

AN OVERVIEW OF ABORTION CARE AND LOCAL HEALTH GOVERNMENT INSTITUTIONS –FACTS AND GAPS ON THE GROUND: A CASE STUDY OF A RURAL TELANGANA

Sudha

Doctorate Scholar, Centre for Women Studies, University of Hyderabad,
Hyderabad, Telangana, India
Email - sudhaworld@gmail.com

Abstract: *The present paper had looked at all the latest policy level development on Comprehensive Abortion Care (CAC) and provisions under it. The paper has illustrated the social mapping done to track various health institutions- public/private/informal/individual practitioners –inside or outside the village visited by the local women for abortion care. The description of the local discourse had with the various stakeholders in the rural region who discussed ‘abortion’ as notion and abortion services dispensed at their facility area. It was observed that medical practitioners from the village and private nursing homes where the local women visit the most for abortion care were more reserves to talk on the topic of abortion and remained mostly silent on it. The study had criticized the existing health system for not being there in favour of women and had reflected the poor health status of rural women in the region where the trend of need for abortion care for rural women are still not too much recognized till date and totally under the private health sector with no guarantee of quality health care and women were subjected to bear the high cost for abortion service.*

Key Words: *Unwanted Pregnancy, Abortion, Public Health System, Abortion Care.*

1. INTRODUCTION:

The present paper is a field study based on women narratives on unwanted pregnancy and abortion care which was conducted in a single village namely Laxmipur (name changed) during the period of 2015- 2017 of Sangareddy district (recently merged into this district, previously located in one of the most backward district of Telangana state). The study has illustrated the social mapping done to track various health institutions- public/private/informal/individual practitioners –inside or outside the village visited by the local women for abortion care. The description of the local discourse with the various stakeholders in the rural region who discussed ‘abortion’ as a notion and about the abortion services dispensed at their facility area. It was observed that medical practitioners from the village and private nursing homes where the local women visit the most for abortion care were more reserve to talk on the topic of abortion and remained mostly silent on it. The study also had interfaced with the local medical practitioners and about their community relations. The study had made an attempt to criticized the existing health system for not being there in favor of women and had reflected the poor health status of rural women in the region where the trend of need for abortion care for rural women are still not too much recognized till date.

2. METHODOLOGY:

This study is a case study on a single village selected from Sangareddy district of Rural Telangana region. This study has collected primary data to know about women questions of those who experienced unwanted pregnancies¹ and abortions for it, in the narrative forms which served the research purpose in questioning the existing health system on abortion care. In-depth Interview was the key research technique used to collect women narratives, interviews with health personnel, other techniques were used as focus group discussions, informal interactions and meetings with the local village community.

Key Area of the Research Question:

To look at the abortion issue with the stakeholders at various health institutions levels in the region in connection with the latest policy level development on comprehensive abortion care (CAC) and provisions under it. Also, have discussions on the local discourses about ‘abortion’ as notion and abortion services dispensed at their facility area with the various stakeholders in the rural region

¹ Women participants who in the past had conceived where they did not want to continue their pregnancies due to any of their individual choices, social and economic reasons or any other reasons other than the medical /therapeutic reasons to terminate the pregnancy

QUESTIONING ABORTION CARE IN GOVERNMENT HEALTH INSTITUTIONS :

During the study a research inquiry was carried out on the Indian state role on access of abortion services at the doorstep of rural women. At the ground level there was no abortion care program was existed in the government institutions at a grassroots level which was witnessed in the social interaction with government stakeholders – Anganwadi workers, ASHA workers, Auxiliary Midwifery (ANM) and Medical Officer at Primary Health Centre. Only in the very recent times from 2018 onwards, the government of India had started mentioning about the Comprehensive Abortion Care (CAC) under RMNCA under National Rural Health Mission. But still no imprints of the Comprehensive Abortion Care (CAC) implementation found in the study region.

3. LITERATURE REVIEW:

New Findings on Abortions Statistics in India

The research paper published in The Lancet Global Health, Susheela Singh et al (2018: e111) had estimated that 15.6 million abortions (14.1 million–17.3 million) occurred in India in 2015. Out of these, 11.5 million took place outside health facilities. According to the ministry of health and family welfare, abortion deaths constitute 8% of all maternal deaths per year in India. In this study estimated the abortion rate was 47.0 abortions (42.2–52.1) per 1000 women aged 15–49 years. Whereas 3.4 million abortions (22%) were obtained in health facilities, 11.5 million (73%) abortions were medication abortions done outside of health facilities, and 0.8 million (5%) abortions were done outside of health facilities using methods other than medication abortion. Overall, 12.7 million (81%) abortions were medication abortions, 2.2 million (14%) abortions were surgical, and 0.8 million (5%) abortions were done through other methods that were probably unsafe. We estimated 48.1 million pregnancies, a rate of 144.7 pregnancies per 1000 women aged 15–49 years, and a rate of 70.1 unintended pregnancies per 1000 women aged 15–49 years. Abortions accounted for one-third of all pregnancies, and nearly half of pregnancies were unintended.

National abortion incidence was estimated through three separate components: abortions (medication and surgical) in facilities (including the private sector, public sector, and non-governmental organizations [NGOs]); medication abortions outside facilities; and abortions outside of facilities and with methods other than medication abortion. Facility-based abortions were estimated from the 2015 Health Facilities Survey of 4001 public and private health facilities in six Indian states (Assam, Bihar, Gujarat, Madhya Pradesh, Tamil Nadu and Uttar Pradesh) and from NGO clinic data. National medication abortion drug sales and distribution data were obtained from IMS Health and six principal NGOs (DKT International, Marie Stopes International, Population Services International, World Health Partners, Parivar Seva Santha, and Janani). The study had recommended that health facilities can have a greater role in abortion service provision and provide quality care. Interventions are needed to expand access to abortion services through better equipping existing facilities, ensuring adequate and continuous supplies of medication abortion drugs, and by increasing the number of trained providers. Research is needed to test interventions that improve knowledge and practice in providing medication abortion and the Indian Government at the national and state-level needs to priorities improving policies and practice to increase access to comprehensive abortion care and quality contraceptive services that prevent unintended pregnancy (ibid; 2018)

In a response to this report published in Lancet Global Health Medical Journal mentions about 1.56 crores abortions took place across India in 2015, the Ministry of Health and Family Welfare (Jan 5, 2018) had released a press report on briefing Indian government program on Abortion care. In this press note presented by then Minister of State (Health and Family Welfare), Ashwini Kumar Choubey stated in a written reply in the Lok Sabha on dated 5 January 2005 that ‘The government provides safe and comprehensive abortion care (CAC) services to women in health facilities. All efforts have been made to provide CAC services in health facilities. Provision of comprehensive safe abortion care services is an important component of RMNCH+A program under Govt. of India’. Also stated that National Health Mission (NHM) provides support to the states for provision of services for comprehensive abortion in the following ways:

- Guidelines on Comprehensive Abortion care services and Medical Methods of Abortions (MMA) have been provided to all the States in the country to facilitate the implementation of these services.
- Provision of comprehensive safe abortion services at public health facilities including 24*7 PHCs/ FRUs (DHs/SDHs /CHCs).
- Provision of funds to States/ UTs for operationalization of safe abortion services at health facilities including procurement of equipment and drugs for medical abortion.
- Capacity Building of Medical officers in Safe Abortion Techniques and of ANMs, ASHAs and other field level functionaries to provide confidential counseling for safe abortion and promote post-abortion care including the adoption of contraception.
- Certification of private and NGO sector facilities to provide quality Comprehensive abortion care services.
- Supply of Nischay Pregnancy detection kits to sub-centers for early detection of pregnancy.

- Provision of Funds to States to plan and implement comprehensive “Information Education & Communication/ Behaviour Change Communication (IEC/BCC)” activities for maternal health including safe abortion care
- Orientation/Training of ASHAs to equip them with skills to create awareness on Comprehensive abortion care issues in women in the community and facilitate women in accessing services.
- Under the Family Planning programme for post abortion cases, steps have been taken to increase the basket of choices of contraceptive services and family planning counselling services to the beneficiaries.

Guidance for Implementation of the MTP Act for State and District Authorities²

Provisions under the MTP Act, Rules, and Regulations for Compliance, the Government of India is committed to ensuring access to CAC for women as part of the Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) initiative under the National Health Mission (NHM). The MTP Act enacted in 1971 and as amended in 2002; the MTP Rules, 2003; and the MTP Regulations, 2003 govern the provision of abortions or MTP in India. The MTP Act and the Rules and Regulations framed there under provide an ambit under which legal abortion services can be provided up to 20 weeks of pregnancy

Conditions under which a pregnancy may be terminated - Key Provisions The MTP Act allows for termination of pregnancy on a broad range of conditions: Continuation of the pregnancy would involve a risk to the life of the pregnant woman or it may cause grave injury to her physical or mental health; Substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities; 1 Pregnancy is caused by rape (presumed to constitute a grave injury to mental health); Pregnancy is caused due to failure of contraceptive in a married woman or her husband (presumed to constitute grave injury to mental health). Sex selection is not a legal ground for terminating a pregnancy. The provider/s must ensure that the ground for termination is clearly stated in the opinion form. The opinion of the provider is adequate to certify ground/s for providing abortion service.

Place where pregnancy may be terminated - Hospital established or maintained by the Government or a place approved by the Government or the District Level Committee (DLC) headed by the Chief Medical Officer (CMO) or District Health Officer (DHO). As per the National CAC Guidelines, pregnancy may be terminated at Government facilities up to Eight weeks of gestation at Primary Health Centre (PHC); 12 weeks of gestation at Community Health Centre (CHC) or 24x7 PHC; 20 weeks of gestation at District Hospital and above facilities. The DLC may approve a (private) place to conduct: Terminations up to 12 weeks; or Terminations up to 20 weeks

Who can terminate a pregnancy - Medical termination of pregnancy can be legally provided only by a ‘registered medical practitioner’ (RMP) – a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a State Medical Register and who has one or more of the following experience or training in gynecology and obstetrics: 1. In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, with experience in the practice of gynaecology and obstetrics for a period not less than three years. 2. In the case of a medical practitioner, who was registered in a State Medical Register after the commencement of the Act and: a. Has completed six months of house surgery in gynaecology and obstetrics; or b. Has experience in any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or c. Holds a post-graduate degree or diploma in gynaecology and obstetrics; or d. Has assisted an RMP in the performance of 25 cases of MTP of which at least five have been performed independently, in a hospital established or maintained by the Government, or a training institute approved for this purpose by the Government.

Medical Methods of Abortion (MMA) from Unapproved Facilities - In case of termination of an early pregnancy up to seven weeks using a combination of mifepristone with misoprostol, the RMP can prescribe the drugs at his/her the clinic provided he/she has access to a place approved for terminating the pregnancy under the MTP Act. An RMP can prescribe MMA at a clinic that does not have the approval from the DLC only when s/he has displayed a certificate reflecting access to a certified place, issued by the owner of such place. MMA must be available in public health facilities as prescribed in the RMNCH+A framework.

Site Approval – A private site has to be approved by the District Level Committee (DLC) for providing MTP services. There are separate requirements for approval for first and second-trimester abortion services. [MTP Act: Section 4 (b) and Rule 5]The certificate of approval by the DLC needs to be conspicuously displayed at the site to be easily visible to persons visiting the place. [Rule 5 (7)] Public sector sites do not need separate approval for providing MTP services. [MTP Act: Section 4 (a)] [MTP Act allows the provision of medical methods of abortion (MMA) up to seven weeks of pregnancy at an unapproved site provided it has access/referral linkages to an MTP approved site. For the purpose of access, the RMP should display a certificate to this effect from the owner of the approved site. (Rule 5

²Women who had conceived in the past and later do not want to continue their pregnancies due to any their individual choices, social and economic reasons or for any other reasons except the medical.

Explanation)] MTP site approval does not need renewal unless the Chief Medical Officer (CMO), upon inspection, has a reason to believe that the facilities are not properly maintained and procedures are not conducted under safe and hygienic conditions, and the DLC suspends or cancels the site's approval. [Rule 7 (1)

Consent - The woman has to be counselled and her consent received in Form C prior to the procedure, as specified in the MTP Act: Section 3 (4) and Rule 9. Written consent has to be obtained in Form G for invasive procedures such as amniocentesis and the 'declaration of pregnant woman' contained in Form F (Section D) has to be signed for non-invasive procedures such as USG. [Rule 10]

Latest Review on the Amendment to the Medical Termination of Pregnancy (MTP) Act 1971

On a recent development on this issue a parliamentary panel meeting dated 13 February 2018 held on the amendment to the Medical Termination of Pregnancy (MTP) Act 1971, Sharma, Neetu Chandra (2018) had reported that the committee strongly recommends the government to amend the MTP Act, 1971 to remove the weak spots and raise the permissible period of abortions to 24 weeks with this bar not applying to unborn babies having serious abnormalities. The members of the committee also supported to remove the 'married' word so that anyone can get an abortion without having to depend on sham clinics as a last recourse. The committee noted that awareness about abortion is very low and about 80% of women do not know that abortion is legal in India, leading to widespread dependence on illegal service providers for termination of unwanted pregnancies. In changing times, our laws should also be modified accordingly," said Suneeta Mittal, director, and head, obstetrics and gynaecology at Fortis Memorial Research Institute in Gurugram. Mittal, who was also a consultant on the panel drafting the MTP Act, added that for terminating a pregnancy, a woman doesn't need her husband's consent. She stated that women should be given equal reproductive rights. Many women are divorced, single or, in a live-in relationship. If they are living independently, they should also get freedom and an independent stance for taking a decision whether they want to deliver a baby or not. The panel report said poor women and girls are not only deprived of basic sexual and reproductive health in general as they do not possess the decision-making power to deliver a baby or maintain a time gap between pregnancies, but they also have little access to safe abortion services. The committee underscored this as the prime reason for the high percentage of abortion deaths in India. The committee also recommended that the family planning programmes should spread awareness about the legal validity of the process, campaign extensively about safe abortion services available in government facilities, and that the government should also come down hard on illegal abortion clinics mushrooming in every nook and corner of society.

4. CASE NARRATIVE ON TRACING COMPREHENSIVE ABORTION CARE (CAC) PROGRAM IN RURAL TELANGANA :

For this study, an exercise of social mapping was done at the village level in order to locate where the local women go for abortions when experienced with unwanted pregnancies. For this, an attempt was made to trace the whole structure of the local health care system which was in place both formally and informally. The purpose was to enlist all those existed institutions which were found to be catering to the rural women needs on abortion matters. It was important to know about them by their geographical locations and the category of the institutional settings whether it was a private or informal health care providers or state-based health infrastructure units in this rural region. For this, both formal and informal health care providers of abortion services were identified at the village and the regional level. The purpose was to question the credibility of these institutions for their role in the provisions of abortion care for the local women and where do they stand whether at par with meeting the set parameters drawn under the abortion law of the country. Also to interface how the ground reality had surfaced in this rural region and its critical relations with the local rural women seeking abortion care. The study had criticized the existing health system for not being there in favour of women and had reflected the poor health status of rural women in the region where the trend of need for abortion care for rural women are still not too much recognized till date.

Anganwadi and Sub Health Centres - As an Embodiment of State Health Machinery at Village Level

The Government health institutions here are referred to all health initiatives by the Government of Telangana which either sponsored by the central or state-based health programs focused on women with special reference to the sexual and reproductive health programs. For this all the government functional units in Laxmipur village-like four Anganwadi centres and one Village Health Centre were mapped out and had formally met with all office bearers of these health institutions at a village level. The four Anganwadi workers of their Centres who were catering to the allotted number of households specific to their caste and religion locations like Scheduled caste- Madiga, Mala,/ Schedule Tribes - Lambada /OBC- Mudiraj, Yadav, Padmashali, and others,/Minorities - Muslims, Christians / Other Castes- Reddi and General Population – other locals from the nearby villages and migrants from other states

Anganwadi Workers – as key stakeholder in government health structure

The Anganwadi Centres which subsequently became the entry points to interface with a large number of local village women in the initial stage of the fieldwork. The initial five months of the fieldwork was spent on visiting the local Anganwadi centres and interact with all-local Anganwadi teachers and women helpers working at these centres. The initiative was to gather information on the issue of abortion incidences in this village which subsequently led to reach those women who had the real incidences of abortion in their past lives. The Anganwadi centres were located in different caste localities and had personally approached four local Anganwadi workers at their centres located in different locations and talked to them about the stories of the women who had gone for abortion due to unwanted and unplanned pregnancies. It was informed that on an average 20-26 pregnancies are registered each year and out of this 1-2 abortion are spontaneous abortion and 1-2 abortion is induced (majorly on medical grounds due to abnormality). It was an impression made that only those women had registered their pregnancies here at the health centre who wanted to utilize the benefits of pregnancy/maternity care services- immunization/nutrition diet items/regular Ante-Natal Care checkups and free cost delivery and later postnatal care. Anganwadi Worker had refused that no women visit to their centre to seek an abortion. Very rarely comes such cases and did not remember in their recent memory that any women visited them for pregnancies termination. It was mentioned by one Anganwadi worker that doctor from the local BBL hospital gives medicines for abortion. On approaching the same local doctor where he denied by stating that we had never given any medicine for abortion purpose which contradicts to the statement given by the local women at these centres told that BBL hospital doctor gives tablets for abortion.

Local ASHA³ Workers Stakes on the Incidences of Abortion in Village

All Anganwadi workers and ASHA workers of the village were identified as key informant as they were evident to be in continuous touch with local women and keep track record of all pregnancies of household wise. They are mainly appointed under the government program for maternal and child health who were involved in the process of identifying newly pregnant women and do their registrations at the local health centre afterward all registered women then become beneficiaries to get health services and maternal care.

Salma (ASHA Worker) a Key Informant Given Insider View on Abortion

Salma (name changed) was the senior-most ASHA worker of the village. Her appointment was done since the inception of the ASHA under the NRHM was implemented at the village level in 2007. She had given good insight into the abortion matters with women in the village. It was said that in her last eleven years of work experience she had come across roughly thirty-forty cases of women who had gone for abortion for unwanted pregnancy. On asking whether these women were married or unmarried, she nodded her head by saying obviously they were all married and at the same time denied for any incident for abortion in case of unmarried women. She had given a general statement that most women did go for abortion after they already had one child or two children and insisted on women goes for abortion only after getting approval from their husbands. Both husband and wife have to agree and it's to be the wish of both going for an abortion decision. She stated, "*aurtien apne aap nahi jaati hain*" (women do not go by themselves). In the context of Muslim women in particular stated by her that abortion is not practiced among Muslim women here. It is not allowed in Islam. She stated, "*aurtein husbad se dur rehne ke liye family planning apna sakti hai par abortion nahi*

³ Accredited Social Health Activists (ASHA) for the first time was recruited under the Government of India launched National Rural Health Mission (NRHM) in April 2005 to address the health needs of rural population, especially the vulnerable section of the society. The purpose for as the sub-centre which is the peripheral level of contact with the community under the public health infrastructure caters to a large population of 5000. The Auxiliary Nurse Midwives (ANM)³ is overworked, which impacts upon outreach services in rural areas. To complement the work of ANM, ASHA is selected through a selection process to fill the gaps in the health care delivery system. The ASHA is appointed to take steps to create awareness and provide information to the community on health. ASHA will mobilize the community and facilitate them in accessing health and its related services available at the Anganwadi/Sub-center/primary health centers. ASHA will also provide primary medical care for minor ailments such as diarrhea, fever, and first aid for minor injuries, work as provider of DOTS under RNTCP. She will also act as depot holder for essential provisions which will be made available to every habitation. ASHAs must primarily be women residents of the village that they have been selected to serve, who are likely to remain in that village for the foreseeable future. ASHAs must have Class VIII education or higher, preferably be between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, a semi-literate woman with a formal education lower than eighth standard, may be selected. (The Hans India, October 25, 2015). Although ASHAs are considered volunteers, they receive outcome-based remuneration and financial compensation for training days. For example, if an ASHA facilitates an institutional delivery she receives Rs 600 and the mother receives Rs 1,400. ASHAs also receive Rs 150 for each child completing an immunization session and Rs 150 for each individual who undergoes family planning. Telangana is the only State paying an honorarium of Rs 6,000 to Accredited Social Health Activists (ASHA) workers. ASHA workers, who rendered health services on the field for a salary of Rs. 1,000 to Rs. 1500 per month, had been enhanced to Rs. 6,000 per month from May 2017 onwards. In the state as per estimation 7,045 ASHA workers had been appointed in the State and they were given 23 days training with the intention to provide best medical services in rural areas under the guidelines of National Health Mission (NHM). (Telangana Today, 28 October 2017).

kara sakti, ye islam mein mana hai. Aurtein karna bhi chahe wo nahi kara sakti” (Women may take precaution to avoid pregnancy but can't do abortion as it is not allowed in Islam. Even if a woman wishes to go for an abortion she can't). She said that family size among Muslim household ranges from 3-10 children. She was mentioning a case where a Muslim woman had delivered a sixth child but not ready for family planning operation. Ironically the ASHA worker too being from a Muslim community and worked in this field for almost one decade were observed with speculation as later there were more Muslim women found in the village who go for an abortion for unwanted pregnancies.

It was observed that ASHA workers got little reluctant to share anything on abortion matters of the village and later denied to interact on this issue. They had expressed that if anything committed from their side would unnecessarily put them into some trouble. Also, the rigorous research inquiry on abortion stories from the village and following up with them had bothered them like doing any kind of inquiry of their work or like any official in disguised had visited them with the agenda of doing inspection in their duty area. Due to the nature of the research work on abortion which has legal angles also made these workers suspicious or put them in doubt whether their involvement in the research work may risk their job so they pretended for not to be in a position to help in anyways by stating that 'it is up to the women or their family where do they want to go for abortion as it is the personal matter for them. They do not come to us for the purpose of abortion medication. Only those pregnant women come to us who wants to take free facilities of the government schemes for pregnant mothers and free delivery at the government hospital. And this our job to maintain all health records of such pregnant women, follow up visit with them for Ante Natal Care(ANC)- immunization, regular health checkups every month during health day, and take them to PHC for scanning and later for their institutional delivery purpose.

Government Machinery-on the Registration of Pregnant mothers vs. Abortion Care

The issues of abortion due to unwanted pregnancies were found totally out of the purview of government health institutions. The three-tier structure of the state health system was found entirely focused on handling the institutional delivery cases where normal delivery cases were taken to PHC, the high-risk pregnant women were either taken Area Hospital in Narsapur or at the District Hospital totally depends on the nature of risk involved in the delivery cases. It was found at a ground level that Sub Health Centre at Village level where ANM, ASHA, and Anganwadi Workers were dealing with local village women on their pregnancies matters, but did not want to talk about the abortion incidences taking place in the village outside of their registration records. Totally the focus was on the newly identified pregnant women and attending regular follow-ups with them and taking them to have institutional delivery at the government institutions. Local health centre records only done therapeutic abortion done for the registered pregnant women Local ASHA worker do not refer women for doing abortion in government hospitals as it involves lot of legal process and late in delivering the timely medical services women need for abortion Regularization and controlling women bodies- women(married) entity are justified for giving birth of two legitimate children and targeting them for undergoing female sterilization. In contradiction women doing abortion due to unwanted pregnancy was considered very private to women by the government senior health officials and according to them that 's why they go to private doctors or take medicine to terminate the pregnancy The perception of women doing abortion after the sex determination test is highly prevailed and restrict the approach of women doing abortion for other reasons and sometime prevent women to have abortion in time.

District Health Department on 'abortion and rural women'

The Primary Health Centre located at the distance of 7 KM away at the Mandal level where Women Medical Officer and other staff were deputed by the health department of the district and doing the job of Implementation and monitoring of Family Health Welfare Program. Under the Government health institution the Primary Health Centres at Mandal or subdivision level located at Domadgu and Jinnaram subdivisions, Community Health Hospital at Zonal level located at Narsapur and General Hospital at the District level located at Sangareddy Headquarter

Lack of Abortion care in Government Health Institutions

In an interview with the Medical Officer stated that 'we do have the only medical facility for the 'babies' delivery and do not have any provisions for abortion care services at the PHC level'. And for the question whether any records are maintained at the PHC level on abortion for which she had completely denied. Also, it was observed that there was no mention of any record/prescribed forms related to abortion. in a training held at PHC level with ASHA and ANM health workers on the health record maintenance. The medical officer told that 'we take the cognizance of only those abortion incidences where women are advised to abort the pregnancy on the medical grounds such as the development of abnormalities in the growth of the fetus or if carrying the pregnancy further risks the life of the mother or in case of miscarriages only. Follow up for such cases are done only for those pregnant women who have themselves initially registered at the sub-centre of the village either directly by the ANM or through ASHA workers during their home visits to identify newly pregnant mothers to avail the provisions of Ante Natal Care (ANC) and Pre Natal Care at the Sub

Centre/ local Anganwadi Centre/ Primary Health Centre (PHC)/ Community Health Centre (CHC) /Area Hospital/General Hospital at district level. Mostly such cases come in our notices only after the third month of pregnancy onward to nine months or in case of registered women had miscarriages naturally. All such cases are referred to the Community Health Centre (CHC) at subdivision level at Narsapur and General Hospital at Sangareddy at the district level.

It was very clear from the statements made by the Medical Officer that there was no state machinery to reach out to those women who do not want to continue their pregnancy for the various social reason and in need of abortion care. There was no establishment of abortion care service provisions at the government health infrastructure at Primary health level and also the Medical Officer did not provide any clarity on the subject of women seeking for abortion for non-medical reasons due to unwanted pregnancy within the government health sector. So without any doubt it can be presumed that due to non-availability of health care services required by women for the abortion at the government health institution premises they were compelled to visit such private health clinics who were giving substandard quality of health care and could be more chances of running such private clinics illegally or even in case not registered with the government agencies or non renewal of the license as per rule. This was also coming out from the women narratives who had visited such private health clinics as they had abortion care services at the cost which a woman or woman's family can afford in comparison to the other Nursing homes or Big Hospitals charging the high fees for availing abortion.

Absolutely there was complete silence on the subject of 'abortion due to unwanted pregnancy' from the sides of health officials at PHC level and grassroots health workers at the village level and unmet the abortion needs of women/couples or women's family living in this part of the rural region by the public health sector in contradictory to their national agenda of pro family planning approach and free access to abortion care under the legislation of Abortion law. Under such circumstances women in need of abortion care had limited options and only left to visit the Private health clinics wherever the abortion services were available. In the of absence of such proactive abortion care program within the outreach of rural women with unwanted pregnancy situations got more marginalized and pushed them sometimes in a more impoverished state for example - if the spouse behave in non cooperative manner or women living in abusive relationship wants to abort unwanted pregnancy or due to loss of job or poor economical conditions or poverty do not want bear the pregnancy further or its against the women wish to continue the unwanted pregnancy or the couple take decision to abort the pregnancy for any other reasons etc.

5. CONCLUSION : Intentionally Women Made Invisible for their Abortion Need

In the lack of appropriate health institutions for abortion care and non-existent of the free discourse on women needs of abortion care had made women invisible going for abortion due to unwanted pregnancies. Consequently in many ways had pushed women to be mostly at the receiving ends on facing the situations of unwanted pregnancies and women found to be more vulnerable in performing their sexual and reproductive roles in a patriarchal ideology based dominated society and had faced domestic and sexual violence on the other end. Also very subtly the revelation made about how the local rural women were subjected to the risks of unsafe abortion when approached to the unauthorized health institutions and more chances of attended by the untrained medical practitioners or using out dated invasive abortion technology.

The belief system of women going for abortion in secrecy, again and again, sustaining to get normalized in the mainstream discourse of abortion and becoming very easy to be unnoticeable and unrecorded before the government health institutions which actually had undermined the women entitlement for the abortion care. In the poor visibility of any government infrastructure on abortion care had boosted the private health sector in taking a lead for the provisions of abortion care without meeting any benchmark for giving quality abortion care. Rather the abortion cost for the services in the private health sector had added more burdens economically on women in facing the situational need for abortion care due to unwanted pregnancy and bear the cost.

REFERENCES:

1. Ministry of health and family welfare (2018). Abortions, Press Information Bureau, Government of India. January. <http://pib.nic.in/newsite/PrintRelease.aspx?relid=175379>
2. Ministry of Health and Welfare, Government of India (February 2015). Guidance: Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection. February. 7-11, 23.
3. Sharma, Neetu Chandra, (2018). Parliamentary panel suggests abortions be allowed till 24 weeks of pregnancy, 2 min read. 13 February. <https://www.livemint.com/>
4. Singh, S., Shekhar, C., Acharya, R., Moore, A. M., Stillman, M., Pradhan, M. R., ... & Sundaram, A. (2018). The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*, 6(1), e111-e120.
5. *TelanganaToday* (2017).Telangana has 27,045 ASHA workers. 28th Oct. <https://telanganatoday.com/telangana-has-27045-asha-worker>