always afraid to listen to anything adverse about their daughter.

While Nazima had the miscarriage, she did not disclose to her parents and siblings about it. Nazima says that….

When they call on phone me, I tell them I am fine, doing daily chores, or attending to my children or teaching them. I also tell them that I am still in my in-laws' home. I have not come back yet. When they call me, I get out of my bed to talk to them so that I sound fresh. But sometimes they feel something is not good. I tell them that I don't work much. We have a lot of women here to help. So, don't worry about me.

Once I had conceived, my mother-in-law told me to clean the rugs and those were very heavy. Since I cleaned them with a broom knowing that I cannot lift them. But she told me to lift them and then dust them off. My in-laws although they are my relatives do not treat me well. Although, when I had a miscarriage, they came to see me. My sister-in-law (wife of husband's brother) also came to see me in the theatre saying that …"mei che pewan panun paan yad". [That I can relate to you as I have gone through this. (had a miscarriage)].

But when I came home after having D&C in the PHC, nobody came to see me. I was just lying in the bed, bled for so many days. Nobody visited me. It is my husband who took care of me. Since he does not know how to cook, I instruct him. You know what, I have done so much for my in-laws. I always wanted to earn their goodwill. "Dale te musli wole mei panas, toti ne kanh mujrahi". I would do a lot of work so that they would talk to me nicely. But they never acknowledged.]

Nazima says…

Since I was young and I was married into a joint family. We had a lot of family members. And when I saw the cauldrons in which they would cook. I was like Oh God what shall I do. They were too big for my age. It was not easy to manage. But thank God I somehow managed.

Her husband is very supportive. During this time, he takes care of all the things including the children.

We share a good relation. We decide on things together. But whenever I go somewhere, I always ask him. Whatever in-laws tell us we have to abide by but when you are comfortable with your husband, things become easy. My husband supported me and told me to go for Masters in Arts in Psychology (MA). Once I

had a daughter, I went to my parents' home and my husband had already submitted the form. So, I did my MA. And now he is telling me to go for Bachelor of Education and Masters in Education. He is quite supportive.
Khabar kecha asen koor pervin, toti che temis laschul tulun. Gupun hish asan ath wairivis manz. [However, qualified a woman is, she has to do household chores. She is treated like an animal with no regard for her worth. I am feeling suffocated. I want to write a book about the life of a woman and how drastically it changes after marriage. Amis kore iuthuy khandar che karan, amis kus tawan che pewan. [When a girl is married, hell is let loose upon her.]

9. Interviewer: Rafia Farooq
Interviewee: Kulsooma
Date of Interview:21.09.2018
Place: Drugmullah, Kupwara

Kulsooma has been married for two years. In this period, she has suffered two miscarriages. When she experienced the first miscarriage her fetus was two months old. The doctors had predicted that she might have to induce abortion because the foetus's heart was not beating. She was being told to wait for some time till they find a heartbeat. Upon waiting, she found herself bleeding and her foetus got miscarried. Once she went to the doctor, USG was done and Kulsooma had to undergo D&C.

Kulsooma after having done D&C says that she again had some pain and found on another USG that the whole uterus has not been cleared of blood and tissue. After the first abortion, she was advised by the doctors to take a rest which she took for a couple of months. She was in her maternal home all this time. All along she has accessed private health services. She says that she would prefer to go to the public facility but the doctors there are on rotation, so each time you have to start your treatment afresh. So, there is a surgeon in LD

(the premier hospital in Kashmir) who has a clinic in Chogul, which is 13 km away from Drugmullah.

Kulsooma says…

"When my first abortion happened, we (me and husband) kept it secret and when things were out of control then only, we disclosed it to other family members."

After that Kulsooma again conceived and her foetus was two months old and she again miscarried. She says that doctor had advised her not to lift heavy things. She had shifted the refrigerator from one place to another, which perhaps triggered the miscarriage.

When my husband came to know that I have miscarried, he scolded me. He said, "you should have told me at least. I would have helped."

Now she is pregnant with her third child. She says that she is scared that the pregnancy should come to its full term. There has not been any fetal movement up to five months. When sixth month of pregnancy entered, she could feel some foetal movement.

Kulsooma says…

> *Since I am pregnant for the third time, it is very stressful. I am scared that the foetus should not get aborted. When I think about it, I get disturbed a lot, then I divert my attention quickly. You know when you lose a child you feel devastated. Life becomes so painful. It almost ends.*

Doctors have told Kulsooma that she has a very weak uterus which is why she experiences miscarriages. Some of the tissue had been extracted from her uterus to get it tested(histopathology). But the report came out to be negative. She had done all her tests from a private facility.

Whenever she had an abortion, she would go to her maternal home for recuperating. When she would be fine, she would go back to her in-law's home. And in her maternal home, she had support from her sisters and her mother. They were very considerate towards her.

Upon asking why is it so important to have children, she says ...

> *What will a couple do if they do not have children? Their life will be worth nothing. The importance of a woman in her in-law's home enhances when one has children. Otherwise, one is nothing but a domestic help. A woman has an innate desire to have her children. Since my condition is a different when it comes to reproductive health. I don't have any preference. I am fine with either a boy or a girl.*

She emphasizes that all this time her maternal family was of great support to her. Her father has passed away when Kulsooma was young. Her mother shouldered all the familial responsibilities and brought her children up. She says that she is proud of her mother who did so much for them.

Kulsooma says that…

> *Since they are nice to me, I will never ask/ for my share in property. My mother and my brothers are so considerate towards me. I cannot do that. Even if my husband tells me to go and get my share of the property, I will leave him but I will never ask for my property.*

10. Interviewer: Rafia Farooq
Interviewee: Shabeena
Date of Interview:08.09.2015
Place: Drugmullah, Kupwara

Shabeena is a 27 year-old lady married early in her life. She has studied up to class eight class. Shabeena lives in a very modest house. Once I entered her house, she was lying and resting in her kitchen. She looked very frail and weak. She had her Jethani (brother-in-law's wife) there who at the beginning of the interview spoke on her behalf. After a while this young lady started not only speaking but pouring her heart out.

Shabeena has experienced spontaneous abortion five times. For her narrating the experience was bone-chilling. She has two daughters already aged 5 and 7. Since her jethani is childless she has given one girl to her.

Shabeena says…

> *I thought she would feel deprived and she would sigh sadly seeing my two daughters, so I decided to give one of my daughters to her. I have promised her that I will never take her back. My husband did not agree but I convinced him. So, I gave my daughter to her and I will not take her back till I die.*

About one of the experiences of miscarriage she narrates…

I was not feeling well that day. It was raining outside. I could see that I am bleeding but I thought it will stop. I went to a doctor who lives nearby. He gave me some medicine and sent me home. I was now taking a rest at home. But suddenly, I found myself writhing in pain. I called other family members as they were sleeping. They called the neighbours. They came out with the lanterns to take me to hospital. The moment I reached the outer door of the hospital, I delivered a baby boy. I just fell on the veranda of the hospital. It was normal. I could hear his cries. The neighbours picked him up and wrapped him in a blanket. And we went inside the hospital. There was no doctor in the PHC and I was referred to Srinagar. The baby was alive and healthy. The baby was kept in ICU and after a week he passed away. It was a baby boy. He was beautiful with long tresses of hair. Afterwards I was not feeling well. I again went to the doctor and while examining he found the placenta still inside the uterus. And again, I had to go for D&C. It was so painful a procedure, that I was not letting doctor touch me. I threw him out. I did not let him do it.

All these episodes of abortion have made her anaemic. The day I visited her, it was just the 16th day of her latest miscarriage. She had to go for D&C again. All the doctors had advised her to take healthy food so that her HB improves but she says that she doesn't take it.

"When I ask my husband, did you get some fruits for me, he says he couldn't find them in the market."

The doctors have advised her to wait to conceive and give herself time to heal. Her second daughter was just four months old that she had conceived. The doctors had told her that she is not ready for the next child yet. And consequently, she miscarried. Her husband according to her does not care about her deteriorating health and does not give her time to rest or heal.

Shabeena says….

Not only did recurrent abortion bring a lot of hardships and misery to Shabeena but she is also constantly being threatened by her husband that he will go for the second marriage because she is not able to stay pregnant and produce a baby boy.

> *Had he cared about my health; he would not come even closer to me. But he does what he wishes. I fear that he may scream and call neighbours to tell them that I am not a good wife. He has already started telling me that he will remarry. I told him, go ahead but on the condition that you two (you and your new spouse) will not live in this house. You will live at some other place with your new wife. He is way older to me and he does not understand what my feelings are. I have told him so many times that if he will take some medicine instead of me so that my body takes rest for some time. He does not agree. I have to do all things by myself. And sometimes I forget to take the pill and I conceive. I have told doctors as well rather insisted that they should sterilize me once for all. I don't want any*

children. I am about to die and my husband says that we should have one boy at least. I remember when our second daughter was born my husband was so upset. The doctor said if you are so worried and upset, I will adopt your daughter. From that day my husband is after me saying that it is important for him to have a son. He hardly understands that it is up to God. Whenever I went to the doctor my husband never accompanied me. I sometimes take my brother-in-law with me. The doctor scolded me for not having my husband along. Now I wanted to give my husband medicine without his knowledge. But I fear that he may come to know about it and he will make an issue out of it. I myself once decided to go for the insertion of copper-T. But I had heard that many women bleed because of that. So, I gave up the idea. Now I am insisting my husband to do something about it. "Mohniv che asan taet". [Men are quite difficult to deal with]. All the villagers talk ill about him. He is just impossible to handle.

Her jethani has also suffered two miscarriages. Before that, she gave birth to a stillborn baby. She has undergone two D&Cs and one of the D&C was conducted by an untrained health worker and consequently resulted in her infertility. She was diagnosed with goitre and the doctors had advised her to go for surgery but they could not afford to pay for it. So, the lady was left childless forever and it is Shabeena who gave her one of the two daughters. Her husband does not have any say in the family. It is their brother- in -law who decides all things in the family. *"We don't say anything because he manages everything well. He spends money on me as well."*

Shabeena says…

I cry and cry because all these things are so difficult for me to handle. I don't sleep. It is my jethani who takes a lot of care. Whenever she finds me sad and engrossed in thoughts, she

cheers me up. She has been very close to me throughout. She is more than a sister to me. When there is no one there to talk to me I become restless. It feels suffocating. She has been a great support.

She says…

> *I was married at a very early age. There are my friends who are still not married. The other day, I met a friend with whom I have spent my childhood. When she looked at me, she was taken aback looking at my condition. She could not believe her eyes looking at my pale face and frail body. "Tem chen dandas tal unguj". [She was shocked to see me.]*
>
> *Before marriage, I did not have my regular cycles. I went to a doctor who prescribed me medicine. I was already very weak. There was a lot of confusion in determining my latest pregnancy. When I missed the first period, I went to a medical shop for the pregnancy test. It was positive. I shared the news with my husband once I was home. But unfortunately, I started to bleed in some days but it was very scanty in the beginning. After some days, I again tested and it still showed positive. This time the chemist said that I was four and a half months pregnant. I was not satisfied because I could have felt the movement of the baby then. Finally, a doctor advised me to go for USG. My husband did not allow me to go for USG because he told me that I could miscarry when I go for USG. But I was writhing in pain. Somebody came to my home gave me an injection. After some time, I bled profusely. The blood gushed like a stream. The blood was thrown out at a distance. There were huge clots. I was carried by few people and was put in a vehicle. I was taken to the hospital. My blood pressure was high. It was not coming under control. Now the doctor started cleaning my uterus. And*

believe me, he extracted two and a half small buckets of blood. He told me that the foetus had already been developing and something bad happened that it got miscarried. The doctor to whom I went before was not able to tell me anything about it. I was in the hospital for the night. I spent 2500 rupees on this episode. The doctor said that my uterus is weak which is why this happens to me. Not only miscarriages she had a premature birth as well which according to Shabeena was a nightmare.

She says that now she will go to the doctor and she will take her husband along and the doctor will counsel him as well.

"He does not listen to me. He has never understood me and he won't understand me in future as well."

11. Interviewer: Rafia Farooq
Interviewee: Sakeena
Date of Interview:08.09.2015
Place: Drugmullah, Kupwara

Sakeena was an Asha before her marriage. She was married at a very young age. Nobody agreed to get her married at such a young age. However, she got married and is now married for eight years. Her parents have already passed away. She says that life changes after getting married.

Sakeena has studied up to class 10th. Her family has chosen a match for her. It is after five years of her engagement that she got married. She has been married in a family where her aunt (mother's sister) is her sister-in-law (Jethani). She says that she is kind to her. She is now living with eleven new family members. So, there is a lot of household work than what was in her maternal home.

Sakeena says…

> *Before marriage one is like a queen. Since I am not well. I am taking a rest. I find myself disabled. That was not the case before marriage. Before marriage, I remember when I would be ill, I would never sit at a place and take rest.*

Sakeena is facing recurrent pregnancy loss. She has been married for about one year. In this period, she has already experienced two miscarriages. She had conceived right after one month of her marriage. When she missed her first menstrual period, she went for a pregnancy test that tested positive. She was bleeding a little at the beginning which she shared with her sister-in-law. She again had a haemorrhage for about one week. That was perhaps the implantation bleeding as she says and after that she tested positive. After forty days of conception, once she was sleeping in the night, she could feel some sensation in the abdomen and she abruptly started to bleed profusely. Not only did she bleed but she also shed a lot of tissue. The next day she was taken to the hospital and USG was done. The doctor wanted to see if the uterine cavity is clear. She had almost clear uterine cavity with some little mass of tissue inside. The doctor (from the same village) gave her medicine. She started to bleed again which continued for eight days. She took rest for those days and then on the twelfth day she went to her maternal home for healing and rest.

After almost three months she again conceived and she was fine for the first forty days. During this period there was no bleeding. But she could feel some pain in the abdomen and she went to a doctor. It was only 25th day from her last cycle. The doctor said not to take the test so early. At that time, she had a urine infection for which the doctor prescribed some medicine. The infection was cured. She waited for forty days and then she tested positive. After that, she suddenly could feel some pain in the abdomen and she went to the doctor. She did USG then which confirmed that she is pregnant. After few days of her confirmed

pregnancy, she had some symptoms of miscarriage again. She went to the Kupwara hospital which is about 7 km away. The doctor there gave her some injections. Once she came back home, she went to the washroom where she miscarried. She says it was excruciatingly painful and she cried all night long.

After she recovered a bit, she again had intense abdominal pain. She was feeling a strange sensation in the abdominal region. She again went for USG which confirmed that she had a cyst on the uterus. Because of which the doctors said that there are a lot of chances of miscarriage. But she has again now conceived and the doctor has advised her to take complete rest. She is pregnant for four months now. A few days before, she again experienced some bleeding and went to the hospital for USG which showed the foetus is normal. She did all her USGS from a private facility. She also bought her medicine from her pocket. She says that her husband is a tailor which makes it difficult to pay for such expenses.

"I am in-law's house and it is difficult to take rest here. My in-laws are nice to me but she it is more comfortable to be in a maternal home during this period."

So, she is planning to go to her maternal home. Her husband is supportive and takes care of her and spends a lot of money on her illness.

Now she is pregnant for four months, upon asked what she wants a boy or a girl, her reply to that was …

> *We have no such preference that we should have a son given my condition. Yesterday only we were about to sleep and I asked my husband will it be a boy or a girl. He slapped me so hard (laughing). He said I wish I had a girl and you are looking for a boy even after all this.*

12. Interviewer: Rafia Farooq
Interviewee: Basheera

Date of Interview:03.09.2015
Place: Drugmullah, Kupwara

Basheera was married at the age of nineteen years. She has been married for one and a half years. In this time, she has faced two spontaneous abortions. She conceived six months after her marriage. She was very anxious to get pregnant from the very beginning. Now she was pregnant for four months and everything was going fine. One day she found herself bleeding profusely. She suspected it as a spontaneous abortion. She went to the doctor who diagnosed her with the same. It was very distressing for her. During the process of spontaneous abortion, all the fetal tissue was not removed naturally. So, after few days she again went to the doctor who this time recommended D&C. Although, she went for D&C, unfortunately, all the tissue was not removed. After some days, Basheera developed severe abdominal pain. So, she again went to the doctor and again had a session of uterine cleansing which the Basheera says was very painful. All this time she was in her maternal house so that she is adequately taken care of.

This was the tenth month of her marriage when she had miscarried. After a gap of about four months, she again conceived. She says that she was happy but suddenly something bad happened again. She miscarried once again. This time she had done her ante-natal check-ups as well and had done all the vaccinations.

Since she has miscarried twice so the doctor has told her that her chances of staying pregnant will only go up if she gets adequate rest. Upon asking her whether she got adequate time for herself. She gave me an account of one day's work. She said that…

> *I get up early in the morning, prepare breakfast for my family. I do all the cooking and cleaning. I clean the courtyard almost daily. I clean the cowshed as well. And sometimes my mother-in-law sends me to the house of neighbours to help them with different chores. How can I rest when I have to work in my*

neighbour's house in addition to my household chores? It is a hell of a work and that too for a body that is already weak. I wish, I conceive so that I go to my maternal home and take rest there. I had no grudges if I was not able to become a mother. God has been kind to me; I conceive but then He takes it away from me which is far more painful. I know God will send his blessings again but you see my health has completely deteriorated. I wish I conceive again and I wish that my in-law's allow me to go to my maternal home. You know how hard it is to negotiate with them. It is difficult to convince them. I want to eat good food but I can't get it. I want to eat fruits but believe me, in villages there is no such culture. Also, my in-laws are not that better off that they can afford all such things.

I want to share all the things with my husband but he does not listen to me. I cannot go on complaining about my in-laws to my parents because I have married on my own. It was a love marriage. It happens, one who marries on her own. Your family is angered and you lose their support forever. I was sick all this time, my father did not visit me instead my brother came and gave me some money to buy medicine. I was happy to have chosen my match but my family did not support me. My father does not even know where I am married. He has never come to see me.

Her mother-in-law entered the room and greeted me. She also joined the conversation and I continued telling her that how important rest is for her if she wants to conceive. Her mother-in-law asked her, what is she telling you and what did you tell her? Basheera replied, "she is asking me about the two abortions which I faced".

Her mother-in-law says when she faced an abortion, I did not let her work. I did not even tell her to fetch water from the public tap. She is herself responsible for the abortions. Her sister-in-law (brother's wife) was pregnant and she went to assist her when it was her delivery. She

went to Srinagar with her that too when it was her fourth month of pregnancy. I had already warned her not to go to Srinagar. But she still went which is quite a distance.

Basheera says that…

> *For the first two days, I was fine. In the hospital in Srinagar, I did not climb stairs. I was at one place. But while I was in the hospital, I could see slight bleeding. This time the bleeding was very scanty. I told my sister-in-law about it. She took it casually. She did not tell my husband about it. Had she told her brother, may be my child would have been saved. Afterwards, I told them that I will go home. Now I was bleeding. Once I reached home which is 90 km away, I had not disclosed to my mother that I was pregnant. Now that I was bleeding, I had to tell her. They took me to a private doctor who recommended USG and gave me some injections. But the bleeding continued for a long. After the USG report, the doctor said that the foetus is gone. After this much happened, my mother-in-law blamed me for the miscarriage. I told her that even if I had not gone to Srinagar. This foetus would have met the same fate.*

After the first miscarriage, she again conceived after three months. When she missed her first period, she went to a doctor to get herself tested which came out to be positive. The second miscarriage happened at the time when she was 65 days pregnant. It was the month of Ramadhan when Muslim keep fast in the day. During that time most of the household chores are done in the evening. After finishing her work in the evening and after having cooked food for the night (sehri). She had pain in the back. She thought it must have been because of the work which she had done in the day. She also told her husband about it. He said that it may be because, you are exhausted. When she slept, now that it was Ramadhan. She had to get up for sehri after midnight. When she got up, she says she was writhing in pain.

I experienced the same pain during my D&C when I first miscarried. Since I was bleeding, after having the morning sehri, I slept till late in the morning. When I got up the whole mattress on which I was sleeping was drenched in blood. I told my husband to call his sister and mother. They all came and they told me to sleep in the upside position which I did. But that did not stop the bleeding. I told my in-laws to call my brother so that he takes me to the doctor. The moment he came we left to see a private doctor who did USG and confirmed that the foetus is normal. He gave me some medicine and sent me home. It was after few days that I started to bleed. The bleeding was heavy. I think as if there was some poison inside me which came out. From that day, I am still fine and it has been two months since that episode.

Now she is herself convinced with the fact that all she needs is rest.

She says that the doctor strictly advised her husband not to let her work or clean the house with a broom as one has to bend while cleaning. The doctor had said that her uterus is weak which is not able to carry a pregnancy. So, she needs to be at a place so that she stays pregnant. The doctor had advised her that the moment she will bow down she will put herself in a danger. But she says however hard she tries to take rest but she cannot. She says the doctor also advised her husband not to have sexual intercourse with her for few months which she says cannot stop because for her husband it is not easy to stay away. Her mother-in-law added that after her two abortions she would do all the difficult job of the house herself. She says even her husband (father- in-law) would fetch water from the tap. She says that her daughter-in-law will never acknowledge it. But Basheera was prompt to add that she has no lesser burden. She says taking rest is not in my hands.

I keep on working. I don't stop. My husband tells me no matter how messy the household is you should not care. But I cannot leave things unattended. My

parents also tell me that once you conceive you should come here but I cannot do that. They tell me that you cannot stop working there. But let me tell you there is a huge difference between in-law's home and maternal home. The comfort which one can feel in the maternal home is unparalleled. But at the same time, I think that I have sister- in- law there who will not welcome me. That ways in-laws home is better. Here you have a different kind of comfort and yes here you have no comfort in terms of attending to your health. Though my brothers tell me to come home and take a rest here for nine months but I don't feel like going there.

She adds…

You see how important it is to have children. It has been one and a half years that I am married. I am seeing other women around who got married at the same time. If they can have children, why can't I? Life is worthless if one does not have children. Not only are children important for in-laws but they are important for maternal home as well. Since I miscarry again and again my maternal family are so concerned. The moment I miscarried they were crying like anything.

Her mother-in-law interrupted her and said she is just talking meaningless. Her mother-in-law said that...

Having a child is not a matter of pride for her parents but her in-laws, because the child would belong to us. I wish she understands that. If she has a child. That child is mine. A house becomes home only when a child is born. I wish she (daughter- in-law) changes her thinking. daughter-in-law. She delivered a baby and she went to her in-laws' home after five months. Now I have no concern for her, neither has she any concern for me. I wish if my daughter-in-law had a child, we would play with him/her. We would feel good.

This lady again wanted to make her point in front of her mother-in-law. Her mother-in-law was annoyed by the statement she made.

She said…

> *Look my nanand (sister-in-law) was married at the same time when I was. She delivered a baby sometime back. I am not jealous of her but I wish I too had a child. And I pray those women who want children should have them. Look at my mother-in-law, she is happy and content that her daughter is now a mother. Her all relations would be satisfied because now she is a mother. Similarly, when I will have a child, my relatives including my mother will be happy and content. One is only respected in in-laws's family as well as in the maternal home if one has a child. It has been now one and a half years; I also feel that I should have a child by now. So, I keep on telling my husband that you should spend double the money on my treatment so that I give birth to a baby. I tell him that, I exist only for you as long as I give birth to a baby. So, you have to make that happen. A child is support you see. This time I have mother-in-law and father-in-law. They too are not in good health. Tomorrow they will be gone. So, whom should I bank upon?*

"I have no problem with my reproductive system. That's is fine according to doctors. Then I went to a faith-healer. He told me to read Awrade Sharief (a religious book). So, I did that too.

Blaming her, her mother-in-law said to her that…

> *It can be because of your faults and sins. So, you should repent and regret and ask for forgiveness from your God. Then only can things be alright. If you deliver a child that is our pride and our respect. Now the moment she will conceive I will make her rest. I will not let her work. That is up to me. That I owe to her and I*

will do that. I will not mind if our household remains messy and unattended. But one thing I must confess here is that she is so arrogant. And I assure you that will land her nowhere. "Takeryar che asan pozar khorus suo che nebere kan asan narmi che asan pashminas suo che nael asan."[Harshness belongs to footwear that has a lowly place and tenderness is for pashmina which one wears and endears]. It would not matter to me that I have to do the entire household by myself the time she stays pregnant but she should leave her arrogance and be humble. She fights with us and does not eat for days.

To this, her daughter- in-law replied that if one does not work how can one eat? Once her mother- in-law left she told her to once you finish talking to her you should come fast and help her relatives. Upon leaving Basheera told me that…

Look what did she say? They can't understand me. When I am pregnant, I am being told to do all the household work. She does not help me at all. Nobody in this house helps me. And when I get angry, I tell them that they are being unjust, then one does not even want to eat.

If I make the same complaint to my husband, he says that this is what you have come here for? Tell me is not my anger genuine? And yes, I have had a love marriage. My husband should understand that I preferred him over my family. I angered all my relatives and went to him. But he does not understand that. And now I repent and say was it worth it? Though they married me off with extravagance but deep inside they were all sad. My father does not come here. I am all alone.

During my first pregnancy, I went to the doctor so many times. I have sought all my health care through private service. I might have spent 20,000 rupees that time. My brother and my husband gave me the money. I had no problem in my

cycles before marriage. After my first abortion, I got forty days' rest in my parents' home but when it was my second one, I did not even rest for one week. It is not possible to rest in your in-laws' home, however, you try.

I am unlucky. You know how painful it was for me. The day it was my D&C, the same day my sister-in-law gave birth to her baby boy. You can now imagine what I must have gone through. And then my in-laws did not visit me when I was in my maternal home. And even in my maternal home people told me that since you married against the wishes of your parents. This was destined to happen.

And believe me the worth and respect you have in your maternal house. You can't have that in your in-law's house. You have a different worth before your mother but for your mother- in-law, you are worthless. Similarly, your brother will have regard for you at least and cannot say ill of you. The same is true for the father. But for your husband, he can go to any extent in humiliating you. That is why it is said about husband….

"Hengen manz rachhe te, rangan manz mandchaye."[He takes care of you and endears you once you are alone but in front of everyone, he scolds you and can go to any extent demeaning you.]

Basheera says…

A woman has a right to live even if she is childless. Tell me what is the meaning of that life when everyone is after you. Also, one wishes to at least sit and take a rest when you have your child. Otherwise, these in-laws don't even bother to tell you to sit down and rest.

The doctor had advised them to take rest and do not go for intercourse for few months.

"When I go to the doctor, he tells me to stay away from my husband for some time. My husband is away for work for many days when he comes back. I tell him to stay away but he

does not agree. Lekhenden mohninen nish cha challan." [You can't negotiate on this with your husband who is after all a stranger.]

13. Interviewer: Rafia Farooq
Interviewee: Zubeida
Date of Interview:06.02.2018
Place: Drugmullah, Kupwara

Zubeida has been married for fourteen years. She is from the adjacent village and has been married in Drugmullah. Her husband is a mason and switches to other jobs and sometimes sells walnut kernels. Zubeida has never gone to school. She is a housewife and has three children. In the course of her married life, Zubeida has lost four children. She has lost two children (a girl and a boy) right after they were born. Zubeida had two miscarriages; one happened when her feotus was six months old and another was seven months old.

Zubeida had conceived immediately after her marriage and gave birth to a baby boy exactly after nine months but her son passed away just after three days of his birth.

"*We named him also and he passed just after three days."*

After that, she immediately conceived again and gave birth to another baby boy who is now thirteen years old. After that, she again conceived but she had an abortion in the sixth month of her pregnancy.

I had my first abortion when my foetus was six months old. One day I was sleeping and at about 3 am in the night, I could feel some pain and I started bleeding. Right after that, it intensified and with that, I lost my child. I was taken to the hospital but to no avail.

"Totam ous bache khoonas manz photmut. Mei howukh suo. Temis ous tyuth mass".[*The moment I reached the hospital my feotus was already dead. Someone showed the feotus to me. Although, it was six months old but it was fully formed. It had beautiful locks of hair.*

Zubeida was taken to the hospital in Handwara which is 15 kms away. She was given injectables and put on some medicine and after that, she underwent D&C and was discharged. After that, she rested for a while and then moved on. Zubeida had another miscarriage just after one year of her first abortion.

> *That day I was just sitting in my home. My back started aching. I started bleeding profusely. Our neighbours came when they heard my cries and took me to the Kupwara hospital in a vehicle. Once I reached at the gate of Kupwara hospital, the feotus just fell down at the door of the hospital. It was already dead.*
>
> *After that I had another D&C. It was such a costly affair for me. It took me almost 15000 rupees. When I was pregnant, I could feel the pain occasionally and doctors thought that I have urine infection and were treating that. But I had some problem related to my foetus which they were not able to figure out. Although, I had two USGs in a private clinic which revealed that the baby was fine. But just in two days the baby perhaps changed its position and abortion happened.*

Zubeida says that she accessed a private clinic and preferred to do that because going to a private clinic is reliable than going to a government hospital. *"Haspatal katte che gasan saf reel. Azze cho tohi patah kotah che lagan mamooli karre doud gadde kiraya, tor watun, sahal cha". [In a government hospital, you cannot have a clear USG. In private you have to reach the hospital and then pay for the vehicle and medicines. Overall, it is a very costly affair.]*

Since Zubeida has gone through a lot. Once I asked her how has she coped with all this she says…

"Khodaye *che patte diwan sabr, natte che ye mushkil."* [*It is just God who gives you the strength to bear such a loss. Otherwise, it is not easy.]*

Zubeida has also experienced a perinatal death.

I had completed eight months of pregnancy and my daughter was born. Since she was premature. We took her to the hospital as she was not well. But she could not survive. I was taken to Kupwara hospital where it fell into my shalwar at the gate of the hospital. I was struggling to sit but I could not and the driver of the vehicle helped me. He happens to be our neighbour. I fainted and the nurses took me inside the hospital where they cleaned me. It is all destined what can one do.

About the use of contraception Zubeida says…

We never used any kind of contraception during our married life but now I went for ligation. Everybody said I should go for it. But my health is already compromised now.

Zubeida says…

> *My husband supported my ligation because he could see my health deteriorating. I had developed high Blood Pressure (BP) and thyroid problem also. Husbands do support but you have to help yourself which nobody can do. They do their bit and that is it. But let me tell you even though I have gone for ligation. Still, I can conceive if it is God's will. What will our effort yield us if He wills? He can send a child to this world. That's up to Him.*

Since they wanted to have two boys but they had only one. Zubeida says…

> *I have only one boy now. I have entrusted myself to God. But yes, I cannot forget the children who I lost. "Tome daag rozan ate. Kotah karre insan bardash.*

otre aes mei koor wachass seth. Azze chene kunay. Maelis majje koor asen ya ladke tomen kheter che asan donway hewee".[*Those scars will be always there. Only sometime back I had this little girl held against my bosom and now she is not there. For parents, it does not matter whether you have a boy or a girl. You feel equally for your children.]*

14. Interviewer: Rafia Farooq
Interviewee: Masooda
Date of Interview:06.02.2018
Place: Drugmullah, Kupwara

Masooda has been married three years ago. Her maternal home is in Nagri which is twenty km away from Drugmullah. She has studied up to class nine and was married three years after passing the class. Her husband is a baker. Mb (20) says that they don't have much income and they have little land.

We had land but once my father-in-law passed away my husband had to take responsibility for his sisters. Since he had four sisters. He married them off selling land. So, we are left with little which we use as a kitchen garden. It may be one kanal or so.

Just after one month of her marriage Masooda conceived and gave birth to a baby girl. Once she was pregnant, she had registered herself under NRHM in a local PHC. Masooda says…

I had registered myself under NRHM but once I went to the local PHC for delivery they refused my admission. So, I had to go to CHC Kupwara where I delivered a baby girl after a minor caesarean. Why did they refuse that, I don't know? I got my money also in the account after delivery.

When Masooda's daughter was 14 months old she again conceived. At that time, she did not know that she had conceived and had a miscarriage afterwards. Masooda says…

> *I didn't know I had conceived. I missed my periods and I thought that I am weak and I don't have much blood in my body. My little daughter would also hum songs for a newborn. And I missed periods consecutively for two months. Then I thought that I must go for the pregnancy test. Once I did that it came out to be positive. I straight away went home and did not seek any medical advice. My pregnancy must have been in the third month that I miscarried.* " *Sarev wonukh tche che kori futmut dil, taway gov iye atur"*.[*People said that I have a little daughter. She must have felt bad about it as her sibling would come. That is why it happened.]*

Masooda showed me her USG showing a non-viable feotus of eight weeks and one day with no foetal movement and no foetal cardiac activity.

Once Masooda talked about it she broke down and I had to console her. She was not pacifying but there was something else also which made her cry. The ASHA also tried to pacify her by citing the examples of many women of the same village having experience of miscarriages. Somehow, she gathered herself and again started talking to us.

Again, asking her why she didn't go to the doctor immediately after seeing the positive pregnancy test, Masooda says that…

> *I thought of going to the doctor, but I did not see a doctor. There was no reason as such. It was after a month that I started bleeding. I went to the same place where I had taken the test and he recommended some medicine and injections. Once I went home, I did not feel any difference in the bleeding. I went to the lady*

doctor and she recommended an ultrasound. I did that in a private facility and went to the doctor again. She said that the baby is gone and now I have to get admitted for uterine cleansing. I went home again and then told everyone at home. The same day I got admission to the hospital and underwent uterine cleansing without any anaesthesia. It was very painful, as painful as childbirth. I had my husband and other family members with me. I was discharged the same day. I had to get all the medicines on my spending lot of money.

Asking about how did she have any rest after the miscarriage. Masooda says…

It has just been forty days since my miscarriage. I was bleeding for many days but it has now stopped. I could not get any rest because we had separated from our family. It has now been two months but we are living in the same house. So, my in-laws are always around. During the time I was pregnant my mother-in-law would tell me scornfully that …

" Zanen che asaan yed alhount toti che tome kame karan, lekhendis garas manz che ne chalan".[Those women who have hanging belly due to advanced pregnancy do work and look at yourself you don't do anything. It is not approved of in in-law's house.]

I was told by the doctor not to lift any weight but I had to carry pitchers of water on my head and the doctor said that it may have triggered the miscarriage. And while I would carry the pitcher, I would always be afraid that I may fall and lose my pregnancy. "Toti che mei yi koor nate ashen mei kermet oumo pamov seth ael".[I am thankful to God that I at least have one daughter, otherwise, they would have made my life hell by commenting on my childlessness. Once I had an abortion my mother-in-law would taunt me.

Masooda says that …

> *I do not have a supportive husband. He has made my life difficult. I would have gone to my maternal home for some days to take a rest but my husband is not letting me go there. Neither is he allowing me to call them on the telephone. They cannot come to see me. I didn't have a love marriage. It was an arranged one. Still, I am not allowed to visit my parents. My husband had a brawl with my parents because he was having an extramarital affair which they objected to and he had an argument with them. My husband is in love with a girl from the same village. They are living nearby. I tell him not to engage in such a thing as we have a daughter now but he does not listen. So, we fight every time and in this fight one day he kicked my belly twice, while I was pregnant. He is very violent. His parents also do not stop him. They kind of approve of it. I got my family members here to talk about it also but he continues doing that. He would not sleep in my room. And would sleep separately and phone her and during the day he would tell me that he has not slept for the night. That would affect his work in the day. First, I was wondering what the matter is and then I got to know about it. When I would call him, his phone would be in a waiting mode. I asked for his sim card. He did not agree to give it to me. He hid this sim and memory card of the phone. But somehow, I came to know who this girl is. She is married. She is a mother of three children. I told my husband's uncle about this; he went to her home telling her that if someone tells you about it don't disclose anything about it. Unfortunately, his family also supports him. I also told his aunt about it. She said that women often lie. My husband has been involved in this affair since childhood. This is my biggest weakness. I would leave him but I am concerned about my daughter. I came to know about him once my daughter was born. I*

somehow managed to get the photographs of that woman. But I feel sorry now as I have torn her photos. Otherwise, I would have shown those photos to expose him to his family. I sacrificed so much for my husband. I left all my family, my uncles and my aunts. I am so concerned about my daughter. But my husband does not care about it all.

"Mei trov sorue amsend bapath magar iye sor rout me.yei gasene yad thavun. Bei chemis waen wane, iye che aki kane bozan bei kane travan [I left everything for this swine, but he is extremely indifferent.]

Masooda says…

You know what, he does not listen to me at all. When I call him, he ignores me? One day I had to talk to him regarding a very private matter but he did not respond to me after repeated calls and I got a candle and put my arm on its flame and burnt my arm. Still, he did not respond. He treats me like a dog. I was his partner, but he least cares. Each time I tell him not to do this, he hits me. He is such a human being that whenever he sleeps with me, he talks to me nicely and admits that he is wrong. But in the morning, he does the same again.

Masooda says that whenever she gets intimate with her husband, they do not use any contraception. That is why her second pregnancy was conceived. She now wants to use it.

I know myself, my health, my recent miscarriage and then my baby girl. I can't think of pregnancy. I want to wait for three years and then see. Also, there is a lot of uncertainty when it comes to the relationship with him. So, I don't want any baby at the moment. I will go to the nearby PHC and do something about it. I will not tell him about it. The day I had miscarriage, I was kept in a separate room

and nobody would enter that room. The food I was given was not suitable for me. I wished to eat a pie. I told my husband to get it for me. He ignored it. Nobody would come to help me when I had to get up. I would do things on my own. And they were saying that what is wrong with you, you are alright and why can't you do things yourself. My mother- in-law is always rude to me and my husband is afraid of her. That is the root of the problem.

15. Interviewer: Rafia Farooq
Interviewee: Fatima
Date of Interview:10.01.2018
Place: Drugmullah, Kupwara

Fatima who is basically from Kolkatta, West Bengal. She is married to a Kashmiri man. There is a practice in Kashmir where many men marry women from other states of India when they don't find a suitable match in Kashmir. These are the women who are brought by some influential person, who then sells them off to men who want to marry such women. Back home, she has two sisters and a brother. Her father has already passed away. She has an ailing mother at home who seldom contacts her.

Fatima says…

"I am completely new to the village. I had to adjust to the cultural conditions of this place. Not only that, I had to face the harsh winter when I came to Kashmir."

She could be seen wearing farren (a long, woollen gown worn by Kashmiris during winter to keep herself warm).

Fatima has been renamed by her in-laws. It has been four months that she is married to a person named Parvez (name changed). Parvez had to pay 36000 rupees to marry her. He is a labourer who works in Punjab. So, he will be away from home for six months. Till that time

Fatima will be taken care of by her brother-in-law and his wife. There is a place called Shirpora in district Kupwara where the person selling these women resides. There is a proper place in his house where he keeps such women. Parvez said that he has followed the proper procedure and has got affidavits and other documentation from the court to bring Fatima home.

Once Fatima was married to Parvez she conceived in one and a half months of her marriage. She immediately went to the local PHC and got herself registered under NRHM.

> *During the conception, I was not keeping well and was struggling with intense vomiting. One night I just woke up to intense bleeding and was rushed to the local PHC who could not handle my case and I was subsequently referred to CHC Kupwara which is ten kilometres away from the village. A scan was done that confirmed it as a case of spontaneous abortion. The doctors gave me some medicine and sent me home. The pain was not subsiding, so the next day I went to a private facility where they recommended another USG. I was also given three injections at a time for the pain relief. I was hospitalized for few days. The doctor there confirmed that the medicines given to Fatima in CHC were not correct. Bleeding was still not stopping. From there she was referred to another private clinic when her condition worsened.*

Upon asking what could be the reason for her spontaneous abortion, her jethani said that, “it could be because of the intense vomiting because the day she vomited hard, the same night she started to bleed.”

Fatima says…

In the private facility, I had to undergo D&C which was a very painful experience and at the end of it, I was not at all satisfied because the bleeding would not stop. I developed intense headache afterwards. After this incident, I have developed an aversion towards my husband and I didn't want to share bed with him.

Her jethani said that…

The day she miscarried, from that day she sleeps with me only and refuses to sleep with her husband. Throughout all this, she developed a strong attachment towards me and would not leave me even for a moment. She has developed a fear for her husband and does not talk to him.

Fatima, herself says she will never sleep with her husband again. She adds,

koi fayda nahin hai, sirf nuksan hai [There is only loss in it. There is no benefit.]

Since a village is a very closed space, the matter that she will not sleep with her husband is known to all the households around and who make fun of her, laugh over his husband and everybody tells her that this is something which is not advisable.

Fatima says…

"Having no facility and lack of proper care at the Kupwara CHC cost me 4000 rupees which according to Fatima was very difficult to arrange. After few days when things were under control, I CHC Kupwara dismissed and denied it."

16. Interviewer: Rafia Farooq
Interviewee: Jabeena
Date of Interview:26.02.2018
Place: Drugmullah, Kupwara

Jabeena lives in a house that is entirely made of wood planks. It is an old house where Jabeena lives separately with her husband and three children. Jabeenahas two girls and a boy. She has studied up to class eight. She was married eight years back. Her husband is an embroider. They own few kanals of land which they cultivate themselves.

Jabeena had conceived three months after her marriage. She gave birth to a daughter and it is after one year that she gave birth to another daughter. Jabeenasays that once she gave birth to two daughters, she became desperate to have a son.

"Bei ases nechiv garan. Myane derkakenen che mei doup mei gasse akh ladke asun." [I have a sister-in-law who has daughters. I wanted to have a son.]

Jabeena after giving birth to two daughters again conceived. She had gone to many shrines and prayed to have a son. Everybody had suggested that she should not abort it. It could be a boy. And she felt that it would be a boy. So, she decided to carry it. Everyone in her close relation has just one daughter and the rest had sons. She felt that she too should have sons like them.

> "*Bei gaseha pagal agar ne mei nechiv asehe" [I would have gone mad if I didn't have a boy.] One day when I was in my maternal home for few days, I lifted a bucket of water and moved it from bathroom to kitchen. I felt some pain in the abdomen and I started bleeding then and there. My husband was also around and I told him about it. He said the bleeding is little and you will be alright. I went to the doctor and the doctor gave me some medicine so that the bleeding stops. It didn't stop. Then I came back to my in-law's home. I was hoping that the bleeding will stop but it didn't. I bled for twenty days. In those twenty days, I visited PHC again and again and I told the nurse that I have a hunch that it could be a boy. So, they should save it. But one night when I was sleeping, I found*

myself drenched in blood. The blanket, the mattress and the quilt had blood everywhere. I waked my husband up. I was not able to talk. I just showed him that I needed some help. "*Muhnivis mehez che asan patah totan, zanne keh gasse keh gasses ne." [Till that moment husband don't understand what a wife is going through.]*

I came out of the bedding and went to washroom to wash myself up. Once I reached at the door of the room, a huge blood clot fell between my legs. It was a strange feeling. My husband also in desperation went to call other members of the family. My husband knocked at the door of his brother who lives in the same house and who drives a truck. He told him that they should take me to the hospital. Since it was night and we thought doctors too must be sleeping. There will be nobody in the hospital. So, we waited until dawn and then went to the hospital which is in the village itself. The nurse examined me there and she right away performed D&C as there was lot of tissue inside the uterus and I was discharged. Fortunately, I didn't get any infection onwards. I rested for few days and then I was alright. And after that, I was again left with two girls and I was desperate to have a son. I went to many shrines I should have a son and after a year I again conceived a gave birth to a son. I was very relieved.

Jabeena decided not to have any other child. And husband also does not want to have any child now. Now she has gone to the PHC and where the nurse placed copper-T inside her.

Once I used it didn't suit me. I fell ill. I would get pain in my legs and back and I lost weight also. I turned pale. One day I went to my maternal home and I met a cousin. She got worried seeing my condition. She told me that I am not well. She

asked me whether my husband is good to me or not. I said he is good to me. Then she again told me that something is wrong. I said yes, I have put on copper-T and since then I am not feeling well. She scolded me and said to me I am not an old woman I should not have done this. She then and there took me to a local PHC there and got it removed.

Jabeena wants to have a second son but her husband is not interested.

"I wanted to have another son. I would tell my husband that my son should have a brother but he is not agreeing. He says that we are fine with one boy and two girls."

Upon asking why was she so desperate for having a son, she says…

In villages this is a norm. We should at least have one son. I wonder if I had two girls only how my life would have been. In old age who would have taken care of me. Even though if I don't marry my girls off and bring grooms my home. They will never take the place of a son.

"Panens peth che asana aash, wopras keh wane insane. panun agar pozar wale ya walos te panun che asan panun toti".[*One has still some amount of confidence in close relations. We cannot expect anything from strangers. Even if we don't have good relation with our loved ones. The essence of relations lasts for ever. That is not the case with those who are not related to us]. We have one evidence in the village itself. There is a family who brought girl a groom home. But she stayed there just for one year and constructed a new house. Her parents were left alone forever. Once we become old, we become dependent on our sons. We cannot rely on someone who is not your son. Even if I bring home my brothers' son, he cannot be as loving and faithful as your own son.*

Regarding her husband, Jabeenasays…

> *My husband is supportive and whatever decisions we take; we take them together. My husband loves his girls but I love my son very much. If I had another daughter, I would have died. You ask the local nurse she will tell you how desperate I was for a son. I am sure that if I had another daughter, I would have got heart attack.*

17. Interviewer: Rafia Farooq
Interviewee: Ateeqa
Date of Interview:16.03.2018
Place: Drugmullah, Kupwara

Ateeqa is a resident of Drugmullah. Her maternal home is in Tikipora, Kupwara. She is a matriculate. She has been married at the age of 22 years. It has been eight years that she is married. She has one son. Her husband is a soldier who has recently completed his training.

Ateeqa used to live in a joint family where she had to work a lot. Doctors would always advise her to take rest during her pregnancies but she would get up and do a lot of household work. That is why she had three miscarriages. She had a sister-in-law in the family who would not let her live in peace. Her sister-in-law had been married thrice and she was divorced and would live with her parents only. She was divorced because her in-laws wanted her to leave the job. She says…

> *While living in a joint family, I was the oldest daughter-in-law. I had to carry on with many responsibilities. I could not cope. So, me and my husband decided to live separately. We are now living with a sister of mine who lives in the town of Kupwara. Since PHC is in the village that is why I have come here wearing a*

burkha. So that nobody recognizes me as my in-law's home is in the vicinity of the PHC.

Ateeqa says that…..

It was after seven months of my marriage that I conceived. Once I missed my periods. I went for the pregnancy test. It came out to be positive. The pregnancy was advancing quite well for the first three months but after three months, I started bleeding. I was advised by the doctors to take rest. But I could not take any rest. I had to attend to many household chores. That is why it happened. I went to the doctor after I had a miscarriage. He recommended some medicine for uterine cleansing. Fortunately, I didn't have to go for D&C. I didn't have an infection.

Ateeqa again conceived after five months of her miscarriage.

I again conceived after five months. I had another miscarriage when my feotus was seven months old. It was only two months away to be delivered. Before that I felt something is not right with me and my pregnancy. I went to the doctor. He told me that my pregnancy is not advancing well. But he did not tell me clearly what the issue was. He admitted me to the hospital and delivered seven months old stillborn foetus without any invasive procedure. It was very difficult. Afterwards, I had to undergo D&C as well. I was admitted to the hospital for two days. I bled for three months afterwards. I was exhausted.

Since Ateeqa says…

I had another pregnancy loss after sometime. And that time the feotus was three months old. When I started bleeding, I again felt that it might be a miscarriage. I

went to the doctor and he confirmed that it was a miscarriage. He prescribed the medicine and the tissue inside the uterus got cleared on its own.

Since Ateeqa was facing recurrent pregnancy loss, the doctors had told her it is because she was married to her cousin[48].

When my third miscarriage happened, my husband was away. I was bleeding but I had to do households chores also. One day while I was working in the kitchen, the kitchen sink had a block. I was trying to unblock it, but it was not getting unclogged. My younger brother- in-law was there only. Upon seeing this he got up and hit me on my arm telling me that I have made it messy which is why it is blocked. I held his sleeve and told him why he hit me. He pushed me hard. It was so humiliating. The next day I told my sister about it and she took a photo of my arm and sent it to my husband who was away. My husband told me to leave the house and I went to live with my sister. We are still living there. Now we will buy a piece of land and build a house separately. Although my in-laws have land but we won't ask for it ever. My sister-in- law is causing all the problems. She also provokes my father-in-law and brother -in law against me. It is so unfortunate that those who are close to you do not care at all. But those who are not even remotely related to you help and understand you. He hit me when I was bleeding due to a miscarriage. The next morning, I left the house.

Ateeqa says…

Due to all these miscarriages, I became so weak. I would think that if God gives us hope of a child, then why does he take it back? When my seven-month-old

feotus was lost we all have cried. I kept on crying for days together. But that after a point one has to get up and move on. My husband would console me. He would tell me that, "Ase gasou rozen theek, bache banen beyi". [We should remain healthy. We will have more children].

I talked to Ateeqa, in the PHC where she had come for her check-up as she is again pregnant.

I am seven months pregnant now. This time I took a lot of care. I have done three USGs so far. And my pregnancy is advancing well. We have never used any method of contraception. But this is the last child I am having. After this, I will go for ligation. I have already talked to my husband about it. Since my mother-in-law is not alive. I wish she was alive. She would at least help me. I know mother-in-laws are not easy to deal with but still somewhere I feel that if she would have been alive, she would at least understand my situation. She would help me in one or the other way. However, my husband is good and understanding which is at least a reason to be happy. "*Aki tarafe che asan husband tei ake tarafe sorue duniya..bas khandar gasse asun seht patte chune insan tchenan".* [If everyone is against you, only husband is on your side. Then it doesn't matter what the circumstances are. Everything feels easy and manageable].

18. Interviewer: Rafia Farooq
Interviewee: Rahat
Date of Interview:13.01.2018
Place: Drugmullah, Kupwara

Rahat has been married for three years. After her marriage, she gave birth to a boy who was born one and a half years after her marriage. Her husband is a shopkeeper. Rahat belongs to Bandipora. She has studied up to the tenth class.

She had a lot of complications when her son was born. That day she lost a lot of blood and was taken to Kupwara hospital and from there she was referred to LD hospital Srinagar which is almost a 100 km from Kupwara.

> *Once we reached LD Hospital, the doctor said that I will not give you any assurance to deliver an eight-month baby. It was a very difficult situation for me as my blood group is O-negative. But somehow doctors managed my situation and delivered a baby through caesarean section. "Mei ous sorue paan khoonas manz barith. Bede peth ous khoon rawan"*[*My whole body was drenched in blood. The blood was spilling over the bed]*.

A relative of Rahat who had accompanied her to the hospital says…

> *She was taken to the theatre immediately. She was not even given any uniform to change. She was operated just wearing her own clothes and a farren. The doctors did not give us any assurance that the baby will be delivered alive. When they saw us with baby clothes in our hands, they told us that what guarantee you have that baby will be delivered alive. I told him even if the baby is dead still, we will drape it in clothes. "Agar tich kath te ass ease mah khalone bache kopwore nangay". [We will still wear him clothes. We cannot take it home naked even if baby is not alive]*.

> *And after some time when they called Rahat's name from the theatre, I stood there frozen. I send another person to collect the baby. I thought the baby would be dead. But he was alive. The baby was very weak and very small. It was such an emergency that we collected slippers and trousers of the patient two days after from the out-patient department (OPD).*

After one year only, Rahat again conceived. When she tested positive, she was happy about it. But when she went for USG, it showed that the feotus is not growing well. The doctor advised her to abort the feotus as it was not developing well. The doctor had also told her that she is too weak to carry another baby immediately after the first one.

Rahat says…

> *Labour was induced and D&C was done under anaesthesia. And after that, I fell ill for a long time. And I was charged 7000 rupees. After D&C, I bled for a month. D&C is not an easy thing. It was so painful. Then I was given some supplements by the doctor. And then after one month or so I got my normal period. "Akh safai te sath bache xen". [The pain and discomfort which one experiences during D&C is equal to the pain and discomfort in seven childbirths].*

Rahat says…

> *I had a caesarean when my son my born. It was too early for me to give birth to another child. But we don't use any method of contraception. We have faith in God. He will not send us child so immediately. My husband also does not use any method of contraception. My husband is nice to me. We want two children. When my miscarriage happened, I was so disturbed. "Mei hez gov panisey panas nukhsan." [I lost something of my own].*
>
> *For three months or so I had a hangover of it. I became so weak. Everybody in the village would ask me what has happened to my health. I was reduced to a spine. During my miscarriage, my husband supported me the most. He did not disclose it to his family. He did everything on his own. He told his family that she*

has a uterine cyst and that is why I am taking her to the doctor often. I did not tell any of my family members. My husband also tells me to take a pause and do not work hard because I had a caesarean recently and I have a uterine cyst.

19. Interviewer: Rafia Farooq
Interviewee: Safeena
Date of Interview:22.08.2018
Place: Drugmullah, Kupwara

Safeena lives in Drugmullah.She has been married for 11 years. She is illiterate. Her husband is a labourer. Her first child was born after one year of her marriage. She has two children.

It was a bit difficult talking to her because Safeena had lost her child only yesterday when I met her. She was lying in the bed. I was not comfortable talking to her but she wanted to talk. Yet, she got up and showed a lot of courage and decided to share her experience.

Safeena was pregnant for seven months and everything was going well. She says…

Suddenly, I developed pain in the abdomen and I was taken to CHC, Kupwara. Once I reached there, I delivered a stillborn baby on stairs of the hospital. It was a very painful experience. Something went wrong. During my pregnancy, I went for many antenatal check-ups. Not only this, I have lost another child also when it had come to full term. I don't know why is all this happening to me.

Safeena has had four miscarriages.

I conceive and up to five or six months of my pregnancy everything is fine. Then suddenly I start losing my pregnancy. I had my first miscarriage when I already had two children. After that, I had three successive pregnancy losses, two at nine months (perinatal deaths) and one at three months.

My husband is very supportive. When I had all these miscarriages and losing children every other year. He would take care of me. My sister was also supportive all these years. Whenever I had a miscarriage and would go to a doctor my husband would accompany me. Other times foetuses (although not alive) would be delivered normally. But when my foetus was three months old and I had a miscarriage. I had to go for D&C.

After her marriage that things changed for her. Before marriage, she didn't have any problem like this. She was healthy.

"*Before my marriage, I had good reproductive health."*

Safeena says that…

I have two children only, one son and one daughter. I do not want more children. You see it is not easy for me. My husband tells me often that we should have another son. But I refuse him. All these abortions would not have been there had we used some contraceptives. My husband refuses to use any kind of contraception. He does not allow me also to use any kind of contraception. He says that it is a sin. But now whatever it is, I will go for birth control. I cannot bear more children. My health is not deteriorating and I have become anaemic.

Safeena says that…

Had my mother been alive, I would have shared all this with her. She was very loving. I would find great support in her. But unfortunately, she passed away leaving me alone with all this misery and pain.

20. Interviewer: Rafia Farooq
Interviewee: Shameema
Date of Interview: 07.09.2015

Place: Drugmullah, Kupwara

Shameema has been married for 15 years. Her husband is a labourer. She has given birth to four children but only one could survive out of four. Shameema has delivered a child recently in LD hospital who survived for only a few days unfortunately passed away.

"I am clueless why my children do not survive."

The doctors both in private and in public have not been able to diagnose the cause of the mortality. Her first child was born after one and a half years of her marriage. That was a boy, who survived for 18 months only.

"He got some chest infection and was not breastfed at all because the I could not produce any milk."

After the demise of her son, she had a daughter who survived and is now 15 years old. This delivery took place in the village hospital itself.

"She is the one who somehow managed to survive."

After the daughter, she again conceived and gave birth to a boy who survived for four days and on the fifth day, he stopped breastfeeding and passed away.

"I did not have any child for nine years. I had lost all her hope of conceiving again. I went to a Pir/quack in the village who assured me that I will have a child again."

She conceived after nine years and gave birth to a son. That son too didn't survive. She thought it is because of the normal deliveries of these children that they don't survive. According to her the medicine which they use during the child birth perhaps has done all the damage.

She insisted the doctors to perform caesarean section on her which may help her babies to survive. Now at the time of the delivery of another child the doctors had delivered her baby through LSCS. The child was normal upon delivery. He was kept in ICU on the first day of his birth. But after few days he developed some complications. He was referred to the children's hospital where he passed away after fifteen days.

> *I don't want any children now. I fear that my health already deteriorated will further deteriorate. People around me keep on telling me to try. My husband also tells me that just having one daughter is not sufficient, we should try for more children. I may try again for the child. I am just clueless as to why such mortality happens. Perhaps it is destined to happen. God has decided something for me which I can't change. Having this child after nine years and then losing the child after a period of seven months is very difficult to come to terms with. Yet I continue to live with it and hope for a better future.*

21. Interviewer: Rafia Farooq
Interviewee: Nighat
Date of Interview:27.02.2018
Place: Drugmullah, Kupwara

Nighat was in class 9th when she quit going to school. She was immediately married and just after few months of her marriage, she conceived. Her husband is a labourer. She gave birth to a daughter. When her daughter was one-year-old, she again conceived.

> *I wasn't aware of my conception but when I tested positive, I was distressed. I could not hide my disappointment. Some days later I miscarried and I was so happy that it happened on its own". "I became restless and I told my husband*

that I do not want a second child so early. "Bei chas ne hekan akis watith, wei katte wate bei bikis, weni aes yei leket.[*I am not able to attend to even one child; how can I attend to another. My daughter is very young]*. *But my husband did not agree. He said to carry it. And I carried it up to the fourth month and suddenly in my fourth month, I started bleeding. It happened on its own. I bled like anything. "Mei ous khoon gasan abek peth".[Blood was gushing out like water]*.

She added…

I went to PHC and FMPHW confirmed it as a spontaneous abortion. However, she did not suggest any USG for me. She said since you are heavily bleeding your baby must be gone. She gave me sonme medicine first to stop the bleeding but it did not work. Afterwards, she gave me medicine so that the flow becomes heavier and the tissue inside the uterus is flushed out. Soon, I went for USG which confirmed the presence of RPOCs. I went to FMPHW who performed D&C and got the tissue out. Yet, the bleeding would not stop. I again went to her. She again suspected the presence of some more tissue inside my uterus and I had to undergo D&C once again. The presence of RPOCs resulted in infection. To cure the infection, I had to take medicine. I took the medicine worth 3000 rupees or more. My husband gave me that money. The doctor said that I have lifted some heavy object that might have triggered the miscarriage. He was right as I had washed heavy blankets that day. "Ath hisabas manz chune asan gub tulun".[In pregnancy, you are not supposed to lift the weight as it can cause miscarriage].

Since Nighat was in her in-law's home so she would work routinely without caring that it can have some bad effect on her pregnancy. She could not get any rest after that. And, now she

has again conceived. She is pregnant and this time and she has decided to carry it to term. I have vaccinated myself and I have vaccinated my baby also.

She remarks…

I do not want many children because my husband is a labourer. We cannot afford to keep many children. Although we were not using any kind of contraception that is why pregnancies happened quickly. I think once this child is born, I will go for ligation. I have already talked to the doctor about it. I will also convince my husband about it.

22. Interviewer: Rafia Farooq
Interviewee: Rizwana
Date of Interview:05.09.2015
Place: Drugmullah, Kupwara

Rizwana is married for about ten years. She has three children, two boys and a girl. Her husband works as army personnel. He is posted in Ladakh. So, he comes home very rarely. Besides having three children she has experienced miscarriage twice. Once her foetus was two months old and another time it was one and a half months old. Her in-laws according to her are caring and considerate. Her mother- in-law is very nice to her. She had conceived eight months after her marriage. About her miscarriage, Rizwana narrates…

Everything was going fine. My pregnancy was advancing well. I suddenly bled. I went to a hospital where I was given medicine and it was a confirmed case of miscarriage. After bleeding heavily, I had to undergo D&C. I was in the hospital for two days. Afterwards, I took a rest for some days. I would not sleep with my husband for a long time after this episode.

Rizwana again conceived and was pregnant for two months. She experienced a miscarriage. That was the time when her daughter had fallen ill. Her daughter had to be hospitalized. Since, her daughter was admitted to the third floor of a hospital. Upon climbing the stairs, she had fallen down and that had triggered the miscarriage. She went to a doctor there who confirmed that the foetus is no longer alive. Afterwards, she went to the village PHC where she was being taken care of by FMPHW. Rizwana underwent D&C and was sent home. But her condition worsened after that. She started bleeding profusely. She went to another doctor this time. He referred her to LD hospital in Srinagar. In LD hospital, she had another D&C because she was still bleeding and there was a severe infection.

After two consecutive miscarriages, she gave birth to a son who Rizwana says was born under extreme circumstances…

> *It was with great difficulty that I was giving birth to the baby. However hard I was pushing, the baby was not coming out. Then the doctors used some grip to take him out leaving scars on his face and head. It was brutal and most painful. Now when you see him, he has a bigger head than normal. How unfortunate is that?*

Having two miscarriages Rizwana says pregnancies for her were never easy. She says…

> *I have had two miscarriages. It is very difficult. I would always be scared when I was pregnant. It is difficult to cope up for the first five months of pregnancy. I take medicine to counter the fear and then after five months, I am relieved because then you can feel the baby moving.*

Her life got very busy and complicated once her father-in-law fell ill. He was suffering from cancer. And then for years, they had to take care of him as a result of which their life got affected.

> *We had to regularly take him to a hospital in Srinagar. Our lives also became difficult. Not only that it incurred a huge financial loss but unfortunately, he lost his battle with life. My father- in-law was the main breadwinner of the family and he was also very considerate towards me and my children.*
>
> *Now life has changed for us. We are not in a good financial position. I want to help my family. I am aware that I have my share of property at my maternal home. But I am reluctant to ask for it as it will jeopardize my relationship with my maternal home. If they give me my share on their own, I will take it for sure. Nonetheless, my father keeps on telling his sons that my daughters also have a share of property here.*

Upon being asked why does one need children she said…

> *Having children is a blessing. There are so many worries in this life. "Shuer che kadan insanas daho ghamo. Shuer che insanas asnawan gindnawan." [Your worries are eased and they seem nothing when you have your children around. Your life is filled with fun]. But then having children or not having them is not in one's hands. Before marriage, we don't know what is in store for us, whether we can produce children or not.*

23. Interviewer: Rafia Farooq
Interviewee: Rehana
Date of Interview:22.02.2018
Place: Drugmullah, Kupwara

Rehana is working as an ASHA with NRHM. She caters to the area which is adjacent to the main village Drugmulla called Chailpati and Kumar Mohalla. Chailpati has a majority of the population as Gujjars who as compared to the main village are illiterate and poor. She is a lone ASHA for a population of around 300-400. She says that she is overburdened with work. But ever since she became an ASHA, her financial condition has improved and that has brought some change in her life. She says…

"I can now also fulfil the needs of my family."

It has been more than thirty years that she is married now. She is married in the same village where her maternal home is. She has five children, two sons and three daughters. Her husband is a folk singer and goes to different places to sing in marriages. Rehana says…

My husband rarely contributes to the family. He always has some conflict with his group of singers and lands in a lot of issues. Sometimes they don't pay him. So, I don't rely much on him. He never spends anything on me. I do everything on my own. He rarely visits home. He is away from the family for months together. So, it becomes even more important for me to earn. He has never spent anything on me when I needed it the most. Now that whatever little I am earning I don't ask for any money. I have given up on him. Also, I have kids now who are grown-ups. It would not look nice if I fight with him again and again. Now I have a daughter-in-law. So, I exercise restraint. Rehana has been married at the age of 14 years and it is almost 30 years that she is married. Rehana says she does not know the exact number of abortions she has had in the entire period of her marital life. Perhaps it is more than eight. Just after the two months of her marriage, she conceived and gave birth to her first daughter and when her

daughter was six months, she again conceived. She did not know that she is pregnant. One day she was in her kitchen cooking, suddenly she could feel intense pain. After some time, she started bleeding. Her husband was there but he did not pay much attention to her pain first. She then disclosed this to her mother-in-law. It is when she developed the intense pain, her husband went to a local woman (perhaps a midwife) and called her in. While she was in the pain, she suddenly felt something is coming out and it was a small baby who was not fully developed. She realized that she had been pregnant and she is having a miscarriage. After that, somebody cleaned that space in our house which was littered with foetal blood and tissue. Although I had a miscarriage, I did not get enough rest. I just started working again in just two or three days.

The second time she had a miscarriage in the forest where she had gone to collect firewood.

Once we (other women of the village) had gone to a forest to fetch firewood. We had already toiled enough to collect the firewood and we would collect it by climbing pine trees (which are very high) and cutting the reachable branches. So, once we finished collecting the firewood, we stacked it and lifted it on our heads and were moving towards our home. Suddenly, I developed pain in my abdomen and it was excruciating and I suddenly found myself drenched in sweat. In just a while something fell in my shalwar (trouser). Once I saw it, it was a big lump of flesh and I realized that it is a feotus. It must have been two months old and I did not know that I had conceived. I was shocked. There was a brook nearby where I cleaned myself. I deposited the feotus in the nearby hedge. I lifted the stack of wood and went home and pretended as if nothing had happened.

Rehana again conceived after few months. This pregnancy for her was unwelcome and unplanned. She somehow wanted to abort the feotus, so she tried to find the medicine to abort it. She contacted a woman (acquaintance) from Handwara, (a town which is twenty km away from her place) who arranged medicine for her.

> *These were the days of winter and it was very cold. That time we would not use any medicine for aborting the foetus. It was the first time that I used some medicine for inducing abortion. Once I had medicine, it is after two days that I started to bleed. I bled so profusely that I yelling at my husband. I am telling him that you are responsible for my condition. I felt head of the foetus in my vagina and it got stuck there. I am screaming in pain and I somehow managed to get two firepots (kangri) and kept one on the front side and another on the backside to give me warmth as it was very cold. Whatever money I had that time with me I decided to give that away to a nearby shrine as charity. The moment I did that the foetus fell on the floor and I was relieved. I thought it is two months old foetus but it looked like six months with its body fully developed. Its legs and head were intact. This was after I had already given birth to three children.*

Rehana again conceived and this was the fourth time that she had an abortion.

> *Again, I conceived and this was my fourth time and I am beating my head and screaming as to what happened to me and what the consequences could be. I somehow managed to get the medicine and I took it to abort the foetus. I started bleeding then and there. The entire day, I was bleeding. In the night also the bleeding did not stop and the foetal tissue also came out. Next day we had a marriage in our neighbourhood. I went there, sang songs and danced. I pretended to be normal. That episode ended there.*

Rehana says…

> *After four or five months, I again conceived and this time I did not take any medicine to abort the feotus. So, I gave birth to a baby boy but it was just after eight months that that he became ill and passed away. After that I again conceived and I again aborted feotus using abortifacient drug. I got it from a person who is known to us. He was in our house from his childhood. His brother has a medical shop. So, he told me that he can get it for me. So, once he got it, I took it and I started bleeding and it continued for days together. Then I went to a local nurse who is posted in a PHC and upon seeing my condition, she referred me to Srinagar city hospital. I was in great distress. But somehow, she managed my condition and administered two bottles of saline and performed D&C to clean up. And once I was discharged, she gave me some medicine and some contraceptives. I used them for three months.*

Rehana despite having taken contraceptives from PHC again conceived. This pregnancy was out of contraceptive failure.

> *There was some mistake on my part and I again conceived and this time I feared going to the nurse because I knew she would scold me as I had taken medicine to abort the foetus. I had no option but to see a nurse. She performed D&C on me. She inserted copper-T and it is now for few years that I am fine. But the struggle I had to go through is inexplicable and my general well-being was compromised. I feel ill all the time. In all these struggles and hardships, my husband never supported me. I will never forgive him for that. During this time, I managed these abortions myself. I don't remember exactly the number of abortions I have had. I might have had seven to eight abortions some of them were spontaneous and*

some I induced myself. "Insan chu gasan gunahan manz geer". [Having done all this, I feel like a sinner.]

Rehana says…

Despite having too many pregnancies, going to forest to fetch firewood and then tending to household work would never stop. I would always go to the forest even if it would be the eighth month of my pregnancy.

Every time Rehana had to suffer from an infection due to abortions. And on top of all this, she was abandoned by her husband who would never care about impregnating her. She became pregnant again and again because she did not use any contraception. Upon asked, did her husband know about contraception? She says….

That my husband knew about contraception (condoms) but he always refused to use it. He did not pay any heed. It is when I suffered abortion last time, he started using condoms but upon using them they would rip. The condoms which I got from PHC were not of good quality but now their quality has improved. The last pregnancy and the consequent abortion I had was because of the contraception failure (tearing of condom). As time advanced, I knew that there are various methods of contraception but honestly, I did not have money to buy them at all. I knew that there is something called a condom but did not know about Mala-D.

Rehana's husband has also been involved in an extramarital affair.

He was showing a lot of interest in other women which was so difficult to deal with. But now things have improved a bit. I once saw my husband with the photographs of some lady. He had an affair with his cousin and his parents knew that but they would not stop him. Once my husband was implicated in a case. He

was arrested by police. He was taken into custody and his parents paid the police Rs 35000 to get him out. You know what once you are married off you are so helpless.

"Khandar che asan qabr ye asan Kaden" [Marriage is a kind of grave which one has to endure, no matter what.]

Rehana says that…

If I would have done the same my husband would have left me. Women are sometimes also forced by the circumstances to enter into illicit relationships but what we do is exercise restraint because we know what the consequences will be. And sometimes you need money to feed your children; one thinks of going there but again I restrain myself. I have children who are grown-ups, I cannot do that. It doesn't look nice in the end. If the husband fulfils all the responsibilities of his wife, she will not be forced by any circumstance to do this.

Rehana does not go to her maternal home. She feels she is very busy in her household and cannot find time to go there. Her brothers are settled and she seldom visits them or they rarely come to see her. She has not got any share of property from her maternal home and she will not ask for it. She says that asking for property equals doing cruelty to her brothers. But then she admits that it is her right which is guaranteed to her by the religion.

If they give me on their own, I will take it. But asking for it is something which nobody does in this village because it will offend our brothers and we may end up losing their goodwill and support. Those women who are not that well-settled for them their maternal home does come for help.

Regarding decision making she says…

My husband takes all the decisions and discusses things with his parents. Whatever they decide I have to abide and I accept it.

While wrapping up the interview, a lady from the neighbourhood entered the room, addressing me and saying…

"*Amis che gamech hatte phire". [It (abortion) has happened to her a hundred times.]*

24. Interviewer: Rafia Farooq
Interviewee: Bilkeesa
Date of Interview:27.02.2018
Place: Drugmullah, Kupwara

Bilkeesa lives in chailpati. She has been married for eleven years and her husband is a daily wager. He is attached to a mason and goes to work every day with him. Bilkeesa was born in Trehgam which is a village 20 km away from Chailpati. She conceived immediately after marriage and gave birth to a baby boy exactly one year after her marriage. Bilkeesa has two children; a boy and a girl. Her girl is yet to be in school. Her son is suffering from polio. When her son was born, he was not well. At the time of birth, he was admitted to Children's hospital. He was kept in an incubator for six days.

"I am so thankful to Allah that he can walk himself. I had no hopes that he will walk."

Upon asked whether she vaccinated him, she says…

"Temis hez traye mei polio drops, neche hend viz kare mei thoda laparwahi"[I vaccinated my son and I was always particular in his case. I was a little casual

with my girl in this matter]. I want to send my son to a school which is for specially-abled. My son limps. He wants to move fast. As soon as he does, he falls.

"Iye chenehez toofan". [It gives me immense pain to see him fall.]

"Still, I thank God that I don't have to carry him in my lap. That would have been even more painful."

Bilkeesa had to deal with poverty. Their income was meagre. They didn't have agricultural land or didn't possess fruit orchards. They possess little land which they use for the kitchen garden.

Bilkeesa has experienced three abortions. Two were spontaneous and one was self-induced. Bilkeesa had the last abortion three years before and her memory is still afresh regarding that.

Bilkeesa says…

At that time, we had a marriage of one of our relatives. So, I had a lot to do. That is why I happened to miscarry. The feotus at that time was about four and a half months old. I had to toil a lot those days. We were living in a joint family where you are forced to work. I went to a doctor who confirmed that the foetus is not intact anymore. He gave me some medicine so that whole of the foetal tissue is cleared. Before that, I had one more miscarriage which happened when my feotus was about three and a half months old. My husband was working in the agricultural field and he was lifting heavy logs of wood. I just helped him to lift one of the logs and that actually triggered the miscarriage.

Bilkeesa besides experiencing two miscarriages. Bilkeesa has induced one abortion herself. Upon asking what was the reason for inducing the abortion. Bilkeesa said...

> *My son was just a few months old that I conceived. I got concerned. My son was breastfeeding and I had no support around. And we were not so well off. We had to buy everything on our own. We didn't have land or agricultural produce. That is why I decided to abort the foetus. I went to the local PHC with my child and I pleaded to an employee there to give me the abortifacient drug. He initially refused to comply, then looking at my child (who was very young) he too was motivated to give me the medicine. Once I took the medicine, I started to bleed three days after that and bled for seven days continuously. Then I doubted that all the tissue might not have come out. So, I went to PHC and did uterine cleansing there. There was a threat of infection and then I bought some antibiotics from a local medical shop. And I was fine.*

Bilkeesa has also given birth to a stillborn baby girl. At that time Bilkeesa was at her parental home. Once she experienced the labour pain, she was taken to a hospital. At that time the feotus was moving. But once she reached at the gate of the hospital, the foetal movement stopped. And at the gate of the hospital, the baby fell down and it was dead.

> *"Mei wuch suo panne. Suo hez ase mout drut". [I saw that baby myself. She was very healthy.]*

Bilkeesa says…

> *The doctors at that time said that it was delivered on its own which is a good thing. Had it not been delivered on its own, we had to take it out surgically. The*

doctor did not take any money from us as well, although my husband offered him some. Having three abortions and still birth, I didn't conceive after that. I do want more children but I land in lot of problems. I had three abortions and it is not easy. I would get little rest for just a few days and would again get up to work. It is my parents and my sister who helped me a lot during this hardship. That is how I gathered myself and moved on.

Regarding contraception Bilkeesa says that…

"Question does not arise that we have ever used any kind of contraception. Neither I nor my husband has used it ever."

She adds…

"Mei che maje henz hish kochh". [I have inherited it from my mother that I do not conceive immediately but it takes me few years.]

Regarding contraception, she says…

Although, in PHC they give you contraceptives. But I have never gone there because I have never used any method of contraception. PHC for us is a bit far. If we have to go there at the night, we have to arrange a vehicle. It is far for us because the terrain is not very friendly. If we cannot arrange a vehicle, a patient will simply die. I went to FMPHW and told her that I do not want more children. There I met a lady doctor who has only two children. They could have planned more. And in comparison, my husband is a labourer. How can I keep more children? Lesser children you have still one has to rear them. They should have enough food and clothing. People should not laugh at my children commenting on their attire.

Bilkeesa just after her son was one-year-old says that they had to separate from her in-laws and fend for themselves. She says…

> *That my husband was very poor. He was not able to contribute to the family. My in-laws said that since he is not able to earn anything so he should live separately. It was difficult for us to have two ends meet. I had a one-year-old son who was dependent on milk as it was his only food at that time. My in-laws thought that it is not easy for us to raise him and we would have to face many difficulties but somehow, we managed to bring him up. He would die of hunger had my parents not come to my rescue. My two brothers and my father are government employees. They are well off. So, they would send 1-2 kgs of milk every day for my son. That is how he survived. I have a lot of support from my parents. My mother-in-law has only produced a lot of children without thinking about their well-being (seven children). However, my husband has been nice to me. Why should I lie? He is a good man. We decide on things together. I don't earn myself. I am illiterate. Our father didn't want us to study. He was an honourable man. So, he thought that it is vulnerable to send my daughters to school. I have brothers too who are literate and are now working as government employees. My father would say, "Akis che asan ezath akis che ne asan". When one is bestowed with honour, he has to guard that. I cannot send you school and take a risk.*

Bilkeesa says that…

> *There are both good and bad things about living in a nuclear family. In in-laws' home, there is always a race with sisters-in-laws (husband's brother's wives) about the household work and it gives rise to conflicts very often. No matter how*

much you avoid it. It is the truth that many of the feuds are put to an end once you go nuclear.

About the village she says…

In this village, we don't have reasonable elders. They are very selfish. They want that they themselves should only be benefitted. We have promising young men in the village, but they work mere as labourers. In this village, we have small children involved in drugs and other illicit things.

We go to the forest to fetch firewood. But we ensure that we do not cut trees but we cut their branches. Deodar trees are our children. We value them like anything. Another lady who just joined in said that. Once I cut a small tree mistakenly and I got a headache for twelve days.

25. Interviewer: Rafia Farooq
Interviewee: Zahira
Date of Interview:22.02.2018
Place: Drugmullah, Kupwara

Zahira belongs to Kumar Mohalla of the village Drugmullah. She is illiterate and attends to her household. Her husband is a driver. His income is meagre. It is difficult for them to have two ends meet. She has four children, three sons and a daughter. It has been thirteen years that she is married. Her oldest son is in class seven.

Zahira conceived after three years of her marriage. Her journey of childbirths and abortions started from that. She has a little gap (spacing) between her children i.e 9 months. She had three abortions (two miscarriages and one induced abortion). While she had three abortions, one of her feotus was four

months old and other was three and a half months old and another was two months old.

Zahira had her first abortion when she had already had given birth to three children. A few years ago, once Zahira went to the forest to fetch firewood, she never knew that she will lose her child there in the forest only. Zahira says…

It was raining that day. Once we finished collecting firewood. I stacked it to lift it on my head. There was a log of wood in front of me. I thought since it is raining, I will roll it and keep it away from the rain. The moment I tried to roll it, the foetus, fell down then and there.

"Suo pyou temi vezi wesith, Suohz che khodayas patah." [It just fell then and there. I was in distress, God knows better.]

Upon seeing it I did not scream or cry a single tear. Women have a lot of patience. I endured as much as I could. Everyone says that women are stupid. But no, we are not. We can endure anything and we can endure everything. Men are stupid actually who always are angry with us. After this happened, I bled for about fourteen days. And the irony is that my husband would often come to me and ask for sexual intercourse. I would be so upset with him that I would not talk to him for days. I would not let him for the obvious reason. Even though I would bleed for days together my husband would not care at all. He was concerned about himself alone. He would often tell me…

"Myoon keh koruth". [What about me? (Wanting an intercourse)]

Husbands take us so for granted. They should see us working only. That is what they are concerned about. When you need them the most, they are not around. At in-laws

place also they want just work from you and nothing else. You don't have your mother there who will tell you to stop and heal.

> *"Yeli ne damae loug". [I did not get any rest]*

Zahira says that it is very unfortunate that men do not pay any attention to these things and it is even more difficult when such things take place at in-laws place. What one is required to do is only household work and nothing else. Even though one is bleeding one cannot not stop working.

> *"Ase che lagan huri te pakan." [We pack ourselves with old and ragged clothes(for bleeding) and carry on.]*

The bleeding due to abortion was not stopping. It would have stopped had she taken little rest but she could never do that. She waited up to fourteen days and when the bleeding did not stop, she went to Community Health Centre (CHC) which is in the town few km away. They performed D&C but the bleeding continued for few days more. They also gave her some medicine and she felt a little better.

She again conceived after some time and had another episode of abortion immediately after the first one. This time she was at home. It happened on its own. She was in her kitchen garden tilling the land. Zahira says…

> *"Bei ases khoon khana. Iye che asan khodayas karun. Yemis youn ase yaath duniyahas suo iye, yous nuin ases tmis che newan. Chahe qatal karo amdan ya qasdan". [I was tilling the land and miscarriage happened. It was God's will. Those souls who have to come into this world will come no matter what, and those who do not have to will never make it. Whether you murder someone intentionally or unintentionally in the womb. It is all His wish.*

Zahira was three and a half months pregnant when she miscarried. She was bleeding and it did not stop. She went to CHC Kupwara and had D&C performed. After that her bleeding stopped after twenty-five days.

Zahira had already given birth to four children and her husband had decided that they will not have more children. But she again conceived, when her periods stopped, she was alarmed and went to PHC Drugmullah and had a pregnancy test there. It came out to be positive.

> *I was very disturbed. I informed my husband about it; he did not want any other children. So, he managed medicine to abort the foetus. I also did not want a fifth child. I was already having four and it was difficult to manage the fifth one. I thought I better endure whatever comes into my way rather than bringing another child into the world.*
>
> *"Panenes zoovas karo sakthi".[I will bear it myself.]*
>
> *I took medicine for three days and I started bleeding slowly, then on the third day, everything came out at once. And then I bled for five days. I did not take any rest at all. "Tomen dohan te che wana jungle gasiv"[In-laws will tell you those days also to go to the forest for collecting firewood (laughing).]*

Zahira is living in a nuclear family but her in-laws are living in the same village. She says that in nuclear families one cannot take any rest because there is nobody to take care of children in a such a family.

> *"Doud ase dagh ase atte che pewan wathun te karun. wathan khakhre, khakhre te karan."[Whatever state you are in,whet condition is despite the pain and all, one*

has to get up for work. And yes, husbands do not extend any help. We have to drag ourselves to work.]

Her husband wanted four children and then abortions followed one after the another. After that, her husband started using condoms. But they would not remain intact. They would tear again and again. Consequently, her last pregnancy was the outcome of contraception failure. Before that Zahira did not know what contraception is. She had started using it after her last child was born. Also, her husband refused to use the condoms afterwards.

"Muhniv te gassen manun". [Men should agree using contraception]

Zahira says that …

"Living among in-laws and disclosing things among them is very difficult. Women do hide things. In this concealment, they land in many problems. I have seen many hardships in terms of abortion yet I have never disclosed things to my in-laws."

Zahira says that …

"Myanen wariven gasene patah lagen ki mei che gamech abartion. Panus iye gasse te te gasse".[Whatever happens to me, I will bear that. But my in-laws should not come to know about it.]

She has been told at PHC to go for ligation but she does not agree to it. She is afraid to go for it because her husband does not allow it. Zahira was preparing for surgery those days as she had to go for the removal of the uterine cyst when she was being interviewed. All these episodes of abortion have led Zahirato spend thousands of rupees. She has used only a government facility and has not gone to any private clinic for the treatment.

In the end, she says that …

"Pannnis zuwas che gasan khakhas". [Your general well-being is compromised.]

26. Interviewer: Rafia Farooq
Interviewee: Zohra
Date of Interview:25.02.2018
Place: Drugmullah, Kupwara

Zohra has been married eleven years ago. She has three children. She is 27 years old. Her husband is a barber, hence their income is meagre. That is the main source of income for them. They possess little land. Zohra says….

"We don't have much land. We have little. But I don't know how much it is. We sow maize every year."

Zohra is reeling under poverty. Every day is a struggle for her. She says…

There was a time when my husband would earn as much as a government employee. He would earn 4000-5000 Rs per day but now he earns 100-150 rupees a day and it is very difficult to manage. I check his wallet every day to see his daily earnings. He earns a very meagre amount even if he spends the whole of the time on his shop.

During the period of her marital life, Zohra had three abortions; one was a miscarriage and other two were self-induced. Upon asking what forced her to abort two feotuses, Zohra says that she is very poor and cannot afford to keep many children.

"Myoon khandar anne roupeye duh zenith te bei travak yore shuer". [My husband would earn little money and I cannot afford to produce too many children.]

Zohra says…

Even the son which I have today, I tried to self-induce abortion when he was four months old foetus. My mother- in-law saw the tablets (abortifacient) and she informed my husband about it. My husband was in the forest. She followed him and showed him the tablets telling him to stop me from doing it. My mother-in-law motivated me not to abort it but to carry this baby. She assured me that this is the last child that I will be having.

Zohra says…

I had my first miscarriage when my foetus was forty days old. That happened on its own. After two months, I again conceived and when my feotus was one and a half months. I decided to take medicine to abort it because I had a son at that time who was very young. I didn't want to keep another one. And then I again conceived and my feotus was two and a half months old. I again decided to take medicine to abort it. Again, my child was very young. Not only that I told my husband that I didn't want any children because once I conceive, I fall ill. I get pain in my shoulders, legs and arms. And this pain is unbearable. Since I would be in the in-law's home, I would still get up to work despite the pain. I would wait till my in-law's sleep; I would go and get oil for massage. It was never easy.

For both the abortions Zohra had to undergo D&C. Once she self-induced the abortion, she developed lot of pain in the abdomen. She went to Kupwara and had

her USG done which showed some tissue (RPOCs) inside her uterus. She went to FMPHW for uterine cleansing.

Once I showed USG to her, she confirmed that some tissue is still there. She removed it. I didn't want children. Nobody forced me to take the medicine. I took it myself. I cannot afford to keep children. And that happened in both the cases.

Zohra has faced many difficulties concerning her reproductive health. She says…

"Not only had I three abortions, but I have also given birth to a baby girl only after seven months of gestation (premature birth). It was very difficult for me."

"Mei tul nazre brunhay dode". [Because of an evil eye, I got early labour and she was born prematurely.]

Zohra says…

When my daughter was born. She was not fully matured. She didn't have eyelashes, eyebrows. Her mouth was just a small impression. She didn't have hair or nails. You know how much happiness a woman feels when she becomes a mother. But I would weep for days and nights because I wanted to look at her but I could not. Then my sister-in-law took her with herself and she raised her. And after three months she was still fine. And now she is a grown-up baby and very naughty.

Zohra says…

I never considered using any kind of contraception. And nobody would allow me to do that. My husband also didn't support the idea of birth control. I had to force him. I told him that I do not want any children. He then talked to his mother

about it. I took some injectables and installed copper- T also. But unfortunately, I had an infection in my uterus because of that. I got ill for one month. I did not go to PHC to insert copper-T. I went to a local lady who has some know-how about it. Once my periods were over, I went to her and she tried to insert it but she was not able to place it properly. And for two months, I did not get my periods. I thought may be it is because of copper-T that I did not get any period. But I had no idea that I have again conceived. I and my husband went to Kupwara for USG and it showed that I am two months pregnant and entering into the third month.

"Mi draye aereke chatte. Bei chas wana emi kour akis gareebas khash" .[It sent chills down my spine. This midwife created such a problem for a poor lady like me.]

I told my husband about it. He could not believe that I would be pregnant. And that lady charged me 1500 hundred rupees. You know my husband is very poor. I had forced him to let me go for copper-T yet I became pregnant. Then one of the ASHA told me that why didn't I come to her. She told me that she would have charged me less.

"Pandah shath ropye nee eym tar tukras". [She charged me 1500 for a small piece of a wire.]

After doing USG we directly went to her and told her about it. My husband told her that what would we do now? You had kept her copper -T which has failed, yet you charged such an amount of money. We do not want the money back but tell us what to do now? She was clueless. That is how I thought of self-inducing the abortion.

Initially, when I conceived, I would be totally fine. I would do all the household work on my own. For an entire period of nine months, I would do all the stuff by myself. But since I had all these miscarriages I am not keeping well now. I have pain all over my body, my back aches, my arms and shoulders ache.

Zohra does not use any method of contraception for now. She says that she tried but she fell ill using them. Her husband also does not use any method of contraception. Upon asking what will she do if she again conceives? She says…

I have entrusted that to God. But I do not want any children. Now I and my husband have decided to go for a birth control operation once for all. I have three children now and I think I don't want more children. In today's times, one child is difficult to bring up not to speak of three or four. And then killing children in the womb is a sin.

You know what when my father-in-law came to know that I have consumed medicine for abortion. He didn't talk to me for fourteen days. He said to me that he will call my father and tell him what kind of a sin she is doing here. And then he scolded my husband also and told him that if you do not want any children just go and do something about it and don't kill your children like this. You are killing me by doing this and then we all are becoming sinners. And once you are gone how will you answer your God there and these children will get up in hereafter and question us.

Zohra says…

"You know what, the life of a woman is so difficult and men have no cares. They leave home in the morning and come back in the evening."

Zanne che pewan kechah qabre kadene. Goneth malenich qabr patte warivech qabar patte akhree qabr." [Woman have to endure a lot. Her journey is like enduring three graves. One when she is in her parents' home, another when she is in in-laws home and when she dies.]

Zohra says…

In my in-laws' home, I do all the household chores. I tend to cattle, cook, wash and clean. I am on my toes all day. I always try to keep my mother-in-law happy. I buy things for her. Sometimes I buy fruits for her. Once she fell ill for about a month or so I did all the stuff myself. I would clean and bathe her. Keep her as a bride. And then tending to four cows, goats and then cooking on the hearth. I tie my dupatta to my back and would work. And I would not let anyone feel that I am not well. And after a month when her daughters came to see her, she was angry with them telling them if I was not around, she would have been dead. She told them she is my daughter. You are not. It is how you can make somebody yours. By doing things for them or giving them things. I was loved in my in-laws' home because my husband was an older sibling and me being his wife, we both were loved. I remember when I was married, I was so beautiful. I would tend to the household very diligently. I was very swift and quick; the village people would say…

" noush chakh anmech cherd hish".[They have brought a daughter-in-law who is like a sparrow. Swift and quick.]

Zohra says…

Even if I am not well. I will never disclose that to anyone. I would keep on working. I won't tell anyone to buy me medicine. When everyone sleeps, I warm some water and pour that on my legs. That gives me a little relief. I am not that old; you see but I have developed a problem in my bones. I have become very weak. My mother often buys me fruit to eat. How would I eat myself when I have three children? I cannot eat that alone. Can I? That is why I am so weak.

Regarding the village Zohrasays…

In this village we do not have any facilities. When somebody falls ill it is difficult for us to reach the hospital. Although we have a PHC here but that is in the outskirts of the village. You need a vehicle to reach because the terrain is tough. Even if we manage to hire a vehicle it is only those who can pay can access PHC ad those who don't have anything to pay suffer. We wish to have at least some basic facility like one room and one doctor here. So that we don't face any difficulty.

Besides that, we have a shortage of water here in the village. It is hilly here. The water supply cannot reach here. Now we have a spring in the forest from which we fetch water. But its water level also depends on the winter snow. This winter we won't get much water because it did not snow that much this winter. Our taps run dry during that time. Then we have to walk miles to fetch water. At least water supply should be ensured in this area.

One thing which is good in this village is that while we are free to move, free to go to the forest to fetch firewood and water. Sometimes soldiers also come to the

forest and you know there were those incidents of braid-chopping[49] that time we did not go forest.

27. Interviewer: Rafia Farooq
Interviewee: Zunera
Date of Interview:
Place: Drugmullah, Kupwara

Zunera has been married for nine years. She has four children, three daughters and a son. Her husband is a plumber. They own one kanal of land on which paddy is sown and two and a half kanal of land which is used to sow maize. Her children go to a private school which she takes pride about.

Zunera conceived one month after her marriage and gave birth to a girl. The girl was healthy. After one and a half years she gave birth to another girl. When she had two daughters Zunera again conceived after one and a half years.

Zunera says that...

"Since her children were young, she thought of inducing abortion. She got the drug herself and took it to abort the foetus."

"Dasti aam bache hen. Patte che gasan shuren problem. Bei yeli ne rattan wolei ous kanh."[I again conceived in a short span of time. And then you know other children are ignored. And when you don't have any support. That is why I induced the abortion.]

When I tested positive for pregnancy. I thought to myself what to do. I asked my husband and he told me that I can't say anything about it. It is your own decision.

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I then decided to take medicine for aborting it given that I had to attend to many responsibilities of the household and children. I went to a medical shop and bought medicine for 500 rupees and after three days of having tested positive, I took the medicine and aborted the foetus. I went to a local PHC where doctors suggested D&C. I told them that I had a miscarriage. After that I did USG. It showed that the uterine cavity is clean. But I was again bleeding. I happened to go to Jammu with my sister-in-law. I fell ill there and got swelling all over my body. I had developed infection. My sister- in-law took me to the hospital. They recommended USG. I again did USG and it showed foetal tissue has not been cleared yet. They again did D&C under general anaesthesia and I was admitted to the hospital for eight days. When I was at home, I did many USGs. Each would cost me 500-600 rupees. But in Jammu when they did USG, although they charged me 1200 rupees it showed the actual picture. It took me about 25000 rupees for all this. Once I had an abortion. I did not take any rest. I would move a lot because I thought only then the uterus will clear up. After I took medicine for abortion, I became totally weak.

"Bei ases gamech wawe moor hish. Be ases gamech khatam. Bei neyehas patte maleneniko. Yoot ne dawah khow tyut gov khakhas patte aw mei panche ret beyi bache hene".[I was reduced to a spine. I was exhausted. Then my parents took me home. When I came back from my parents' home. I again conceived after five months.]

Upon asked that why did she conceive just after five months when she recently had aborted the foetus. Zunera says that …

" Muhniven nish cha chalan"[Before men one is helpless.]

Zunera says that I again wanted to abort it but I thought that…

> *“ patte che panesey gasan khakhas”.[It is only me who has to suffer in the end.]*
>
> *I decided to carry it and then I had a son. Having all these issues, I still do not use any method of birth control. I once used copper-T, but I got an infection because of that. So, I got it removed. I have not used any method of contraception. My husband also does not use any method of contraception. But I and my husband have decided that we will go for ligation. When my last baby was conceived. I asked my mother-in-law that I will again induce the abortion. She stopped me and said that don’t you remember how all of us suffered last year when you aborted the foetus. She said to carry it.*

Zunera had a miscarriage (spontaneous abortion) also after her second child. She says that …

> *When my periods got delayed, I became anxious and worried. I went to a medical shop and bought a pregnancy kit. I tested positive. Oh God, it was so distressing. My mother-in-law is telling me what is wrong with me as I looked very worried. I did not tell her anything. It was forty days old. I was so upset. Nevertheless, I carried on with my household chores and went to a well to fetch water. I filled the pitcher with water and as I lifted it on my head, I started bleeding and it continued for days. So, I was relieved as it got aborted on its own. I thanked my stars. I was so happy that it happened as I was not ready for the pregnancy at all. I bled for five days but it was heavy. My husband told me to go for USG after that and it showed the uterine cavity as clear. After this episode, I conceived after three years. That time also I wanted to take medicine and abort it. My natural spacing is two years. Now that I have given birth to a daughter. Before she enters*

the second month I will go for ligation. My husband works in Punjab. His mother called him yesterday telling to come back home and get me operated on (ligation). She said to him…

"Tche chukh malikh. Wale iye ate wucho keh karo". [You are the authority. You come back home and see for yourself. May be you go for ligation.]

Fortunately, I and my husband have a good understanding, and my mother-in-law also loves me a lot. I don't have my mother. She treats me like her own daughter. But there is always a give and take in relations. I also respect her a lot. I have a father who visits me occasionally. But I do not go to my parent's home. I have a brother- in -law who is very caring. He is a teacher. While my husband is away, he takes care of all of my expenses including my children's expenses. He teaches them also.

"Suo chu mei khandar send khote".[He (brother-in-law) is more of a husband to me.]

Zunera says that neither she nor her husband use any method of contraception.

Hearing the stories of people, we were afraid of the side effects. My husband did not use any method of contraception because he has some problem in stomach and for the last three years, he has developed heart ailment also.

"Luku povukh dar". [People frightened me.]

Zunera says that I was so beautiful before these episodes of abortions. I have become weak now.

"bei ases nare trath hish". [I was not only beautiful, I was stunning.]

Zunera says…

> *"I went to my parent's home to take rest after the abortion and when I came back everybody told me that I am looking meek. I was emaciated. But now I want to stop attending to housework and take rest."*

Zunera says…

> *Last time when I was pregnant, we desperately wanted a son, since it is up to God, we had a daughter. We wanted at least two sons. Although all of us know girl are more faithful than boys. I know how faithful daughters are because my father had five daughters.*

28. *A Case of Spontaneous and Induced Abortion*

Interviewer: Rafia Farooq
Interviewee: Ayesha
Date of Interview:26.02.2018
Place: Drugmullah, Kupwara

This is an experience of a comparatively older woman who has been married for thirty years or more. Ayesha is from Diver, Lolab which is 25 km from Drugmulah. She has never been to school. She has been pregnant eleven times, out of which three were miscarriages, one was an infant death and another was self-induced abortion. Eight children, four boys and four girls are alive at the moment. She had all the deliveries at home. All the four sons have studied up to seventh class. The youngest girl is in class tenth. Other girls are illiterate. Her husband is a butcher. He buys sheep from the neighbouring villages and sells meat in Kupwara Town. They have two kanals of land, one for paddy plantation and one for the kitchen garden. Some of her children are doing small jobs and some are not employed. She has been married at the age of 14 years.

Ayesha says…

"Mei aes patah khandar keh che asan , bei ases chalak zabardas. Bei ases sahi chalak".[Even though I was young. I knew what marriage is about. I was very smart.]

Ayesha says…

After two or three months of my marriage, I conceived. I gave birth to a baby only after seven months. It was preterm. The baby was born in the day and it passed away in the night. A village midwife attended to me that time. It was born at home.

"Temi chov ne doud te kihin"[He didn't suckle at all and passed away.]

After that, I again conceived and gave birth to a girl. This saga of pregnancies continued for a long. Besides having eight children at the moment. I had three miscarriages. Those three miscarriages would happen when foetuses would be three months or less. Since we would not care to rest. We would go to the forest to fetch firewood. We would do heavy work. It is not like today that you get rest when you are pregnant. That is why it would happen and after miscarriages also we would work……(laughing). That time we had a joint family. We were thirty-five family members. We would think that it does not matter whether we do household work or not. If somebody has to come into this world, he/she will come no matter what. Nonetheless, having all these miscarriages, one would feel sad.

"Dapan aes khodayan hay suooze, yeth keh gov iye".[I would think to myself now when God sent these children, why would He take them away.]

Besides many miscarriages, Ayesha had also self-induced the abortion because she could not able to bring up many children.

I have self-induced one abortion by consuming abortion-inducing medicine. I had many children you know. It was not easy for me to manage. Once I conceived, the pregnancy was advancing well but I did not want this child. I went to a medical shop and I bought medicine for abortion. I took it. My husband knew about it but my family didn't know about it. At that time also the medicine would be available at the medical shop and was comparatively cheaper. When I had the medicine. I started bleeding. I went to Kupwara hospital when the bleeding was not stopping. They recommended D&C. Since the foetus was about five months old. I saw it. It was almost fully developed. I saw it with my own eyes. When I came back, my husband told one of my daughters to fry eggs for me and give me a plate of rice. Once I started eating it. I could feel that foetus was as if in front of me.

"Iye bache wuch mei zanne palatas manz deede man. Inne kinh ki mei keh pyou sirf yade yout. Mei wuch yei asel peth palaets manz. Bei peyes patte kinne, patte chane mei kunech patehey, suo batte kem khove te keh go".[I could see this feotus so clearly inside the plate of rice. It just happened that I saw it clearly in front of my eyes. It was not an illusion. I saw it. I fell. I fainted. I didn't know what happened afterwards.]

When I came back to my senses. I was totally in distress. I felt guilty. I had committed murder. I am a murderer. God will never forgive me. I am a sinner. The doctor gave me some medicine for clearing the uterine cavity. I did not go for any USG. It was not at all a good experience. After that, I conceived again and I simply carried on with the pregnancy. I did not consider abortion. Not even for a

moment and gave birth to a son. This was the last child I gave birth to and after that, I entrusted myself to God and I did not conceive again.

"Yeli wariyah shuer che asan, patte che gasan insan majboor.hore yeli gareebi te ase."[When you already have many children, one is compelled to take such a step and then when you are poor, you are left with no option.]

Regarding contraception Ayesha says that…

Once a doctor visited my home convincing me to go for ligation. But I did not comply. I was afraid. We never used any method of contraception. Neither I nor my husband used any kind of contraception. I once asked my husband to use condoms. He said to me.

"Mei kar kha gonahgar". [Don't make me a sinner.]

I once also tried having Mala-D for nine months.one has to be very regular with it. It is as important as putting on your trousers. But it would irritate my stomach. I stopped having them. "You know what, you would see many men and women in the village not using any contraceptive because it is a sin to use any kind of contraception."

Since Ayesha and her husband were not using any method of contraception. She ended up having eleven pregnancies because of that she developed a complication in the uterus. And she had to remove her uterus.

"Mei aes gamech bache deen loose, patte paye suo Kaden" .[My uterus had become weak. So, I had to go for a hysterectomy. I was operated in Kupwara hospital in 2014 and my uterus was removed. I was in the hospital for five days.]

"Mardan che ne kanh tensioney. Sirf che zanne gasan kharab. Azze che toti prese gaer". [Men have no such worry. It is only women who suffer. Still, things are better nowadays than they used to be.]

A case of spontaneous abortion and induced abortion

29. Interviewer: Rafia Farooq
Interviewee: Shahnaz
Date of Interview:22.09.2015
Place: Drugmullah, Kupwara

Shahnaz has been married for twelve years. She has four children. She lives in a joint family. She has recently constructed a new house. Her husband is a data operator in the department of education. She is a housewife. She is a young lady in her early thirties. She has studied up to class tenth. Her maternal home is in the same village. It was her parents who arranged for her marriage.

They do not have paddy fields of their own but have some apple orchards.

Shahnaz conceived after one year of her marriage. She has four children, three girls and a son. All girls were born after a gap of two years. She says that after giving birth to three girls. She again conceived. When she missed her first period, she went to the PHC. She did a pregnancy test there which came out to be positive. She became very restless as she did not want to have a child because she was living in a rented house where the landlord was very hostile. She did not want to extend her family where it would not be able to manage her four children. Also, she was busy constructing a house so she thought if she became pregnant it would not be easy to deal with all the engagements at the same time.

"When one has his or her own house one is free to do anything."

Shahnaz says…

I thought when I will have a child, I need my own space without any restriction. I also had the inhibition that my in-laws will mock at me as I am giving birth to children again and again. Having all these inhibitions, I talked to my husband about consuming an abortifacient drug to abort the feotus. My husband did not agree to this first. But I convinced him. And I took the drug and got the foetus aborted. One of the health workers who happen to my friend and a relative arranged the drug. The foetus must have been forty days old. Since it was an early pregnancy cleansing of the uterus was not required. She did not take rest for more than four days because she had not disclosed it to anyone. She adds…n

We would rest but we keep these things hidden from our in-laws and even from our mothers and fathers. We take medicine to abort the foetus and behave as if we have not done anything. So, we can't take a rest. We can only rest for few days and not for longer periods.

I also thought that now we are again living jointly and one of my brother- in-law's will also be married soon. It will not look nice if I conceive again. Because now it is her sister -in-law's time to give birth to children, not mine.

She again conceived after some time because the couple would not use any method of contraception. Once the foetus was four and a half months old, she had a spontaneous abortion. That day it had snowed and I had gone to fetch the water. I slipped on the ice along with a bucket of water that perhaps triggered the miscarriage. Initially, I could feel some water coming out. I called my husband who told me not to move and stay where I was. My husband went to the doctor himself and brought the doctor home. The doctor examined me and said that the

foetus is fine. It will not miscarry. Since I was resting owing to the miscarriage. I took a rest for four days. On the fifth day, I told my husband that I have pain in my abdomen. I got up and went to the washroom. Once, I entered the washroom, suddenly the whole foetus came out at once in my pyjamas. There was a huge bang like noise in my ears and at once the whole of the fetus fell. I fainted and found myself on the floor of the washroom.

After a while, my husband came to look for me. He called the landlady to help me get into the room. The next day morning my mother came and she examined the fetus and it was a boy. We had not discarded the fetus yet. It was so painful to know that it was a boy. I was awake all night crying. The next day morning we went to the doctor. He suggested USG and fortunately, it showed the cavity as all clear. I saw the fetus. It was very beautiful. We buried him.

Temi doh fyoor mei tooti. Asi ous wuchumut ath baran manz khwab, suo drav pouz.

It was a very difficult day. Whatever happened to me, both I and my husband had seen a dream about it. It came out to be true.

It is just a few years now that we are not going to fetch water from a distance. Otherwise, we would travel long distances to fetch water. In a single day, we would get 20-25 buckets of water. It was so difficult. And then I would wash blankets and quilt covers very often. And for the last two years, my back is really bad. I have two weak discs in my back.

Since Shahnaz had three girls. She was desperate for a boy. She again conceived and a saint had told her that this time she will give birth to a baby boy. He had

told her that she will give birth to two sons. One boy, will not be able to take and the other will make it to the world. She had pleaded to God to send her a son. She had also sent her mother- in -law to Ajmer (which is a Dargah of Moin-un-Din Chesti) to tie the thread in order she has a son. Finally, she had a son who is now very tough to handle according to Shahnaz.

She says,

He fights with everyone and beats his sisters too. He does not go to school. He was bitten by dogs and taken away by them. He does all this because he is too pampered. He is a grown-up boy now but I still breast-feed him. I am always following him. In our clan, there are more girls and fewer boys. We all siblings and cousins have three to four girls and one son each.

Shahnaz does not want any children now. She is done with her family size. But she or her husband does not use any of the methods of contraception but still gets periods every month. She says she may have a thyroid problem which is why she does not conceive. Upon telling her what will she do if she again conceives, she says she will see to that.

Upon asking why don't use any contraception? She says she has no answer to that. Shahnaz says……

That I tried to use copper-T once but I got severely infected because of that. I developed puss and then I went to a local midwife and had that removed. She had to try hard to locate it. Sometime before I had no periods. I was happy.

Mei doup balai gaye dafa. Bei bache.

I thought to myself that the worst (periods) is over. I am fine without it.

Now my periods are on time. But we don't use any method of contraception. I don't even conceive. Doctors say that I have some hormonal imbalance that is why I don't conceive. But I am sure I won't conceive. And even if I conceive it will be an embarrassment because my daughter is already in class eight.

Men do not agree to use any kind of contraception. I once told my husband to take a contraceptive pill. He did not agree. I know there is a medicine which is mixed in water and it is given to men. Its effect lasts till six months. It was easy to give him that in a glass of water. But I still thought that I should first talk to him. I once told my husband about it. He said don't ever think that I will take that medicine. Why should I take it? Although he is working in the education department. If there would be some doctors who would make men understand that it is wrong not to use contraception, it will at least make some difference.

Muhniv gasen asen samajdar

Men should be understanding.

You know what I have no interest in keeping any sexual relation with my husband. I wish I never sleep with him. I go to my husband twice a month or less than that. I get very uncomfortable. And it is very painful for me. Me and my husband often fight over this. When my last child was born, it started from that. My husband tells me

Bei anen kanh hanth, suo te thavan te tche te thavath

My husband tells me that I will marry someone who is barren (for intercourse) and I will keep you as well.

I also went to a doctor. He told me 80 per cent of women in Kashmir face this problem. He gave me medicine for 25 days worth 2500 but there was no difference.

A case of neonatal mortality

30. Interviewer: Rafia Farooq
Interviewee: Sameena
Date of Interview:
Place: Drugmullah, Kupwara

Samina had given birth to six children and out of six children, only two are surviving.

Once I was married, I conceived after five years. I was very joyous. I had a baby girl who was born prematurely at eight months. She survived for some time and then passed away. I had another conception after a year. I gave birth to a boy after few days lost him too. And then I lost another child who was born at seven months. He was alive for a night and passed away. Then I lost another child last year only. When he was born, he survived for one night only and he too passed away. This is all because of hypertension. I have another problem that my blood group does not match with my husband's blood group. It is very difficult for me to lose children like this and cope up with such a loss.

Having experienced such a loss, I decided to go to a saint. The saint restricted my movement and didn't allow me to visit my parental home. We have a shrine near my parental house which is always hovered by spirits. The saint said that you could have a negative effect on the spirits and it can harm your baby that if you go there who had restricted me going to maternal home during pregnancy. I went there in the ninth month of my pregnancy and suddenly I felt pain in the abdomen

there. I informed my husband and he came and took me to the hospital and I delivered a baby boy. But he just survived for one night and passed away.

The Mother-in-law of Samina also joined and said that she lost all four children because of her carelessness. The saint had prohibited her not visiting her parental home but she did not listen to him and ended up losing all these children. Her mother-in-law said…….

She has done the same thing time and again. She should listen to her mother-in-law at least. I am not her enemy. I am concerned about her welfare too.

Samina's sister-in-law also joined and said….

That it is a mistake that she does not seek our help. She does things on her own. To which Samina replied that I cannot bother you again and again. You are busy with your household and stuff.

Samina says that,

It is not only me who takes decisions regarding my reproductive health of mine. My husband and particularly my mother-in-law do that. My mother-in-law wants that me should have another child. I considered going for ligation many times but I am not able to make up my mind. I think that I should have at least one son and one daughter. Then only my family will be complete.

Samina replying to her mother-in-law says that…

She is free to say anything. We live separately from them. We are just four family members. My husband is a labourer and he goes in search of work in the morning and comes back in the evening. So, I have to attend to the household all alone.

Even I have to get rice from the rice store. So, I keep on working even if I am nine months pregnant. And every doctor suggests I take bed rest but I cannot do that. I have to attend to so many things.

I have lost four children and it is very difficult to reconcile with it. I have just two children now. I wish their health and well being but I do want more children but I am scared because you know it is not easy. Every time I think of having another baby I think of my health. I have a severe problem with hypertension. That is why my children do not survive.

I went to a saint from whom I got an amulet for spacing. And it worked for me and for the last one year I did not conceive. It has a risk but right now I am not tensed.

Right now, we are using a method of withdrawal and my husband is agreed to that.

Group Discussion
Place: Drugmullah
Participants:5
Age: Below 30
Topic: Contraception

Question: How particular are men and women about the use of contraception and spacing?

In Drugmullah, it is only women who are concerned about spacing between children. Men are not that concerned about birth spacing. Women after giving birth want to space their children but most often itrs that women get pregnant after a short interval of time. Unwanted pregnancies are very common in Drugmullah according to one of the participants.

One of the participants said, *that after I gave birth to a son, I did not want another child immediately. I went to the PHC and got Mala-D tablets for me and would have them every day almost for ten months. I became weak and frail. It is said that having oral contraceptives reduce your blood volume.*

Since, I had a love marriage and my parents were not happy with it. And it is during those days that there was a reconciliation and my parents let me come my home. Since, I was there and my husband was not with me, so I did not take pill those days. But after few days my husband was also invited by my parents and he complied. Once he came, we had a contact and it resulted in pregnancy. Since I had already a child who was just six months old. I was totally out of sorts.

When I missed my period, I bought a pregnancy test kit and it showed positive and I informed my husband about it. He too was worried and then we decided not have the second child so soon. Since, these days the medicine for abortion is not readily available, it was very difficult for us to buy it. My husband went to Sogam which is a far-off village and managed to get the medicine.

By the time I had the medicine I had already been to husband's home. I without informing anyone took the medicine and I started bleeding just after one hour or so. The bleeding was so intense, that I was barely able to walk. Since I had not disclosed it to anyone, so I behaved as if I am fine and I would do all the household chores including fetching water from a tap which is very far. That day I cleaned the entire courtyard. Although, my mother- in- law is an Asha. I did not even disclose it to her. And after a day or two, she saw blood spilled at many places, she understood that I have induced abortion. She scolded me and took me to PHC where FMPHW also scolded me. Since I had developed intense pain in

my abdomen. She examined me and said that I need DNC. She took me to her home and performed it there. She gave me some medicine also, I bled for almost fifteen days. I felt very awkward because men in the house also came to know about it later when I got ill. That was the worst time and then I decided to do something. So, I again went to the PHC and had copper-t inserted. It has been seven months since then I am relieved.

Question: Why don't men use condoms and women have to bear the consequences?

One of the participants said that, *If I tell my husband to use a condom, he will throw me out. Men do not use condoms because they do not like to use them. And even if men use it, they don't dispose it afterwards. We, women, have to do it and that is a burden because every time you have to look for a place to dispose it. It is not easy. One of the families had disposed of it in the open and children playing outside sighted it and they filled it with water and then carried it through the whole community and when elders of the village came to know about it, they came to the house where children had picked it up and scolded the family. They had to face a lot of embarrassment in the community. Similarly, one of the family would flush it off in the commode and they ended up blocking the drain. They had to get workers to get the trench open and once they saw it, the blockage was due to condoms which is why it is not easy to use because there are issues of disposal.*

Another lady also narrated that how she didn't want to get pregnant. She had medicine and got the foetus aborted. She says that…

I had conceived immediately after my first child. It was worrisome as to how can I take care of two young children. Once I informed my husband about it, he

suggested me to induce an abortion. Those days medicine was readily available in the market. My husband got the medicine for me. Once I had the medicine for abortion, I started bleeding like anything. Since, I was in my in-law's house I could not tell them anything. When things got out of control and I was bleeding profusely, I went to the attic of the house. I made a bed for myself and laid there. Everyone is looking for me. My mother-in-law found me and told me why I am there. I said I am just resting because I am not feeling well. I also expressed little anger that I have to work a lot and nobody comes for help. Since, my husband knew. We made a little plan. I told him that we will pretend to be angry with each other and I will go to my parent's house on this pretext only. He agreed and told his mother that I am not a good wife. I don't need her. Let her go wherever she wants. And in that, I gathered my stuff and went to my parent's house. I stayed there for a week till I recuperated. Then I came back to my in-laws house when I was well. This is how it is. When you are well you are needed at in-laws house and when you are unwell they send you to your parents.

Question: Is reproduction only a domain of women?

In this village, we women do everything on our own. We will tell our husbands to accompany us but we will do all the things on our own like going for USG, getting medicine etc. Men in this village are least concerned about women. It is women who have to struggle every day. Another lady who has just delivered a baby said that I don't want another pregnancy immediately. I want to wait but my husband would not use a condom for spacing because he would not enjoy the intercourse if he wears a condom.

So, this participant was insisting Asha help her to go for three monthly injectables called Antra. However, the ASHA told her that will not suit her. Sometimes you don't get your periods because of that and sometimes bleeding does not stop for months together. She was not able to decide which method of contraception is good for her.

An Interview with an Elderly Woman

How do you look at abortion in today's times and how is it different from then?

In today's world, things are different. Women of this age cannot work as much as we could. In the day, I worked in the field and the kitchen garden. I sowed vegetables. And then in the night, my daughter was born.

I had one abortion. Very long back, I remember that time we were constructing a house. We were laying plinth and it was stonework. I lifted a very heavy stone. I started bleeding profusely. It did not stop. I was taken to the hospital. For two days I bled like anything. And with that, my baby was gone. That time, I was almost dead. I became weak. My husband told me that time to look into the mirror and see what has happened to me? And then I was taken to Kupwara for D&C. Oh God, it was so painful.

Bei chas wana khodah diyen najat temi safai nish. Bei karnevhas woker woker, bei gayas khatam, patte keh draye ne mei suo krath kinh. Bei ases tich asel. Kanh waneheyne mei che panch shuer.

That was such a horrible experience. I was screaming in pain. That experience still haunts me. I have not forgotten that. I was so beautiful and radiant. Nobody would guess that I have five kids. But now I have lost all my beauty and youth.

Did you feel bad about it?

Mei aes khodayan suoozmet shuer dah dar dah. Bas paninisey zuwas gov azab.

No, not at all. I did not feel bad about it because God had sent me a lot of children. The only thing that happened was that my general well-being was compromised. I have given one girl in adoption to my sister-in-law who does not have any child of her own. She must be 19 years old now.

Yore peye suo thane, who aye te neyesn, yore weches bei keem karne

The moment she was born, my sister-in-law took her, and then I started my routine work.

Did you have a healthy pregnancy?

Yes. All my pregnancies were healthy. I remember the day when I delivered a baby boy, I lifted a big basket of wood. It was difficult to lift it. My back got bent because of its weight. And then there came a man who offered his help. But I declined and I was quite able to carry it myself and that time I was seven months pregnant.

How often would abortion take place among women in your mohalla?

Teme sath aes ne abortion gasan. Aze chu waqt kharab. Haya ous , sharam aes

That time even if we toiled a lot, abortion would not happen. We are now living in bad times. At that time women were humble and modest. That is why abortion

was rare those times. Today if there is a little hiccup, abortion happens. If there is a slip in the kitchen abortion happens. It would not happen like this in the past. Women were quite strong. There was a time when nobody would go for an abortion. Yes, there were hospitals available at that time when we were young. Nobody would do that on its own. There was a lady in the village who do abortions. It was very easy to give birth at that time. We would work in the day and then would deliver babies in the night. Also, in today's times, it is difficult for women to conceive. Women these days don't work much and have a sedentary lifestyle. There are problems related to the thyroid. My very young daughter has developed a problem. Her periods are yet to come. She is gaining weight also. She has already started developing a problem.

A Talk with ASHA

11 women in the village take condoms from me, 13 take Mala-D, 5 take i-pills. And most of the women in this village use copper-T. There are older women also in the village who use copper-T. When a woman dies, and then at the time of holy bath, one has to remove copper-T.

There is a lot of difference in the approach towards reproductive health in villages as compared to cities. In the village whatever happens to women, they just endure it and do not let anyone know about it. For example, however painful our periods are, we will keep on working. We will have no choice. There is a woman from the city. She is married in this village. She once had an abortion and then her father came to see her. She revealed everything to her father. And her father would listen to her. We all were surprised. Even if we are writhing in pain, we would still get up to work. This is the story of every village woman.

Mei che asan pain wariyah, bei chas pewan marnas, magar bei khalene shah ki ki mei che doud

I have a lot of pain. It is so difficult to bear but I will not utter a word and carry on as my usual self.

Similarly, when we are pregnant, we reveal that to nobody. None of the family members would know. It is only when our tummy comes out, our family would know. We would only share with our friends. Since we don't reveal anything to our family. We behave normally, as a result, we would carry out our routine work. Not only that, up to nine months of our pregnancy we would work. Do every chore. Wash clothes, lift heavy things, Clean houses, fetch water from the public tap, fetch firewood from the forest etc.

But when I see my sister-in-law (brothers' wife) she is still having a better life in terms of finding time to rest and pause. That was not the case when I was of her age. Her mother-in-law (my mother) fetches water from the well herself. She does not let her do it.

Also, when somebody opts to go for induced abortion. She will quietly endure it without sharing it with anyone. She will behave as if nothing has happened. She will eat whatever other family members will eat. She will not take the warm water because her family may suspect something wrong.

A Talk to a Midwife

Begh Apa is a midwife in the village of Drugmullah. She is an elderly lady who has a lot of experience of attending childbirths. Begh Apa says that at first, she

had no experience at all. However, she remained an apprentice to another midwife in the village. That is how she has learnt to deliver babies.

Initially, I was not skilled to handle childbirth. My daughter was pregnant, and it was her delivery time. I went to the forest to fetching firewood. Once I was back, I told my daughter to give me food. She said she cannot because she was in immense pain. Since I had little experience dealing with such cases. I told her not to worry. I will attend to you. Since her husband's house is in the same village, I called her mother-in-law and told her to help me in delivering the baby. I was waiting for her to come but she did come on time. Then I decided to do it myself. Taking the name of Allah, I went ahead to deliver the baby. I had no equipment and I had no medicine. I had just faith in God. I delivered the baby and I delivered the placenta as well. Thank God everything went well. The moment I was done, her mother-in-law entered the room. I scolded her a lot because she came very late. She told me that she had a lot of confidence in me that I could deliver the baby. It was this incident that gave me confidence and I became the midwife of the village. Midwifery is the magic of fingers. You should know how to use your fingers in gauging where the baby is. Is the baby in the upright position? How long will it take to deliver a baby? All this is measured by fingers. So one should know how to use them.

When asked how many deliveries she must have attended, Begh Apa says……

I might have attended to so many deliveries. I think I must have delivered children of two mohallas, one where I live and the other which is adjacent to this mohalla. I have almost delivered every baby in this area. Now it has been a while that I do not attend deliveries because now once a pregnant lady feels labour

pain she is taken to hospital. In hospitals, there is no modesty. You have to be open to male doctors and that is a matter of shame. And at home, we take care of that. Not even a female attendant is allowed to come closer to the pregnant lady. And while the delivery is taking place she is being covered in a big quilt so that nobody sees her.

What equipments would you use to deliver the baby?

At that time no equipment would facilitate delivery. I would carry a sharp knife with me which is still in my pocket. I would use that to cut the placenta. There was no question of administering any kind of medicine. Nowadays, also I do not carry any instrument with me even if I go to conduct a delivery.

How would you manage during the period of militancy to go out at night, if you had to?

During the peak of conflict here in Kashmir, it was so difficult to move from one place to another place at night. But what could one do? When somebody would come in the night to call me to attend the delivery. I had to go.

Once a person came to call me as his wife was in labour. As we were walking towards that house, we were stopped by army personnel. They told that person to leave and I was left alone with them. They started questioning me. Since I could not understand their language, I was trying to make them understand. After a while they let me go and once, I reached the home of a lady to deliver the baby, everyone was scolding the man who had left me alone. I have come to understand that there is nobody who can harm you if you have faith in Allah.

Would you ever deliver pre-mature babies?

Not only would I deliver full-term babies, but I would also deliver babies who had not completed their term. I remember once I delivered a baby which was 4 months old. I delivered that. It was a dead baby with impressions of eyes, nose, lips etc. I remember the death of a baby as well. That lady told me that because of the lightning at that time. Something had happened to her. So, once I delivered a baby, it was dead. It was not that easy to deliver a dead baby.

Do you help women in carrying out an abortion if they request?

I don't do such stuff. Even if somebody comes to me for the same. My advice would always be to carry the baby to full term. I also accompany pregnant ladies to the hospitals and I help doctors also. I have a good rapport with doctors also. There have been few cases where the baby was difficult to deliver because of its position. Then those cases would be sent to the hospitals and I would accompany them. I also tried to help doctors in the hospital. The doctors request me to come to the hospital and help them. They promised me 900 rupees also but because of family engagements, I cannot attend the hospital. (Drugmullah Dated:15.06.2018)

APPENDIX-B

Interview Guide for in-depth interviews

I: Socio-demographic characteristics

1. Name:
2. Age:
3. Residence:
4. Village:
5. Mohalla:
6. District:
7. Caste:
8. Occupation:
9. Husband's Occupation:
10. Income of the family (From all the Sources)
11. Land Holding
12. Education

II: Marriage

1. What was your age when you got married?
2. Did you choose for yourself or did others choose for you?
3. Were you happy with your marriage?
4. Does life change after getting married?
5. How does it change?
6. What aspirations did you have about marrying?
7. Can you tell me the difference between pre-marital and post-marital experience?
8. How comfortable do you feel in a new setting?

9. Are you treated the way you like?
10. Are you part of the decision making in the new family?
11. Before going anywhere or doing anything, who do you take permission from?
12. Who is the prime decision-maker in your family and why?
13. Do you have any property on your own?
14. Did your father give you the due share of the property or will he give it anytime in future?
15. Will you take that property? If so, why?
16. Do you have any children? If so, how many do you have?
17. Do you want to limit your family size?
18. What method do you use to limit?
19. Is that method convenient and successful?
20. Who decided to limit the family? You or your husband and why?
21. Can you negotiate with your husband on such issues?

III: Pregnancy Loss as a Social Process

1. When did you come to know that you have conceived?
2. Were you happy that you were pregnant?
3. Whom did you tell first that you have conceived?
4. Was he/ she happy?
5. Who was the most supportive during your pregnancy?
6. After how much time did you conceive after marriage?
7. How many times were you pregnant?
8. Did every pregnancy result in live childbirth?
9. Did you have a spontaneous or an induced abortion?

   Spontaneous ……. Induced……..

IV: Spontaneous Abortion (Experience in Terms of Health Service Access)

1. Reasons for miscarriage according to the respondent?
2. Reasons for miscarriage according to the doctor?
3. How many months were you pregnant?
4. Had you seen a doctor anytime from conception?
5. How many times did you see a doctor?
6. Did the doctor warn you of a probable miscarriage?
7. Where did you seek healthcare (Private or Public)?
8. How far did you go to seek healthcare?
9. Did you feel any difficulty going there?
10. Who accompanied you to the doctor?
11. Did you see a male or a female doctor?
12. Whom do you feel more comfortable a male or a female doctor?
13. Did they treat you with the same sense of urgency?
14. How did doctors talk to you? How was their behaviour with you?
15. How long were you kept under supervision?
16. Did they go for D&C?
17. When were you discharged from the hospital?
18. Did you get an infection afterwards?
19. Did you get the free medicine?
20. Who accompanied you to a doctor?
21. How much money did you spend on this episode of miscarriage?
22. Who paid the money?
23. Did you get any counselling from doctors about spacing and reproductive health?

24. Did you visit some quack/pir during pregnancy or when you had a pregnancy loss?
25. Did you have any pre-marital problems related to your reproductive health?

V: Experience in terms of physical and emotional pain in Spontaneous Abortion (Miscarriage)

1. Who was at home at the time when you experienced a miscarriage?
2. Whom did you tell first?
3. How did you feel when you had a miscarriage?
4. Did you feel any pain?
5. Could you sleep well that night?
6. How long did you feel the pain of a loss?
7. Did you cry when you had a miscarriage?
8. How long did you grieve (cry, weep, and moan)?
9. Who was there with you all the time you were going through the feeling of loss due to miscarriage?
10. What would give you respite once you were in pain?
11. When did you resume your work?

VI:Induced Abortion and Health Service Access

1. Did you go to the doctor when you were pregnant?
2. How was the pregnancy (normal or complicated)?
3. Reasons for the induced abortion?
4. Who told you first to go for it (Induced Abortion)
5. Did you decide on your own?
6. How many days/ months pregnant you were?
7. Did you induce it yourself? If so, how?
8. Drugs/ other methods

9. How are the abortion-inducing drugs available?
10. How was the behaviour of doctors towards you?
11. How much money did you spend on the episode?
12. Who paid the money?
13. Did you know the sex of the foetus?
14. Did the doctor give you any indication that you have some complications?
15. If yes, what did you do?
16. Did you take medicines?
17. Did you go for a check-up?
18. Did you go for ultra-sound?
19. Which health facility did you go to (Public /Private)
20. How far did you go and how many times?
21. How long were you admitted to the hospital?
22. Did you go for D&C?
23. Were you treated with a sense of urgency?
24. How was the behaviour of doctors towards you?
25. Did you feel any difficulty going there?
26. Were all the equipment available there?
27. Were you admitted to the hospital?
28. What was the total amount you spent there in the hospital?
29. Once you were discharged from the hospital did doctors counsel you about contraception?

VII: **Emotional Experience of Induced Abortion**

1. Did you want an abortion?
2. Did anyone suggest/insist you go for an abortion?

3. Was it your decision alone or was it a joint decision of your family?
4. Did you keep it a secret or did you tell anyone?
5. If so, whom did you tell first?
6. What was it like? How did you feel?
7. How did you feel when you had to induce an abortion?
8. Did you feel any pain?
9. What was the nature of pain?
10. Could you sleep well that night?
11. How long did you feel the pain of a loss?
12. Did you cry when you induced abortion?
13. Did you grieve?
14. How long did you grieve (cry, weep, and moan)?
15. Who was there with you all the time you were going through the feeling of loss due to abortion?
16. What would give you respite once you were in pain?
17. Whom did you feel most comfortable to be with?
18. Did you have any reproductive health issues?

Appendix-C

Reproductive Health and Healthcare Utilization Survey of Women of Village Drugmulla, Kupwara, J&K

	I. **Socio-Demographic Characteristics of Respondents**	
1.1	Name	
1.2	Caste	
1.3	Age	
1.4	Social Category	1. General 2. SC 3. ST 4. OSC 5. Others
1.5	What is your economic activity?	1. Housewife 2. Govt Employee 3. Private Employee 4. Construction Labour 5. Agricultural Labour 6. Other
1.6	What is your husband's occupation?	1. Construction Labour 2. Agricultural Labour 3. Govt. Employee 4. Private Employee 5. Any other (Specify)
1.7	Annual Income	1. 0-20,000 2. 20,000-30,000 3. 30,000-50,000 4. 50,000-75,0000 5. 75-1,00,000 6. 1,00,000 and above
1.8	Education	1. Illiterate 2. Primary 3. Middle 4. Under Matric 5. Matric 6. Graduation 7. Post- Graduation 8. Post Graduation & Above

1.9	Land in Kanals	1. 0 2. 1 3. 2 4. 3 5. 4 6. 5 7. Please Specify
1.10	Do you live in a nuclear or a joint family?	1. Nuclear ( ) 2. Joint ( )

II **Marriage (Married Women)**

2.1	At what age were you married?	1. 13-17 years 2. 18-25 years 3. 26-30 years 4. 30& above
2.2	Who chose the groom for you?	1. Yourself 2. Parents 3. Relatives 4. Friends 5. Others
2.3	How long have you been married?	1. 1-5 2. 6-10 3. 10-15 4. 15 & above
2.4	Are you happy with your marriage?	1. Yes 2. No
2.5	Do your in-laws treat you well?	1. Yes 2. No
2.6	Does your husband treat you well?	1. Yes 2. No
2.7	Who takes care of your financial needs?	1. Husband 2. In-laws 3. Yourself 4. Parents 5. Any other (Specify)

III Pregnancy and Health Service Utilization

3.1	Do you have your regular cycles?	1. Yes 2. No
3.2	Do you have/had any complication in your reproductive system?	1. Yes 2. No
3.3	After how long, did you conceive?	1. Within one month 2. One-three months 3. Three-six months 4. Six months to one year 5. 1 year 6. 2 years 7. 3 years

		8. 4 years 9. 5 years 10. 5 &Above
3.4	Was it a planned or unplanned pregnancy?	1. Planned 2. Unplanned
3.5	Were later pregnancies planned or unplanned	1. Planned 2. Unplanned
3.6	How was the feeling when you first conceived?	1. Happy 2. Sad 3. Angry 4. Any other, specify
3.7	Of all the pregnancies how many were normal and how many CS?	1. Normal ( ) 2. CS ( )
3.8	What was the nature of complication, if any, due to CS?	1.Infection of endometrium 2. Post-Partum Hemorrhage 3.Adverse reaction to anesthesia 4. Deep vein thrombosis in legs or pelvic organs 5. Wound infection 6. Surgical injury to bladder or bowel (Mayo Clinic) 7. Any other (Please Specify)
3.9	How many children do you have?	1. Zero 2. One 3. Two 4. Three 5. Four 6. Five 7. Six 8. Seven 9. Eight 10. Nine 11. 10 and above
3.10	What is the average gap between (spacing) your children?	1. 1-2 years 2. 2-4 years 3. 4-6 years 4. 6- 8 years 5. 8-10 years
3.11	How many girls do you have?	1. 1 2. 2 3. 3 4. 4 5. 5 6. 6 7. 7 8. 8 9. 9

		10. 10
3.12	How many boys do you have?	1. 1 2. 2 3. 3 4. 4 5. 5 6. 6 7. 7 8. 8 9. 9 10. 10
3.13	What number of children is ideal for you?	1. 1 2. 2. 3. 3 4. 4 5. 5 6. 5 & Above
3.14	Did you prefer boys over girls and why?	1. Yes 2. No
3.15	Where did you have your deliveries?	1. Home 2. At health workers home 3. Primary Health Centre (Drugmullah) 4. Primary Health Centre (Chogul) 5. Community Health Centre (Kupwara) 6. Private Facility 7. City Hospital (LD)
3.16	How many deliveries you had in the hospital?	1. 0 2. 1 3. 2 4. 3 5. 4& above
3.17	How many deliveries you had at home?	1. 0 2. 1 3. 2 4. 3 5. 4& above
3.18	During your pregnancies did you make an ANC card from the local PHC?	1. Yes 2. No
3.19	How many ante-natal checkups did you have during your latest pregnancy?	1. 0 2. 1 3. 2 4. 3 5. 4 6. 5 & above
3.20	Did you have all the vaccinations (Tetanus Toxoid,	1. Tetanus Toxoid 2. Folic Acid

	folic acid and iron during pregnancy which are specified in the ANC Card in your latest pregnancy?	3. Iron tablets
3.21	Which facility did you avail during your pregnancy?	1. Private Facility 2. Government facility 3. Both 4. None
3.22	For the latest pregnancy how many USGs were done?	1. 0 2. 1 3. 2 4. 3 5. 4 & Above
3.23	For USGs did you access private or government facility?	1. Government 2. Private 3. None
3.24	Has there been any child mortality in your family?	1. Neo-Natal 2. Infant 3. Under 5 4. None
3.25	What according to you is the amount of money which you might have spent on the latest pregnancy and delivery?	1. 0-1,000 2. 1000-2000 3. 2000-4000 4. 4000-6000 5. 6000 & above
3.26	Did you get any monetary and other support from NRHM at the time of delivery?	1. Yes (specify) 2. No
3.27	Who do you think is the one who was most supportive during your pregnancies?	1. Husband 2. Mother 3. Father 4. Brother 5. Sister 6. Mother-in-Law 7. Father-in-law 8. Sister-in-law 9. Brother-in-law 10. Any other, specify
3.28	Did you ever access aganwadi during your pregnancy for any kind of facility?	1. Yes 2. No

IV Contraception & Spacing

4.1	Do you know about contraception/family planning?	1. Yes 2. No
4.2	Do you know about emergency contraception?	1. Yes 2. No

4.3	Do you use any method of family planning?	1. Yes 2. No
4.4	What method of contraception do you know about?	1. Pills 2. Emergency Contraception (I-Pill) 3. Condoms 4. Copper-T 5. Female Sterilization 6. Male Sterilization 7. Withdrawal Method 8. Injectables 9. None
4.5	What method of contraception do you use?	1. Condoms 2. Pills 3. Copper-T 4. Female Sterilization 5. Male Sterilization 6. Withdrawal Method 7. Injectable 8. Abstinence 9. None
4.6	What method of contraception according to you is convenient to use?	1. Pills 2. Condoms 3. Copper-T 4. Female Sterilization 5. Male sterilization 6. Withdrawal Method 7. Abstinence 8. None
4.7	Why have you not used any method of contraception?	1. Desired Pregnancy 2. Did not think I could become pregnant 3. Moral Reasons 4. Economic Reasons 5. Religious reasons 6. Lack of Knowledge 7. Husband does not approve 8. Fear of unknown 9. Fear of side effects 10. Actual side effects 11. Others…….
4.8	Have you ever used these methods of contraception like….?	1. Pills 2. Condoms 3. Copper-T 4. Withdrawal Method

		5. Abstinence 6. None
4.9	Where from do you get condoms, pills and injectables?	1. Government (PHC) 2. Private (Chemist)
4.10	Who gets them?	1. You 2. Your Husband 3. Relative 4. Any other
4.11	If you go to PHC for the want of contraception, will they give it to you free?	1. Yes 2. No
4.12	Have you ever been counselled for the use of contraception there (PHC)?	1. Yes 2. No
4.13	How do you plan to delay your pregnancy?	7. Pills 8. Condoms 9. Copper-T 10. Female Sterilization 11. Male sterilization 12. Withdrawal Method 13. Injectables 14. None 15. Other……
4.14	Was the latest pregnancy because of contraception failure?	1. Yes 2. No
4.15	Why do you think the method failed?	1. Improper Use 2. Forgot to Use 3. Other 4. Don't know
4.16	Were you using any fertility control when you became pregnant this time?	1. Yes 2. No
4.17	Why were you not using a fertility-control method?	1. Desired Pregnancy 2. Not having regular sexual relations 3. Did not think I could become pregnant the first time 4. Opposition from husband 5. Lack of Knowledge about the method 6. Unable to obtain a method 7. Methods are too expensive 8. Fear of side effects 9. Actual Side effects 10. Other 11. Specify…….

4.18	Who is the best person from whom to obtain information about fertility control?	1. Doctor 2. Nurse 3. Midwife 4. Traditional Birth Attendant 5. Mother 6. Teacher 7. Friend 8. Acquaintances (Other women of the village) 9. Others

V. Reproductive Health and Decision Making

5.1	Who takes the decisions regarding your reproductive health? (Going to doctor, check up, use of medicine etc)	1. Husband 2. Yourself 3. Both (Husband and Wife) 4. In-laws 5. Parents 6. Please specify
5.2	Who decided as to what number of children you can have?	1. You 2. Husband 3. Both (Husband and Wife) 4. In-laws 5. Any other
5.3	Who decided to use contraception first?	1. You 2. Your Husband 3. Both
5.4	Are you and your partner in agreement about your future reproductive intentions?	1. Yes 2. No
5.5	Does your husband support your use of a method to delay or avoid pregnancy?	1. Yes 2. No 3. Don't Know
5.6	Does your husband use any method of contraception?	1. Yes 2. No
5.7	Which method does your husband use?	1. Male Sterilization 2. Condoms 3. Withdrawal method 4. Abstinence

VI Induced Abortion

6.1	Did you ever consider inducing an abortion?	1. Yes 2. No
6.2	How many times?	1. 1 2. 2 3. 3 4. 4 5. Specify
6.3	How did you induce it?	1. Abortifacient Drugs

		2. Any other method (Please Specify)
6.4	Where did you do it?	1. Home 2. PHC 3. CHC 4. Private Facility 5. Any other (Please Specify)
6.5	Who conducted it?	1. Doctor 2. Midwife 3. ANM 4. MPHW 5. Friend 6. Relative 7. Yourself
6.6	Who got abortifacient drugs for you?	1. Yourself 2. Husband 3. Relative 4. Friend 5. Health worker (informally) 6. Any other
6.7	What was the age of the fetus?	1. One month 2. Forty days 3. Two months 4. Three months 5. Four months 6. Five months 7. Six months 8. Six & Above
6.8	What was the reason of inducing abortion?	1.Too many children 2. Young Children 2.Contraception failure 3.Income issues(poverty) 4.Any other(Please Specify)
6.9	How did you feel after having induced abortion?	1. Guilty 2. Happy 3. Relieved 4. Mixed feeling 5. Any other
6.10	Whom did you tell about inducing abortion?	1. Husband 2. Parents 3. Siblings 4. Mother-in-law 5. Other…….
6.10	Did you have D&C after induced abortion?	1. Yes 2. No
6.11	Which health facility did you access?	1. Private 2. PHC
6.12	Where from did you get the abortifacient drugs?	1. Govt. (PHC) 2. Private (Chemist)

6.13	How many times did you have USG after self-inducing abortion?	1. Once 2. Twice 3. Thrice 4. None
6.14	Once you went to the health facility, how were you treated there?	1. Routinely 2. Warmly 3. Casually 4. Any other
6.15	Did you disclose to the health facility that you had self-induced abortion?	1. Yes 2. No
6.16	How much money did you spend on one episode of abortion (INR)?	1. 500-1000 2. 1000-2000 3. 2000-4000 4. 4000-6000 5. Above 6000
6.17	Did you have infection/complication after abortion? (Hemorrhage, secondary sterility)	1.Yes 2.No
6.18	For how long did bleeding last after the abortion?	1. Few days 2. One week 3. Two weeks 4. Three weeks 5. Four weeks 6. One month 7. Two months 8. Three months 9. Three months & more
6.19	How many days of rest you got after abortion?	1. Few days 2. 1 week 3. 2- 3 weeks 4. One month 5. No rest

VII Miscarriage

7.1	Have you ever experienced miscarriage?	1. Yes 2. No
7.2	How many times?	1. Once 2. Twice 3. Thrice 4. Four times 5. Five times 6. Please Specify
7.3	What according to you was the reason for miscarriage?	1. Heavy work 2. Lack of rest 3. Fetching firewood from the forest 4. Getting water from some water source

		5. Doing agriculture labour 6. Falling off 7. Any other
7.4	What according to the doctors was the reason for miscarriage?	1. Developmental Issues 2. Heavy work
7.5	What was the age of the fetus?	1.Forty days 2.Two months 3. Three months 4.Four Months 5.Five Months 6.Six months 7. Six months & above
7.6	Which health facility did you access for D&C?	1. Private 2. PHC/CHC 3. Didn't see the doctor 4. Health Workers Home
7.7	Did you have any infection after that?	1. Yes 2. No
7.8	For how long did the bleeding last?	1. Few days 2. One week 3. Two weeks 4. Three Weeks 5. Four Weeks 6. Five weeks &more
7.9	Did you have any other complication after D&C?	1. Yes 2. No
7.10	What was the nature of complication?	1. Infection 2. Hemorrhage 3. Back and Leg pain 4. Any other
7.11	Which facility did you access for USG?	1. Private 2. Government
7.12	What was the amount of money you spent on the episode of miscarriage?	1. 0-1000 2. 1000-2000 3. 2000-4000 4. 4000-6000 5. Above 6000
7.13	What was the feeling when you miscarried?	1. Sad 2. Angry 3. Helpless 4. Relieved 5. Don't Know
7.14	Who supported you most at the time of your miscarriage?	1. Husband

		2. In-laws 3. Parents 4. None
7.15	How many days of rest you got after miscarriage?	1. Few days 2. One Week 3. Few weeks 4. One month

Summary Statement:

This Interview schedule is merely for the purpose of research. The respondents can deny or accept their participation in the process. They can decline interview at any point in time. They are willing to answer according to their comfort level and according to their will, whole of the interview or part of it. The names of the respondents will not be mentioned anywhere in the research.

Rafia Farooq

Appendix IV

Caste and Occupation profile of Village Drugmullah of District, Kupwara, J&K

S.no	Name of the Village	Caste		Occupation (Total in the mohalla)	
1.	Chailpati/Gujjarpati (97)	Dedad	47	Labourers	78
		Khari	21	Govt. Emp	15
		Chechi	7	Misc	3
		Kohli	7	Zamindari	1
		Melu	7		
		Chara	6		
		Bajad	1		
2.	Kumar Mohalla (29)	Kumar	25	Labourers	18
		Lone	3	Govt. Emp	5
		Peer	1	Butcher	3
				Business	2
				Zamindari	1
3.	Chana Mohalla (50)	Chan	20	Labourers	24
		Lone	8	Govt Emp	12
		Hajam	6	Carpenter	7
		Bhat	6	Shopkeeper	3
		Mir	4	Zamindari	2
		Ahangar	2	Barber	2
		Dar	2		
		Dhobi	1		
		Baba	1		
4.	Bandapora (114)	Bhat	42	Labourers	80

		Malik	21	Employees	36
		Lone	13	Business	3
		Najar	10	Baker	1
		Khawaja	6	Driver	1
		Dar	6		
		Mir	4		
		Dhobi	4		
		Shah	3		
		Teli	3		
		Kumar	1		
		Ganai	1		
5.	Marble Colony (81)	Mir	15	Labourers	43
		Gojree	14	Govt. Emp	19
		Peer	13	Zamindari	4
		Teli	7	Business	1
		Bhat	5	Shopkeeper	1
		Lone	4	Chowkidar	1
		Sofi	5	Tailor	1
		Magray	3		
		Dar	3		
		Sheikh	2		
		Wani	1		
		Rather	1		
		Najar	2		
		Rishi	2		
		Sheergojree	1		
		Dhobi	3		
6.	Magray Mohalla (68)	Magray	23	Labourers	23

		Khan	10	Govt.Emp	14
		Sheikh	10	Business	5
		Mir	8	Shopkeeper	5
		Lone	4	Zamindari	8
		Teli	4	Baker	3
		Dar	2	Driver	4
		Rather	1	Carpernter	1
		Bhat	8	Cook(waza)	1
				Business	2
7.	Peer Mohalla (57)	Peerzada	26	Govt. Emp	20
		Baba	13	Labourer	13
		Shah	6	Contractor	3
		Wani	5	Business	3
		Gilani	3	Imamat	3
		Bukhari	1	Driver	1
		Bhat	1	Tailor	4
		Khawaja	1	Zamidari	4
		Dar	1		
8.	Shah Mohalla (35)	Shah	34	Govt. Emp	26
		Bukhari	1	Contractor	3
				Business	2
				Zamindari	2
9.	Dhobi Mohalla (10)	Dhobi	10	Govt Emp	4
				Dhobi	3
				Labourer	2
				Driver	1

10.	Habib Bhat Mohalla (32)	Bhat	20	GE	10
		Wani	7	Labourer	10
		Shah	3	Zamindari	5
		Peer	1	Driver	2
		Khan	1	Business	1
11.	Waza Mohalla (10)	Sofi	3	Labourer	5
		Bhat	3	Employee	2
		Sheergujri	1	Waza	2
		Gojree	1	Imam	2
		Magray	1	Baker	2
		Wani	1		
12.	Doogra Mohalla (66)	Bhat	23	Labourer	15
		Dar	16	Employee	16
		Peer	15	Zamindari	13
		Lone	4	Tailor	2
		Baba	3	Baker	1
		Shah	2	Shopkeeper	1
		War	1	Driver	1
		Sofi	1		
		Dar	1		
13.	Ganai Mohalla (39)	Ganai	10	Labourer	15
		Wani	6	Employee	11
		Sheikh	5	Zamindari	4
		Khan	5	Baker	2
		Peer	9	Cook	1
		Dar	1	Chowkidar	1
		Bhat	1	Shopkeeper	1

		Lone	1	Driver	1
		Shah	1		
14.	Darzi Mohalla (29)	Darzi	7	Labourers	10
		Wani	10	GE	7
		Magray	4	Zamindari	6
		Sheikh	5		
		Bhat	2		
		Ganai	1		
15.	Sheikh Mohalla (21)	Shiekh	20	Labourers	8
		Ganai	1	GE	5
				Driver	3
				Baker	4
				Zamindari	1 (21)
16.	Satar Bhat Mohalla (27)	Bhat	11	Labourers	15
		Shah	5	GE	8
		Lone	4	Employee	8
		Dhobi	2	Driver	3
		Dar	4	Business	1
		Hajam	1	Shopkeeper	1
				Baker	1
				Imamat	1
				Tailor	1
17.	Aram Mohalla (53)	Sofi	28	Employee	15
		War	17	Labourers	13
		Ganai	5	Zamindari	12
		Khan	2	Shopkeeper	1

		Mir	1		
18.	Nab Shah Mohalla (38)	Shah	20	Employee	10
		Khan	7	Business	4
		Mir	7	Zamindari	6
		Dhobi	2	Shopkeeper	2
		Dar	2	Driver	2
				Laborer	1
19.	Gulshan Qasmi (32)	Shah	14	Employee	18
		Bhat	2	Business	4
		Lone	2	Labour	3
		Wani	2	Tailor	2
		Malik	2	Imamat	2
		Peer	5	Zamindari	1
		Dar	4	Shopkeeper	1
		Beigh	1		
20.	Chohan Mohalla (14)	Chohan	12	Labourers	9
		Najar	2	Employees	3
				Carpenter	1
21.	Chana Mohalla,Gund (14)	Najar	14	Carpenter	7
				Labourer	5
				Employees	3
22.	Pehl Mohalla(24)	Chohan	17	Employee	12
		Wani	6	Labourers	6
		Najar	1	Zamindari	4
				Shopkeeper	1

				Hamal	1
23.	Gund Rather Mohalla (66)	Rather	43	Zamindari	29
		Sheikh	9	Employee	19
		Roshangar	5	Labourers	13
		Malik	2	Contractor	1
		Chohan	1	Carpenter	1
		Ganai	1	Tailor	1
		Bhat	5	Barber	2
24.	Gori Mohalla, Khar Gund (19)	Gojree	12	Zamindari	7
		Rather	4	Labourers	6
		Sheergojree	2	Employee	2
		Peer	1	Shopkeeper	1
				Contractor	1
25.	Wani Mohalla, Faqirpora (11)	Wani	11	Employee	6
				Shopkeeper	2
				Zamindari	1
				Business	1
				Labourer	1
26.	Peer Mohalla,Faqirpora 46)	Peer	34	Employee	16
		Wani	8	Labourer	10
		Bhat	2	Zamidari	4
		Sheikh	1	Business	4
		Mir	1	Contractor	2
				Shopkeeper	2
				Imam	1

27.	Lone Mohalla,Faqir Pora (8)	Lone	8	Employee	5
				Zamindari	1
28.	Mir Mohalla,Faqirpora (13)	Mir	10	Shopkeeper	4
		Lone	3	Employee	3
				Labourers	3
				Zamindari	1
29.	Khalid Abad (17)	Shah	9	Employee	8
		Ganai	2	Business	3
		Sofi	1	Labourers	3
		Magray	1	Zamindari	1
		Dar	1		
		Khan	1		
		Dar	1		
		Wani	1		
30 .	Faqirpora (5)	Sheikh	2	Employee	2
		Mir	1	Shopkeeper	1
		Shah	1		
		Wani	1		
31.	Khar Gun, Dal (16)	Sheikh	7	Employee	3
		Doom	4	Zamindari	3
		Bukhari	2	Labourer	1
		Gazi	1		
		Teli	1		
		Ganai	1		
32.	Moomin Abad (8)	Doom	3	Zamindari	5

		Bisati	2	Business	2
		Peer	1	Labourer	1
		Ganai	1	Employment	1
		Sheikh	1		
33.	Matipora (95)	Shah Faqir	32	Zamindari	51
		Dar	27	Labourer	18
		Shah	15	Employee	24
		Mir	7	Driver	9
		Dhobi	5	Shopkeeper	3
		Tantray	4	Conductor	1
		Darzi	2		
		Wani	2		
		Doom	1		

Total Labourers =431; Total Employee=374; Zamindari 177.The data was collected from the revenue records of year-2009 extracted from the Office of Tehsildar of Drugmullah.